Creating a Culture of Safety in the Neonatal Intensive Care Unit
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Problem: Patient care errors and safety concerns in the neonatal ICU (NICU) prompted an investigation. Nurses expressed a lack of understanding regarding utilization of the hospital’s error reporting system. Errors were grossly underreported, making it difficult to identify areas for improvement.

Evidence: Despite expensive research on patient safety, interventional studies that support implementation of error reduction strategies are lacking. Experts report a strong connection between safety outcomes and culture factors. A Culture of Safety (CoS) has been outlined as key to improvement in overall patient safety. Components of a CoS include just culture, learning culture and reporting culture.

Strategy: Error reporting is a critical component of a CoS. Studies indicate that patient safety education can have a positive effect on reporting behavior. This initiative included an educational module designed to increase use of the hospital’s error reporting system.

Practice Change: The hospital’s reporting system is being increasingly used for reporting errors and near misses. Unit management utilizes reports to inform and educate staff regarding patient safety issues. This allows prioritization of safety concerns and reinforces a CoS.

Evaluation: Collaboration with risk management tracked utilization of the error reporting system by NICU staff prior to and following the educational intervention.

Results: In 12 months prior to education intervention, 32 error reports were completed. The incidence of error reporting increased after the educational intervention, yielding 38 reports over a 2 month reporting period. Data collection continues at this time.

Recommendations: Open, honest communication regarding unit challenges is critical. Leaders must provide feedback on trends identified through error reporting. Focus regarding errors must move from individual error to evaluation of system failures. Simulation activities may provide unique learning opportunities.

Lessons Learned: Creating a CoS is complex and challenging. By understanding the nature of a CoS, nurses can advocate within their organization to prompt attainment of a patient safety culture.

Bibliography:


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