Improving Teamwork, Staffing Adequacy, and Transparency to Reach High Reliability

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Samaritan Medical Center is a 294-bed not-for-profit hospital in Northern New York, providing a full range of advanced inpatient, surgical and outpatient procedures for the entire Northern New York area. In addition, there is a 42-bed emergency department that sees over 50,000 patients per year. Samaritan Medical Center is also unique in that it serves the medical needs of both the civilian and military communities. Fort Drum is a large military base with close to 40,000 active duty military and dependents. Fort Drum does not have a hospital on base, allowing Samaritan Medical Center the privilege of providing much of their medical needs.[1]

In August 2013, Samaritan Medical Center underwent extensive restructuring that impacted many areas of the organization. Although several ancillary departments were affected, there was no question the nursing division faced the most challenges as a result of these changes. Following this restructuring, it became clear that there was a need for better communication, increased transparency, and improved teamwork, with an opportunity to do this in a more efficient manner. There was also a general lack of trust in leadership and fear among many employees as a result. By implementing a forum in which staff can speak openly about their concerns, we have been able to accomplish this increased transparency, better communication throughout the organization, and improved efficiency around operations. There is more trust in leadership, and staff are able to share concerns openly without fear.

PATIENT SAFETY HOUR

At Samaritan Medical Center, our goal is to become a highly reliable organization, empowering a safety culture that relies on transparency to prevent error. In order to improve transparency and empower our staff to share their safety concerns, we introduced the patient safety hour, a 1-hour dedicated time period focused on patient safety every day. The hour begins with a 15-minute daily safety call in which specific areas in the organization are given the opportunity to share patient safety concerns—past, present, and future. The charge nurse on a nursing unit (or equivalent staff member in the ancillary departments) provides a brief report on census, staffing, and safety concerns each day. A group of leaders in the organization, the core team, participates to identify needs and determine how to provide just-in-time support. Everyone in the organization is invited to listen to the daily safety call to encourage house-wide transparency.

The daily safety call is followed by 30-minute safety rounds, in which the core team discusses the issues presented and determines what immediate support and resolution are appropriate, or if more long-term interventions are required. For issues that require immediate attention, members of the core team are assigned to round in those areas to resolve issues promptly. Also during this time, a representative from the staffing office is present to prioritize and address any staffing issues that were presented on the call.

After all immediate issues are resolved, there is a 15-minute post-rounds huddle. During this time, the core team discusses the issues that were resolved during safety rounds. Learning opportunities are also considered in an effort to prevent recurrent issues and facilitate resolution in the future. When immediate resolution is not possible, plans for short-term and long-term actions are established. In order to close the loop on issues that were identified, all issues resolved or plans for resolution are discussed at the beginning of the call the following day along with any incidents reported over the previous 24 hours.

HIGH-RELIABILITY ORGANIZATIONS

High-reliability organizations are those that are exceptionally consistent in accomplishing their goals and achieving a high degree of safety within an environment in which error can lead to catastrophic consequences.[2] The purpose of this article is to demonstrate that by improving teamwork, staffing adequacy, and transparency, hospitals can move 1 step closer to becoming a high-reliability organization. There is significant empirical evidence that suggests that all 3 of these important elements correlate with high reliability.[2–9]

TEAMWORK

Baker et al.[3] suggest that without members who are able to effectively and efficiently coordinate their activities, organizations will not achieve high reliability. Hospitals are considered hypercomplex organizations. This means there are a great variety of components, systems, and levels, all of which have their own moving parts. Thus, individuals, disciplines, and departments must coordinate effectively and efficiently in order to provide safe, high-quality care.

Prior to implementing the patient safety hour, Samaritan Medical Center's patient care services division had a daily bed huddle that involved charge nurses from each clinical unit reporting their current bed status (i.e., number of occupied beds, total number of definite or potential discharges, and expected admissions from the emergency department and post-anesthesia care unit), as well as their current staffing (i.e., whether or not they were staffed to the number of occupied beds). This was an excellent introduction to teamwork revolving around staffing and bed availability among the nursing units. The patient safety hour expands on the basic components of the bed huddle, while including staff from ancillary departments and incorporating a team of leaders to work with unit staff for rapid resolution. Not only have we been able to better understand the connection between staffing and patient safety, but our nurse managers, charge nurses, and ancillary departments have also been able to help each other mobilize resources to those areas in need.

The patient safety hour has allowed us to quickly coordinate units and departments, with many disciplines working together to find different types of equipment to keep our patients safe. Need for anything from infusion pumps to bariatric beds, pull-away alarms to sequential compression devices has been reported on the daily safety call. For example, Samaritan Medical Center's alternate level of care (ALC) unit for patients awaiting nursing home placement has several patients with dementia or those who are considered a "wander risk." As a precautionary measure, these patients wear a device that will set off an alarm if they leave the unit. At a time in which a large proportion of these patients were considered a wander risk, several of these devices were missing. The ALC charge nurse brought this concern up on the daily safety call. Prior to concluding this call, the laundry department reported that they would search for the devices in returned linen. After the call, 2 leaders immediately searched several areas but reported at the post-rounds huddle that none were found. At this time, there was a recommendation from the core team to take a photo of the device and e-mail it to all employees, asking whether they have seen any and to please return them to the ALC unit. Fortunately, now knowing what the device