Quality and Safety Matters

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What is a High Reliability Organization?

Caitlin Cauley
Class of 2020

As future healthcare professionals, we should always be interested in taking steps towards a safer, more dependable workplace environment. With patient's lives at stake, there is little room for error where safety is concerned. While mistakes are made, and negative outcomes do occur, the goal is always to minimize, and even eliminate wherever possible, harm to patients and providers in healthcare. Not only is it important for individuals to practice safely, but also for the system within a hospital or healthcare setting to do so. One concept which embodies both individual and system effectiveness is a high reliability organization. According to the Agency for Healthcare Research and Quality[1], a high reliability organization is one which operates for long periods of time without serious accidents or failures occurring by prioritizing safety over other performance pressures such as finance. In other words, a high reliability organization puts safety first, above all other things.

The concept of high reliability goes beyond standardization of practice. While standardization is important across healthcare to ensure consistent positive outcomes, high reliability equates to persistent mindfulness amongst healthcare workers within an organization. High reliability organizations understand that the world is constantly changing. Rather than adopting static measures of practice, they too are constantly adapting to new threats and learning from previous experiences. Thus, a high reliability organization works under a system which does not simply react to a situation, but rather, anticipates the situation and promotes early detection and quick response. By doing so, high reliability organizations are able to prevent potential problems from becoming catastrophic events. Commonalities among high reliability organizations center around five important ways of thinking which include: preoccupation with failure, reluctance to simplify explanations for operations, successes and failures, sensitivity to operations, deference to frontline expertise, and commitment to resilience.

Understanding these driving concepts are key to the organization's success. Preoccupation with failure involves a conscious awareness that failure is always a possibility. This thought process allows workers to be constantly alert for signs of error and allows the entire staff to improve from "near-misses," or accidents that happened but did not negatively affect a patient. Reluctance to simplify is exactly what it sounds to be; in a high reliability organization, everyone understands that healthcare is a complex and dynamic environment. Rather than relying on simple, surface-level explanations, people working in these organizations delve deeper into the system to find the ***Continued on page 2***

Huddle for Safety

Amanda Sommers
Class of 2020

Huddle, a term commonly used in football, is a strategy being used to increase the safety of patients in hospitals and healthcare settings. Similar to how huddles work in football, a huddle in healthcare refers to a brief gathering of personnel to discuss important aspects of patient care for the day and potential quality and safety issues. Safety huddles are easy to implement and provide significant benefits for care providers and patients.

Safety huddles are important because they enhance communication among the team members. Given the opportunity to think critically, nurses and other team members can identify, anticipate, and plan for potential safety hazards and crisis situations before they occur. Planning is a crucial part of the nursing process that is emphasized in huddles. In a sense, huddles are like "giving report" among multiple staff members of the unit. Since nursing is collaborative, the huddle technique allows all members of a team to be aware and prepared for any situation that may occur unit-wide. Additionally, collaborating with fellow nurses allows for diverse experiences to meld and create an innovative care experience. Utilizing the contributions of multiple experienced minds in identifying resources, planning priorities, and anticipating problems improves the care for many patients.

Generally, huddles occur at a scheduled time toward the start of shift. Huddles should last less than 10 minutes so that it is a manageable mechanism to increase patient safety. Kathy Duncan, a registered nurse with the Institute for Healthcare Improvement[1] suggests implementing the huddle tool with a small segment of the population first and gradually increasing it, until the entire unit is involved. It is also important to remember that huddles are not all inclusive; meaning not all doctors, physical therapists, respiratory therapists, case workers and dietitians are supposed to be included. If it is an orthopedic unit, include a physical therapist. If it is a cardiac unit, include a cardiologist. Having too many people participate may be overwhelming and time consuming.

The main "problem" with the safety huddle is not the safety huddle at all, but people's misconceptions about the huddle. Many people have a preconceived notion that it is poorly spent time or extra work. Martin and Ciurzynski[2] suggest that in fact, huddles between team members provide an enhanced perception of communication and teamwork. As a result of better communication and teamwork, patient care is improved and an increase in workplace satisfaction occurs; ultimately further improving patient outcomes.

Healthcare professionals are constantly searching for ways to reduce care errors and improve patient outcomes. Safety huddles are a quick and effective way to increase patient safety and require no monetary funding to implement. For improved patient outcomes, a safety huddle is a relatively easy strategy this is worth the 10 minutes it takes to communicate with teammates.

1. Duncan, Kathy (2019). Get your priorities straight: Tips for using safety huddles. *Institute for Healthcare Improvement*. Retrieved from http://www.ihi.org/communities/blogs/get-your-priorities-straight-tips-for-using-safety-huddles

2. Martin, H.A. & Ciurzynski, S.M. (2015). Situation, background, assessment, and recommendation-guided huddles improve communication and teamwork in the emergency department. *Journal of Emergency Nursing, 41*(6), 484-488. https://doi.org/10.1016/j.jen.2015.05.017

Ask Me 3 Campaign

Anastasia Maltsev
Class of 2020

Effective healthcare is a collaboration between members of the healthcare team and patients and their families. In order to enhance patient care and achieve safe, optimal patient outcomes, it is imperative that all parties involved, especially the patient, have a clear understanding of his/her health condition, the associated health implications, and the long and short-term plan of care.

To address this concept, the Ask Me 3 Program was founded by the Institute for Healthcare Improvement (IHI) and National Patient Safety Foundation (NPSF)1. Ask Me 3 consists of three questions which are associated with patient and family understanding of medical conditions and plans for optimal health. These questions can be implemented by and with any individual along the continuum of health, including the patient and his/her support systems. The questions can be presented to patients through posters and brochures which have been translated into many languages, thereby increasing linguistic comfort and promoting a positive attitude surrounding cultural competency. These questions are: What is my main problem? What do I need to do? Why is it important for me to do this?[2] These are simple, yet very effective in sharing requisite information associated with health and care.

The main purpose of these questions is to establish a baseline for communication between healthcare professionals and patients and their families. All individuals affected by medical conditions and their consequences should use these questions to have an open dialogue with the healthcare team. These questions serve as a basic guide to communication that can be enhanced with additional questions and inquiries for clarification.

Using these questions increases patient and family participation in the planning and implementation of care[3]. This is necessary for establishing the patient's wishes and discussing concerns. The Ask Me 3 program can aid both the healthcare team and patient support system in aligning care with the patient's wishes and desired outcomes to reach the most optimal health outcome. Having an open discussion about care and preferences has the potential to increase patient and family satisfaction[3], thereby creating an atmosphere of health promotion that allows for the smooth implementation of care, strengthening adherence to the plan of care.

As the Ask Me 3 Program can be implemented in nearly any health promotion situation, it is imperative that all providers educate their patients using this strategy for conversation with their healthcare team as an opportunity for understanding and clarification. These questions, which are simplistic in nature, have the potential to greatly impact comprehension and compliance when adopted by the healthcare team, patients, and their families.

1. Ask Me 3: Good Questions for Your Good Health. (n.d.). Retrieved from http://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx
2. Institute for Healthcare Improvement. (n.d.). Ask Me 3 Brochure (English) [Brochure]. Boston, MA: Author.
3. Toibin, M., Pender, M., & Cusack, T. (2017). The effect of a healthcare communication intervention — ask me 3; on health literacy and participation in patients attending physiotherapy. European Journal of Physiotherapy, 19(Sup1), 12-14. doi:10.1080/21679169.2017.1381318

High Reliability Organizations

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root of the problem. Next, sensitivity to operations emphasizes the staff's awareness of what is going on around them. Also known as situational awareness, having a sensitivity to operations means understanding how the current state of the working environment may pose a threat to safety, patient-related or otherwise. This thought-process leads into the next important concept which is deference to expertise.

Deference to expertise is perhaps the most significant related to nursing care. In a high reliability organization, it is understood that those closest to the work are the most knowledgeable. This concept places a priority on the opinions and expertise of those most involved, regardless of hierarchical status. It balances power where safety is concerned, which encourages any and all staff members to speak up involving safety. In regard to nursing care, this is important because nurses spend the most time interacting with and caring for patients. They will have the most experience when it comes to identifying mistakes and potential problems on the front-line of care. Nurses working in high reliability organizations are highly valued and should be eager to share their knowledge, whereas nurses working in poor environments may feel disempowered and reluctant to share their experiences.

The final concept which supports each of the other concepts and is the foundation for high reliability organizations is commitment to resilience. Commitment to resilience means that everyone working in the organization is dedicated to constantly improving the system, regardless of failure or obstacles. It is through a commitment to resilience that the organization can continue to strive for excellence and improve despite the constantly changing and unpredictable nature of healthcare as a whole. If every member of an organization is determined to do better for themselves and for their patients every day, this is an excellent start to achieving the goal of creating a high reliability organization which promotes positivity, growth, quality, and, most importantly, safety, for everyone involved.

1. Agency for Healthcare Research and Quality. (2019). Patient safety primer: High reliability. Retrieved from: https://psnet.ahrq.gov/primers/primer/31/High-Reliability

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