Creating and Maintaining a Just Culture of Safety and Advocacy in Perioperative Services

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KEYWORDS

• Safety • Advocacy • Nursing culture

KEY POINTS

- A culture of safety and advocacy is the most effective environment in which to address workplace challenges successfully and deliver outstanding, safe patient care.
- A safe or just culture encourages employees to be vigilant, to identify and examine close calls to prevent errors.
- Such a culture emphasizes patient safety, retains employees, curbs spiraling healthcare costs, and meets regulatory and patient expectations of care.

BACKGROUND

Current work environment emphasizes continuous performance improvement, reimbursement issues, spiraling health care costs, and core measure baselines for delivering improved, evidence-based care. These driving forces are compelling a change within the health care system. A shortage of registered nurses, and an aging perioperative workforce of registered nurse, in particular, is prevalent. Organizational change is a challenge for organizations both large and small. However, a culture of safety and advocacy is the most effective environment to deliver outstanding, safe patient care, successfully address workplace challenges, and recruit and retain competent caregivers.

As we have advocated for our patients, safety issues have been managed primarily through incident- or occurrence-reporting systems and processes. This approach focuses on incidents that have already happened. A more recent approach focuses on prevention: the identification and exploration of near misses. This term is misleading; such instances are really near hits or close calls. In reality, close calls are underreported, because the transition from the shame and blame environment, in which people are punished for their mistakes, to the culture of advocacy and safety (also known as a just culture), in which errors and close calls serve as opportunities for improvement, has not been effectively made.

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At present, a much keener awareness that systems and processes significantly affect the incidence of errors and close calls, and that punishing individuals does not have a significant impact on reducing medical errors is present. A process is designed to produce an outcome. When the outcome differs from what is anticipated, it is most likely the process, not the practitioner that needs fixing. A commitment to improved systems engineering does not imply that individuals don't make mistakes. The difference in a culture of advocacy and safety is that errors and near misses are approached with an open mind, a focused intention to identify the cause, and to make improvements to avoid recurrences. Individuals are encouraged to report errors and close calls that promote investigation, improvement, and prevent recurrences. Such a culture must be supported at all levels of an organization, beginning at the top.

A surgical services Director known for his commitment to safety and advocacy was given responsibility for a recently-purchased surgery center. In a very short time, the Director identified culture issues in the new center. The physical environment was inefficient, clinical practices did not meet standards, and the staff was neither engaged nor interested in learning. The Director knew that, without significant improvement, the center could not serve patients or the community well. In establishing a culture of safety and advocacy, the Director focused everyone's attention on delivering safe and effective care. The Director described the components of a culture of safety and advocacy. The staff responded when their observations were heard and appreciated, and the Director supported when they faced a challenging situation. The staff developed the confidence to address behaviors that interfered with productivity, such as bullying or refusing to explore alternatives to "the way we've always done it". Staff and surgeons learned that the culture of the center included collaborative practice. Nurses and surgeons who had bullied the team were counseled, and there was a steady progress toward evidence-based, cost-effective, collegial practice. Leaders emerged among the staff whose influence on their colleagues resulted in a more cohesive staff and a general willingness to grow professionally.

In every environment, surgical team members who continue to interfere with smooth and efficient practice and those who are hostile, who bully, or who think the rules do not apply to them are present. When the culture of safety does not "start at the top", administrators can often be persuaded to side with physicians and surgeons, anesthesia providers, and even prominent nursing staff on circumstances that they have been involved in that produced a hostile work environment. When administrators focus on profitability, increasing the bottom line to provide funding for growing modalities of care, and do not understand the impact that a culture of safety has on achieving those goals, the facility as a whole is affected. Culture begins at the top, and a culture of safety and advocacy cannot succeed if counterproductive behavior is supported and rewarded by the administration.

LEADERSHIP, ADMINISTRATIVE, AND MANAGERIAL SUPPORT

Although a culture of safety and advocacy is supported by senior leaders and management in the workplace, it is driven by the staff members. Empowerment evolves as the staff members experience support from the management and administration, and witness consistent application of standards, bylaws, and policy, with an emphasis on best practice. This approach resets expectations and provides the environment for staff members to define the change and take ownership of the process. Once the staff members trust that they will be supported, not blamed, for bringing attention to opportunities for improvement, they report errors, close calls, and unacceptable practice, including disruptive behaviors that interfere with positive outcomes.