

CREATING A COLLABORATIVE CULTURE WITHIN THE HEALTHCARE SYSTEM TO ENSURE PATIENTS REMAIN SAFE AND FREE FROM HARM

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Research Focus

- Explore several key conditions necessary for the successful transitioning to a more collaborative approach to patient safety
- Improving our safety record entails
 - Creating an environment and a culture that facilitates practitioners sharing information and experiences about patient safety
 - Engaging in pro-active, solution-focused problem-solving,
 - Supporting actions for positive change

Focus Continued

- Even with best systems mistakes will occur
 - to share information
 - to implement, track, and evaluate any interventions
 - to be open to constructive feedback.
- Healthcare is a high-risk, complex industry, and avoiding all mistakes may be unrealistic.
- We all have the responsibility and can demonstrate leadership by
 - promoting initiatives to report potential (i.e., near miss) or actual (i.e., adverse events or error) unsafe situations.

Focus Continued

- Why healthcare professionals are afraid to report or disclose their events.
 - fear of litigation, fear of communicating the news to the patient, poor reporting systems, lack of education about errors, and inability of administrators to follow through with the required system changes
- Improving safety records will require
 - Commitment from healthcare professionals
 - Commitment from their leadership team

Purpose of a reporting system:

- Intent of any learning system is to improve, to inform and educate, to increase organizational accountability, and to facilitate public confidence in the healthcare system.
- Common understanding across disciplines, open communication, continuous learning and innovation, and transparent and accountable processes.
- Requires intentionality and commitment
- Is non-punitive (blinded reporting system); (b) user-friendly and (c) it generates timely, quarterly, and annual reports.

Building Collaborative Relationships - Create a shared Vision:

- Collaborative knowledge partnerships, an appreciation for the commitment, and importance of leading through the change by being visible, vocal, and inclusive of diverse perspectives and needs.
- Identifying patient safety goals, values, and missions.
- Adaptation of a new philosophy, and corporate commitment.
- Close the distance between front office and frontline

Reporting Process:

Emphasis must be on improving the reporting process not necessarily on changing the reporting tool more importantly we need to identify who is responsible for actioning the reports.

- **Actioning Reports**
- **Transferable Learnings**

Study Recommendations

- Establish an Organizational Community of Practice to Support networks of Professions
- Surrey Memorial Hospital Introduce a Quality Assurance and Patient Safety Portfolio
 - Step one – Who owns the process
 - Step two - Virginia Mason Medical Center
 - Step three – Engage aviation experts
 - Step four - Toyota
- Organizational implications

Thank You