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Describing clinical faculty experiences with patient safety and quality care in acute care settings: A mixed methods study

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ABSTRACT

Background: A major safety initiative in acute care settings across the United States has been to transform hospitals into High Reliability Organizations. The initiative requires developing cognitive awareness, best practices, and infrastructure so that all healthcare providers including clinical faculty are accountable to deliver quality and safe care.
Objective: To describe the experience of baccalaureate clinical nursing faculty concerning safety and near miss events, in acute care hospital settings.
Methods: A mixed method approach was used to conduct the pilot study. Nurse faculty ($n = 18$) completed study surveys from the Agency for Healthcare Research and Quality (AHRQ) to track patient safety concerns: Incidents; Near misses; or Unsafe conditions, during one academic semester, within 9 different acute care hospitals. Additionally, seven nurse faculty participated in end of the semester focus groups to discuss the semester long experience.
Results: Clinical faculty identified a total of 24 patient occurrences: 15 *Incidents*, 1 *Near miss event*, and 8 *Unsafe conditions*. Focus group participants ($n = 7$) described benefits and challenges experienced by nursing clinical faculty and students in relation to the culture of safety in acute care hospital settings. Six themes resulted from the content analysis.
Conclusions: Utilizing nursing clinical faculty and students may add significant value to promoting patient safety and the delivery of quality care, within acute care hospital settings.

1. Introduction

A major safety initiative in acute care hospitals across the country has been transforming hospitals into High Reliability Organizations (HROs). This involves developing best practices for safety that are characteristic of other high-risk industries, such as aviation, manufacturing and nuclear power. Many hospitals are training employees in safety behaviors. The training includes all levels of employees and providers, and it is expected that clinical nursing faculty and student nurses are compliant with the expected behaviors.

2. Background

Over the past decade, national reports have highlighted serious quality and safety concerns in the United States healthcare system [Institute of Medicine (IOM), 2001; Kohn et al., 2002]. In the document *To Err is Human*, the IOM (1999) reported that approximately 100,000 patients die in hospitals annually due to potentially preventable errors. Needed changes were outlined in the chasm reports (IOM, 2001, 2003, 2006). One essential change outlined in these reports was a need for healthcare educators to incorporate safety and high quality care into the curriculum and into clinical practice (Beischel and Davis, 2014; Brady, 2011; Cooper, 2013; Djukic et al., 2013; Dolansky and Moore, 2013; Pollard et al., 2014).

Given this recommendation from the IOM, a nursing education initiative was launched in October of 2005 to enhance the safety and quality of patient care. With funding from the Robert Wood Johnson Foundation, nursing leaders established a National Advisory Board for Quality and Safety Education for Nurses (QSEN) in order to evaluate and enhance nursing school curricula on the topics of quality and safety. Phase one of the three-phase project focused on defining six competencies. Five of the six identified competencies were from the IOM Report (patient centered care, teamwork and collaboration, evidence-based practice, quality improvement and informatics, and safety). For each competency, a set of core knowledge, skills and attitudes that pre-licensure nursing students should master was developed (Cronenwett et al., 2007). Phase two involved integrating the six competencies into selected nursing programs as well as launching a website (QSEN.org) which

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would showcase the nursing schools' work on these initiatives. The third and final phase involved developing the faculty expertise necessary for nursing schools to teach the competencies.

Not only do we need to ensure that our nursing school curricula enhance the topics of quality and safety in nursing programs, but we also need to ensure that our hospitals are providing high quality safe health care [Agency for Healthcare Research and Quality (AHRQ), 2008]. Clearly there is a need to change our hospital systems and processes to achieve substantial increase in reliability over present levels. The prevalence and gravity of healthcare deficiencies are in contrast to the remarkable achievements that industries outside of health care (such as the airline and nuclear power industry) have had in attaining and maintaining significant levels of safety (Chassin and Loeb, 2013). These industries have been called High Reliability Organizations (HROs) as they are able to maintain levels of reliability that are exceptionally high. Industries first to embrace HRO concepts were those in which their past failures had led to catastrophic consequences such as airplane crashes, nuclear reactor meltdowns, and other such disasters. The success of these industries inspired AHRQ in 2005 to assemble a group of leaders from hospitals that were dedicated to the implementation of high reliability concepts to health care. The group explored the challenges, organizing concepts, and the use of these concepts in hospitals. In addition, the Joint Commission developed an interest in combining their knowledge of health care organizations with the knowledge of experts in high-reliability industries (Chassin and Loeb, 2013). This interest led the Joint Commission to develop a framework with 14 components that can be practically applied to assist hospitals with the needed substantial changes. The framework has three main domains that are leadership, safety of culture, and robust process improvement. They recommend adopting a culture of safety that includes a questioning attitude and developing a dynamic system for reporting safety events and near misses.

Despite these efforts to improve quality and safety, updated estimates developed from studies published from 2008 to 2011 indicate that 210,000 to 440,000 deaths per year were associated with preventable harm in hospitals (James, 2013). Many factors may contribute to these statistics such as knowledge and performance deficits in healthcare providers, staffing issues, communication breakdowns, fragmented care, poorly designed complex systems, and limited focus on prevention (James, 2013; IOM, 2010; Zilberberg, 2011). Most hospitals utilize the incident reporting system to track and analyze cases of patient harm (Levinson, 2012). However, according to the Office of Inspector General, hospital employees did not report 86% of adverse events to the incident reporting system, mainly due to employee misperception regarding what comprises patient harm (Levinson, 2012). Nurses frequently identified incidents via patient observation and routine safety assessments (Levinson, 2012). Approximately, 70% of identified incidents led to investigations and 13% resulted in policy change (Levinson, 2012).

Given these alarming statistics, more must be done to address the quality and safety issues that plague our healthcare system. Although commendable work is being accomplished on national and state levels to improve safety and quality of health care, there is no published research to date that examines the efforts of baccalaureate clinical nursing faculty to address safety events in the practice setting. As a result, the purpose of this study is to explore the nursing faculty's experience with safety events and near misses in the clinical practicum setting.

3. Methods

This cross sectional study used a non-experimental, descriptive, mix methods design. After receiving Institutional Board Review Approval, the authors recruited participants for this pilot study who were clinical faculty at one university's School of Nursing Baccalaureate Program, located in the northeast. All clinical faculty who taught during the Spring 2015 semester ($n = 30$, teaching a total of 39 clinical rotations) were provided with information about this study and invited to participate. A total of 18 clinical faculty who taught 20 clinical rotations to sophomore and junior baccalaureate nursing students in acute care settings during the Spring 2015 semester consented to participate (for a 60% participation rate) in weekly online surveys about the quality and safety events that they observed in the clinical agency setting with their students. For each week that a participant completed an electronic survey, they were offered one entry into the end of study raffle for one of two $75 gift certificates to a store of their choosing.

3.1. Education

All participants were provided with HRO safety culture training regarding the role of health care agencies as HRO. Based on their schedule preferences, the clinical faculty participated in the 45-minute training either in person with a facilitator at the School of Nursing or through a PowerPoint that was emailed to them to complete. Concepts reviewed in this training included mindfulness in practice, strategies for clear communication, and developing a questioning attitude in an effort to prevent errors. Five of the clinical faculty had also participated in similar training as a mandatory education requirement of the hospitals in which they were concurrently employed; ten had not received prior training or had not heard of the HRO term before their participation in this study.

3.2. Demographics

Eight demographic variables were identified for data collection that included the following: (1) type of clinical rotation (e.g. Maternal-Child, Medical-Surgical, Mental Health, Pediatrics); (2) type of floor/unit; (3) number of students in the clinical rotation and undergraduate year/semester; (4) highest academic degree of clinical faculty: (5) years as clinical faculty at any institution; (6) years as clinical faculty at School of Nursing conducting study; (7) employment status at the institution where faculty was teaching clinical; and (8) participation in any type of HRO training.

3.3. Quality and Safety Survey

To provide insight into the experiences of the clinical faculty, the researchers developed a survey instrument that aligned with the recommendations of the Agency for Healthcare Research and Quality (AHRQ) (Table 1). The authors utilized the AHRQ Common Formats: Healthcare Event Reporting Form, Patient Information Form, and Summary of Initial Report (AHRQ, 2013) as a guide for the weekly electronic survey questions. The following definition was provided at the beginning of each week's survey: “A patient safety concern is reported as one of the following types: (a) *Incident*: a patient safety event that reached the patient, whether or not the patient was harmed; (b) *Near miss (close call)*: a patient safety event that did not reach the patient; or (c) *Unsafe condition*: any circumstance that increases the probability of a patient safety event” (AHRQ, 2013, p.1).

Participants were asked if they and/or their students identified a patient safety concern in clinical that week. If participants answered “no” that they did not identify such an event, then the survey closed and they were thanked for their participation. If participants answered “yes” that they and/or their students identified a patient safety concern during clinical that week, then they were led to eight survey items (Table 1). Each week, participants received an electronic invitation and one reminder to participate in the week's clinical quality and safety survey. Data was collected anonymously through the Secure Sockets Layer (SSL) encrypted survey platform, Key Survey, and was not linked back to individual participants when data was analyzed or reported. Only one of the researchers had access to the list of participants who were emailed the electronic survey (LR). Data and identifier information were kept in a separate electronic and secure, password protected file