CREATING A CULTURE OF SAFETY IN YOUR ASC

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Culture encompasses the values and attitudes of the employees in an organization.[1] Employees working in an unhealthy culture are individually focused, placing priority on their wants and needs. In a healthy culture employees share values and attitudes. This system of shared values is the glue that binds employees to enhance team and organizational performance.

Patient outcomes depend on our ability to work together and manage increasingly complex business and clinical operations. The healthcare industry has learned about the concept of a safety culture from high-reliability organizations (HRO) in other industries like aviation and nuclear power. These organizations are able to achieve and maintain safety despite enormous risk and complexity.[2] In healthcare we have yet to replicate the safety records of such HROs.

THE PROBLEM

Every year millions of patients suffer from adverse events such as healthcare-associated infections (HAI), medication errors, retained instruments, patient falls, and wrong-site surgery. Certainly a disproportionate number of these incidents occur in hospitals. However, surgery centers are not immune to adverse events. In fact, one study identified the surgical environment as the most common location of adverse events. In that study 43% of the incidents were preventable.[3]

THE SAFE SURGICAL CHECKLIST

High reliability organizations and their remarkable safety records have been the focus of much scholarly study since the Institute of Medicine's report *To Err is Human* was published in 2000. Largely as a result of this study, the World Health Organization introduced the concept of the safe surgical checklist in 2008. The Centers of Medicare and Medicaid Services (CMS) mandated utilization and reporting of a safe surgery checklist in ASCs in 2012.

What we have learned, however, is that the checklist has limited impact unless implementation occurs in a culture of safety. The same can be said of our risk management programs. Reporting and documenting "incidents" or "occurrences" has limited impact to improve processes and

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mitigate risk absent a culture of safety. In fact all our efforts to improve patient outcomes are optimized in a culture of safety. Therefore it behooves us to consider the characteristics of the safety culture in HROs in light of our own ASCs.

CREATING A CULTURE OF SAFETY

Books and articles on this topic agree that four elements are essential for a culture of safety:

1. Psychological safety: Members feels safe to communicate safety concerns without fear of reprisal.
2. Learning orientation: There is an emphasis on learning from our experience, especially our failings.
3. Systems orientation: Members and processes are connected through systems that resist dependence on individuals and require careful risk management.
4. Organizational leadership enables items 1 through 3, listed above. Without this leadership, a culture of safety cannot be achieved.

How does your ASC rate on these four elements? Is your staff comfortable raising safety concerns? Is this input welcomed without real or implied threat? Are you empowered by your ASC owners to be responsive to such concerns? Can you count on their cooperation to address the problem? Do you have a robust risk management program? Do you actively follow up on all "incidents" and use them as opportunities for learning? Are you a fanatic about having a systems orientation to eliminate performance dependency on individuals? Only a systems approach can ensure consistent performance regardless of which team members are present on a given day. Is your organizational leadership publicly and privately committed to a culture of safety?

IN THE FIELD

I visit many surgery centers. Patient safety issues frequently arise within the context of a compliance audit. A prime example is the Universal Protocol, or "Time Out" to verify surgical site identification (SSID). In my observations, compliance with this protocol is highly variable. Some ASCs are scrupulous while others are undisciplined and inconsistent in implementing this crucial final step in the SSID process. At times, the circulating nurse and scrub verbalize the time out without surgeon or anesthesia participation. The nursing staff is frustrated and even uncomfortable, knowing this is an important patient safety issue. They feel helpless because the surgeon, who refuses to participate, is the facility owner and their attempts to voice concerns fall on deaf ears. Yet the surgeon is the only one who can ultimately verify the surgical plan, since it originates with the surgeon. This scenario underscores the importance of organizational leadership committed to patient safety.

Some ASCs fail to embrace a culture of safety until forced to do so by an untoward event and the consequential legal liability. Bad things do happen, even in well-managed ASCs. In ophthalmology, bad patient outcomes can be devastating and life altering, which frequently leads to a lawsuit.

STARTING POINT

Do not let your ASC become a casualty of complacency. Commit to playing it safe! A good starting place is to survey your ASC staff and physicians on their perceptions of your patient safety culture. This will help raise awareness about patient safety and provide insight regarding the current status of your culture. It will also identify opportunities for improvement and provide baseline data necessary to evaluate the efficacy of your improvement efforts. The Agency for Healthcare Research and Quality has developed a toolkit for this purpose. You will find surveys on patient safety culture, a survey user's guide and an action-planning tool to guide you as you develop a plan to improve you patient safety culture. ASC patient safety resources are also available here.

Implementing this survey is a great first step to playing it safe in your ASC. Just do it! *AE*

REFERENCES

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