CLARITY

White Paper

Clarity Solutions and PSO Advisory Services Tailored to Support Nursing Professionalism, Quality Improvement and a Just Culture

Case Scenario: A seasoned ICU nurse with 20+ years' experience makes a medication administration error at 9:00 p.m. resulting in permanent harm to a 25-year old patient. How would the hospital staff and leadership react to this event? How would the institution treat this nurse?

A New Culture Dedicated to Nursing Quality and Professionalism

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Medication errors can occur in healthcare institutions and even the most experienced nurses can be second victim to these sometimes devastating medical hazards. While the tendency is to assign blame, focus solely on "who did it?" or bind staff repercussions to patient outcome, this reactionary response can create missed learning opportunities about systems and behaviors that may need to be modified to mitigate medical hazard reoccurrences. There is potential for errors to be made by even the most seasoned nurses; this heightens the importance for healthcare systems to change the way they respond to these events.

To support quality and professionalism, healthcare delivery needs a tool that cannot only enhance nurse error reporting transparency, but a solution that provides a safe environment that encourages nursing quality and professionalism.

Improving nursing quality and professionalism requires a highly structured, fair, and reliable process that captures systems, behaviors and other factors that may lead to adverse patient safety outcomes and medical hazards. In addition, it requires a strong governance model and new systems that healthcare organizations can use to capture information, investigations and follow-up from an event, root cause analysis to identify contributing factors, as well as a workflow tool that prompts follow-up for staff in ensuring interventions and action items are completed. To support quality and professionalism, healthcare delivery needs a tool that cannot only enhance nurse error reporting

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Nursing Cognition Leads to Safety Improvement

Why wouldn't a leader want to know what happens in his or her healthcare system? When it comes to healthcare delivery, any strong Risk-Quality-Safety (RQS) strategy that improves outcomes while reducing costs must include the cognitive powers and interventions from those individuals that are consistently providing direct patient care: nurses. Nurses represent over half of the work force in the healthcare industry.[i] It is in every healthcare organization's best interest to detect hazard-producing defects and respond by building strong defenses into the nursing staff's working environment designed to mitigate those deficiencies.

Nurses must feel safe to report hazards and know there is a support system and institution dedicated to helping them and others learn from these occurrences.

Creating a program that fosters systemic and behavioral changes to improve patient safety requires more than just empowering nurses on the unit level. Nurses must be knowledgeable about the factors that lead to errors, be willing to act to fix the problems contributing to the errors, be advocates for public policies that will support safer work environments, be participants in research on the compelling questions that touch on nurses' contributions to patient safety, and be committed to modify their own behaviors that may contribute to unsafe care.[ii] Nurses must feel safe to report hazards and know there is a support system and institution dedicated to helping them and others learn from these occurrences. In support of these challenges, many forward-thinking institutions have initiated and begun operating institution-wide Nursing Peer Review and Nursing Quality Review committees. The mission of these committees is to understand the factors that inhibit or promote a culture of safety so barriers can be removed and learning from events can be shared throughout the organization.

The Agency for Healthcare Research and Quality's (AHRQ) charge to the Institute of Medicine (IOM) after the release of 'To Err is Human' in 2002 was to

identify key aspects of the work environment for nurses likely to have an impact on patient safety.[iii] Creating an environment where nurses feel safe to report their mistakes cannot be achieved in a single action. Rather, it is necessary for healthcare systems to implement solutions that complement practices that can identify trends in behavior or system failures so the incidents, near misses, and unsafe conditions that are reported can be turned into actionable opportunities to improve environment safety and quality.

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Electronic Workflow Tool Supports a Culture of Safety and Nursing Excellence

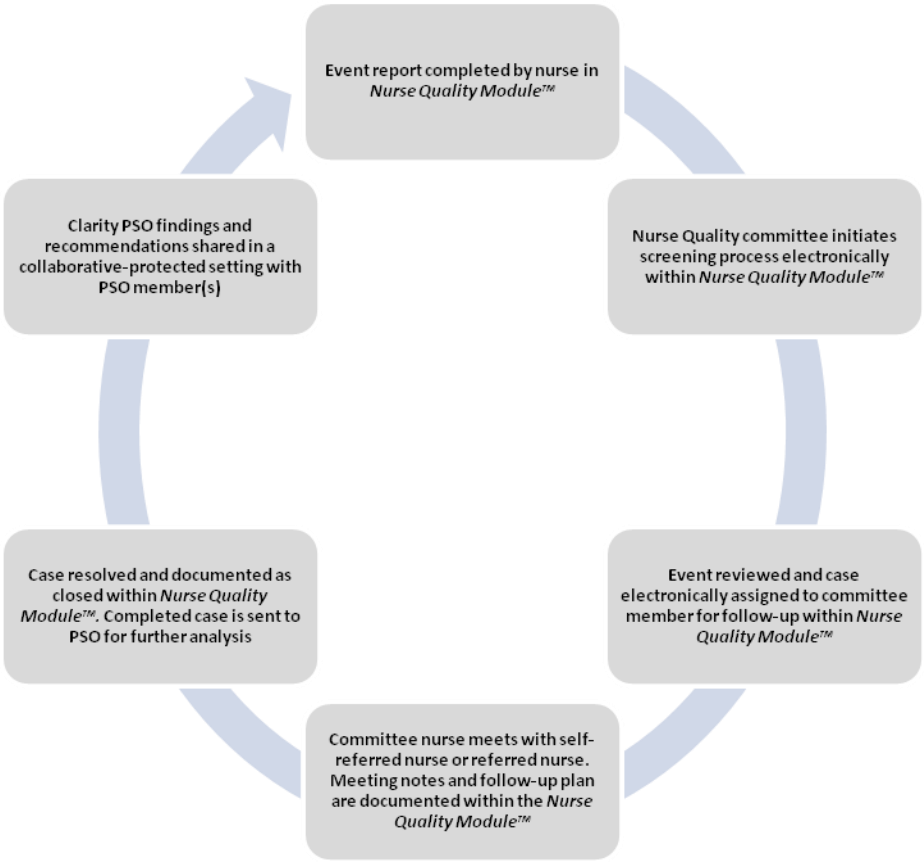
A research study conducted in 1983 identified 14 characteristics found in organizations that were best able to recruit and retain nurses during the nursing shortages of the 1970s and 1980s.[iv] These characteristics became what defined the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® that today make up the *5 Magnet Model Components* – key attributes that exemplify nursing excellence. To meet these requirements, organizations need strong nursing leadership as well as a system to identify issues, create action plans, and ultimately improve patient outcomes.

Clarity Group, Inc. worked with its clients to determine how an electronic tool might be used to support nursing excellence. The clients chose to use Clarity's Healthcare *SafetyZone*® Portal ("the Portal") as their system wide web-based event management solution. The Portal's automated workflow allows for follow-up and investigation of events in real time, and most importantly, the events reported into the Portal become data that can provide a comprehensive picture of the quality and safety culture within an institution.

Working with the healthcare nursing leaders who were already operating effective Nursing Peer Review programs and using the Portal, they designed the ***Nurse Quality Module™***. The architecture and data collection forms were built from nursing leaders who are Magnet-recognized organizations – focused on improving quality and nursing professionalism. Since the module is customizable, institutions can continually enhance their committee workflow,

data collection, and follow-up to drive improvements in nursing quality and safety. The diagrams below show the workflow of the ***Nursing Quality Module™*** and how institutions are using it to facilitate confidential event reporting and follow-up within nursing peer review and quality committees.

Nurse Quality Module™ Workflow



During the nurse "screening process" in the diagram, the event and or referral submitted into the ***Nurse Quality Module™*** is reviewed by the committee members. The committee screens for staff members who may already be in a disciplinary process or for indications that the event may warrant disciplinary proceedings. If staff disciplinary proceedings are identified by committee members, nurse follow-up will be handled separately from the review module and committee process. The confidentiality and privilege protections afforded

to those healthcare institutions that use the ***Nurse Quality Module™*** are described in further detail below.

PSO Protection and Confidentiality for Nurse Quality and Professionalism

Patient Safety Organizations (PSOs), established by the Patient Safety and Quality Improvement Act of 2005 (The Patient Safety Act), were created to collect voluntarily reported patient safety events. These events are collected through a common reporting taxonomy so that the reporting of harm or unsafe conditions can be done in a standardized way nationally.[v] The Patient Safety Act provides confidentiality and privilege protections to a healthcare provider, broadly defined in the Act, that collects data for the purpose of enhancing quality and patient safety and who reports these data to a qualified patient safety organization listed with AHRQ, such as Clarity PSO.

Fears in reporting events by nurses are minimized as events reported to a PSO are protected from legal discovery and may not be used against a provider in disciplinary actions.

Per the statute, organizations contracted with a PSO can conduct their nursing committee review processes within the confines of their patient safety evaluation system (PSES) – a federally protected space granted to providers contracted with a PSO. Fears in reporting events by nurses are minimized as events reported to a PSO are protected from legal discovery and may not be used against a provider in disciplinary actions. Information collected via the ***Nurse Quality Module™*** by the nursing staff and providers contracted with Clarity PSO remains confidential and protected from discoverability in a court of law.

In addition to providing protections to those providers who contract with and report information to Clarity PSO, all data reported into the ***Nurse Quality Module™*** can be analyzed by Clarity PSO to provide clients with benchmarking information on patient safety events. The benchmarking information fosters awareness about possible patient safety risks occurring not only at the local level, but also at the national level. Through aggregating and identifying national trends as well as providing a dashboard to measure improvement after the implementation of a new system and behavior interventions, Clarity PSO helps

providers become better positioned to meet the national benchmarking requirements and quality requirements of various certification programs, such as the ANCC Magnet Recognition Program®.

Conclusion

The science of medical error reduction is complex and involves multiple levels and systems of the healthcare environment. More specifically, reducing medical errors is not a matter of finding and punishing the one person (e.g. the ICU nurse) involved in the medical hazard. Rather, chief nurse executives and programs such as "Nursing Peer Review" or "Nurse Quality Review" committees can establish programs founded on just culture principles, which can bring about awareness and belief in the notion that medical errors occur because of complex reasons that are neither entirely predictable nor traceable to a single person. Ultimately, providers can foster a just culture of safety by looking actively at processes, not passively at patient outcomes.

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With an electronic workflow tool like the ***Nurse Quality Module™***, and by contracting with a PSO, leadership and care providers that provide direct or indirect patient care related to an event can be systematically engaged in identifying and creating interventions to help improve systems and professionalism to eliminate preventable harm to patients in the future. A workflow tool that promotes follow-up, investigation, and trending to identify factors that may have led an experienced nurse to make a medication error, now turns the ICU nurse into a leader and a teacher – raising the bar of nursing professional practices.

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For more information on the **Healthcare *SafetyZone*® Portal – *Nursing Quality Module™*** and Clarity PSO please visit: **www.claritypso.com** or contact Clarity Group, Inc. directly at 773-864-8280.

Endnotes

[i] Henderson, J. Maureen. "Healthcare Industry Is Primed For A Job Boom, But There's A Catch." Forbes. Forbes Magazine, 23 June 2012. Web. 1 Mar. 2013.

ii Page, Ann. Keeping Patients Safe: Transforming the Work Environment of Nurses. Washington, DC: National Academies, 2004. (p. 32)

iii Page, Ann. “Nursing: Inseparably Linked to Patient Safety.” Keeping Patients Safe: Transforming the Work Environment of Nurses. Washington, DC: National Academies, 2004. (p. 32)

iv "Forces of Magnetism." nursingcredentialing.org. Web. 1 Mar. 2013. http://www.nursecredentialing.org/Magnet/ProgramOverview/HistoryoftheMagnetProgram/ForcesofMagnetism

v Department of Health and Human Service. *Patient Safety and Quality Improvement Final Rule*. 42 CFR Part 3. Federal Register. Vol. 73, No. 226, 21 Nov. 2008.