Implementing Safety Culture at the Frontline of Healthcare

Eric Ernst, RN, MS, BSN
Nursing Science and Healthcare Leadership
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Agency for Healthcare Research and Quality (AHRQ)

SBAR
- Situation
- Background
- Assessment
- Recommendation/ Request

- Literature review
- Methods
- Conclusion
Healthcare safety

• Interacting systems
• Intricate networks
• Safe designs
• Understanding human factors
• Prevent, recover, mitigate
The Impact of Errors

• Up to 98,000 deaths due to medical error each year
• Errors considered a sign of an individual’s incompetence or recklessness
• Medical errors, adverse events and near misses go unreported
The Impact of Errors

• Unreported events are missed opportunities to learn and improve
• Providers may experience adverse consequences
Building a Culture of Safety

- Create an environment in which safety is a top priority
- Foster a culture that encourages learning from errors
- Five components:
  - Trust
  - Accountability
  - Identifying unsafe conditions
  - Strengthening systems
  - Assessment
Safety Culture and Patient Outcomes
Safety Culture and the Second Victim
Implementing Evidence into Practice

Frontline Safety Culture: Implementation Guide

- Bridge the gap between policy and practice
- Errors are treated not as personal failures, but as opportunities to improve the system and prevent harm
Implementing Evidence into Practice

Methods

Frontline Safety Culture: Implementation Guide

Adverse event management

Just Culture
- Psychological safety
- Active leadership
- Transparency
- Fairness
Conclusion

• Reporting Culture and Learning Culture
• Support second victims
Thank you, questions?

- Thesis committee:
  - Jill Joseph, M.D., Ph.D., M.P.H, Chair
  - JoAnne Natale, M.D., Ph.D
  - Janice Bell, Ph.D., M.P.H., M.N., F.A.A.N

- elernst@ucdavis.edu
- www.linkedin.com/in/eric-ernst-connect