The Nurse’s Role in Promoting a Culture of Patient Safety

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Abstract

There are varying consequences of medical errors. Ironically, these errors involve those intending to help, not harm patients. Though errors are often blamed on individuals, the true roots of these errors are found in the combination of the workplace environment in which healthcare is delivered and in the interaction among healthcare providers. To understand the causes of error, it is important to consider the dynamics of healthcare as a system, influenced by individuals and culture. For medical errors to decrease and for patient safety to improve, our healthcare system needs to change.

Nurses are in a unique position to improve patient safety because of their inherent proximity to patients. This position gives nurses the needed insight to identify problems in healthcare systems and to be part of patient safety solutions. However, to do this, nurses must be supported and encouraged without fear of retribution, as well as have an understanding of how organizational culture change can be accomplished. As such, the purpose of this paper is to present an overview of patient safety problems associated with organizational culture and how nurses can be part of organizational change promoting patient safety. After completion of this module, nurses will be able to:

1. Describe the risks medical errors pose to patient safety
2. Discuss the culture of safety
3. Compare and contrast the culture of safety with the culture of blame
4. Describe strategies to promote a culture of safety in the healthcare environment
The Problem of Medical Errors

More than 140 years ago, Florence Nightingale warned, “the very first requirement in a Hospital is that it should do the sick no harm” (Nightingale, 1863, preface). This concern was echoed in Crossing the Quality Chasm: A New Health System for the 21st Century, where the Institute of Medicine (IOM) called for safety in the delivery of healthcare indicating that “patients should be safe from injury caused by the care system” (Institute of Medicine, 2001, p. 8). Today, the increasing complexity of healthcare has contributed to the growing problem of medical errors (Wachter, 2004). According to the Committee on Quality of Healthcare in America, the majority of quality problems and medical errors occur “because of fundamental shortcomings in the ways care is organized” (Institute of Medicine, 2001, p. 25), not individual error or negligence (Kohn, Corrigan, & Donaldson, 2000).

The pervasiveness of medical errors garnered widespread attention after the IOM published its seminal report, To Err is Human: Building a Safer Health System (Kohn et al., 2000). This report was a catalyst in focusing national attention on the need for patient safety improvement and higher quality healthcare. The report found that medical errors not only impede the quality of care but are responsible for 44,000 to 98,000 patient deaths per year (Kohn et al., 2000). The costs of errors are estimated at $17 billion to $29 billion (Kohn et al., 2000) and have devastating effects and emotional costs for patients and their families (Gibson and Singh, 2003).

In an effort to respond to the concerns cited in the IOM reports, the U.S. Senate Appropriations Committee directed the Agency for Healthcare Research and Quality (AHRQ) to “lead the national effort to combat medical errors and improve patient safety” (Agency for Healthcare Research and Quality, 2004, p. 1). Since that time, AHRQ has taken the lead in
advancing the patient safety agenda by funding health services research in this area. Patient
safety can be defined as “freedom from accidental injury; ensuring patient safety involves the
establishment of operational systems and process that minimize the likelihood of errors and
maximizes the likelihood of intercepting them when they occur” (Kohn et al., 2000, p. 211).

What are Medical Errors and Adverse Events?

Medical errors are defined in a number of ways. The AHRQ defines them as “mistakes
made in the process of care that result in or have the potential to do harm to patients” (Agency
for Healthcare Research and Quality, 2004, p. 57). The IOM defines errors as “the failure of a
planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to
achieve an aim (i.e., error in planning)” (Kohn et al., 2000, p. 28). An adverse event is defined
as “an injury caused by medical management rather than the underlying condition of the patient.
An adverse event attributable to error is considered a “preventable adverse event” (Kohn et al.,
2000, p. 28).

Why Do Errors Occur?

There are two approaches to understanding human error. One is the “person approach”
(Reason, 2000), which focuses blame on the individual for failures such as forgetfulness or
carelessness. The other approach focuses on systems and how they contribute to errors (Reason,
2000). Reason identified types of errors as: active and latent (Reason, 1990). The active error
type of incident is the result of noncompliance with a procedure, or making a mistake such as not
assuring the correct identification of the patient before administering the medication. A latent
condition involves problems within the system. Reason noted that latent errors “may lie dormant
within the system for a long time” (Reason, 1990, p. 173). It is important to note that “latent
errors pose the greatest threat to safety in a complex system” (Reason, 1990, p. 173) because they may lead to additional errors.

Research in patient safety funded by AHRQ has identified a number of factors associated with medical errors including:

- Communication problems—including both verbal and written communication among all levels of healthcare providers in various settings;
- Inadequate information flow—need for information to appropriately care for and manage the patient through the continuum of care;
- Human problems—lack of appropriate clinical knowledge, failure to follow policy and procedures;
- Patient-related issues—lack of appropriate patient education;
- Organizational knowledge transfer—lack of appropriate orientation, staff development, education, and training;
- Staffing patterns—inadequate staff and supervision can contribute to situations that are at high risk for medical errors;
- Technical failures—medical equipment failure or occurrence of errors related to poor design of medical equipment; and
- Inadequate policies and procedures—lack of procedure to guide delivery of care (Agency for Healthcare Research and Quality, 2004).

Nurses are in a unique position to improve patient safety because of their proximity to the patient and their critical role in healthcare delivery. This position gives nurses the needed insight to identify and address errors.

**Recognizing and Reporting Errors**
Medical errors cannot be addressed if they are not recognized and reported. In one study, 74 percent of nurses surveyed perceived errors “were reported less than 50 percent of the time” (Osborne, Blais, & Hayes, 1999, p. 35). In another study, nurses perceived that only 60 percent of medication administration errors were reported (Wakefield, Wakefield, Borders, Uden-Holman, Blegen, & Vaughn, 1999). In both studies, nurses perceived an underreporting of errors.

Barriers leading to underreporting of medical errors by nurses include: burdensome documentation requirements, inability to report errors anonymously, hesitancy to report on another, unclear reporting requirements for errors without an adverse outcome and “fear of lawsuits” (Uribe, Schweikhart, Pathak, & Marsh, 2002, p. 273). Additionally, nurses are often reluctant to report errors if they perceive that reporting errors will not lead to needed changes (VanGeest & Cummins, 2003). A number of articles have addressed various reasons medication errors are not reported (Osborne et al., 1999; Wakefield, Wakefield, Uden-Holman, Borders, Blegen, & Vaughn, 1999).

Failure to acknowledge and report errors impedes efforts to improve patient safety. Only when errors are openly recognized can the reasons causing errors be addressed and subsequent errors prevented (Hughes, 2004). In fact, the IOM reported that “the biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm” (Institute of Medicine, 2001, p. 79).

Acknowledging errors requires an environment based on trust and mutual respect where nurses are motivated, supported, and encouraged to be part of patient safety improvements without fear of retribution (Page, 2004). Cultures that encourage and sustain this type of work
environment promote innovative ideas that can lead to improved patient care. The AHRQ indicated that “a culture of reporting where information is confidential and non-discoverable is the most significant incentive to reduce medical errors” (Agency for Healthcare Research and Quality, 2004, p.25).

**Organizational Culture Influences Medical Errors**

Organizations have cultures, and daily work life is infused with it. Culture influences communication, social relations, and individual actions and motivations, as well as the rules, perspectives, and ideals by which people live (Hecht, Jackson, & Pitts, 2005). Factors such as how nursing units are arranged, the working atmosphere, and the relations among people vary among organizations, even within the same industry. Organizational culture can be defined as:

“the underlying values, beliefs, and principles that serve as a foundation for an organization’s management system as well as the set of management practices and behaviors that both exemplify and reinforce those basic principles. These principles and practices endure because they have meaning for the members of an organization.”

(Denison, 1990, p. 2).

Healthcare organizational culture has a profound effect on patient safety and quality of care. Simply put, if the culture does not promote a safe environment where errors are identified and reported, patient care delivery will be adversely affected.

Errors are more likely to be reported when clinicians “feel safe to do so and it becomes a culturally accepted activity” (Cohen, 2000, p. 729). Failure or resistance to reporting errors because of fear is characteristic of a culture of blame (Larson, 2000). A culture of blame is exemplified by the lack of communication and silence following medical errors and adverse events. Conversely, a culture of safety is defined by the Advisory Committee on the Safety of
Nuclear Installations (ACSNI) as “the product of individual and group values, attitudes, perceptions, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of an organization’s health and safety management. Organizations with a positive safety culture include communications founded on mutual trust, shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.” (From the Health and Safety Commission of Britain. Organising for Safety: Third Report of the ACSNI Study Group on Human Factors (sic) (as cited in Sorra & Nieva, 2004, p. 1)

In other words, a culture of safety emphasizes “why” the error occurred rather than “who” made the error (Hughes, 2004). Characteristics of the culture of safety and the culture of blame are compared in Table 1. To prevent medical errors, healthcare can apply lessons learned from high-risk industries that have been successful in changing their culture, resulting in decreased errors and safety improvement.

**Lessons from Other Industries**

The aviation and nuclear power industries, both considered high-risk industries, have implemented incident-reporting systems in an effort to improve safety (Barach & Small, 2000). The aviation industry gathers data about the occurrence of errors, near misses, and incidents that could potentially lead to errors via confidential, voluntary, self-reporting systems (Aviation Safety Reporting System, 2004a, 2004b). The culture within aviation emphasizes effective communication and teamwork (Pape, 2003), while avoiding a culture based on blame and punishment (Helmreich, Musson, & Sexton, 2001; Hughes, 2004). Dotan reported in one aviation case example that changing a reporting system from a punitive system to one focused on improvement resulted in an increase in reports, but a decrease in the accident rate by 50 percent (Dotan, November 2003).-
The experiences and lessons learned from these industries can be applied to healthcare. For example, interventions used in aviation were applied to the process of medication administration and resulted in a significant decrease of interruptions during medication administration (Pape, 2003). Research conducted comparing pilots and healthcare professionals’ perceptions of fatigue are also very informative. A study of pilots, nurses, and doctors explored perceptions of fatigue and found 26 percent of pilots, 55-64 percent of nurses and 47-70 percent of doctors reported they could perform effectively when fatigued (Sexton, Thomas, & Helmreich, 2000). While nurses, physicians, and pilots are “expected to function without error” (Sexton et al., 2000, p. 747), the differences cited in the research may be partially accounted for by the differences in work cultures of healthcare providers and pilots. The culture in the aviation industry promotes safety by restricting pilot flight and promoting rest times to avert the adverse effects of fatigue. (Federal Aviation Administration, 2001, 2005a, 2005b) The IOM report Keeping Patients Safe: Transforming the Work Environment of Nurses recommends limiting the hours of nurses providing direct patient care to twelve hours in a 24 hour period and 60 hours in a seven day period. (Page 2004)

Studies aimed specifically at healthcare providers present sobering data about fatigue and patient safety. In a study of 393 nurses, it was reported that errors were three times more likely to occur when a nurse worked a prolonged shift, e.g., longer than 12.5 hours (Rogers, Hwang, Scott, Aiken, & Dinges, 2004). In another study of more than 600 nurses, concerns related to the effects of rotating shifts and adequate sleep patterns were identified as factors that affected patient safety. The investigators found that the odds of a nurse making an error were “twice as high” among nurses who rotated shifts compared with nurses working straight days or evenings (Gold, Rogacz, Bock,
Together, nurses should explore innovative solutions, based on evidence, to address work-related fatigue so as to minimize the occurrence of errors that threaten patient safety (Hughes & Rogers, 2004).

**Patient Safety and the Role of Culture: A Case Study**

It is important to understand what a culture of safety entails in the workplace. The following case study illustrates the differences in a culture of safety versus a culture of blame. This case study presents two organizations with different cultures and their responses to a patient safety concern identified by the nursing staff. Other organizations may discover different or additional factors that could lead to “near misses” or “errors” and may develop customized strategies to improve care. This case study is provided for illustrative purposes only.

Laura Brown, RN is a new nurse working with a preceptor, Sally Grant, RN at a community hospital. Laura receives medication in a syringe from the pharmacy for one of her patients. Prior to administering the drug, she notes that the route of administration for the medication in the syringe is oral. While doing so, she notices the syringe looks like an intravenous (IV) syringe. Laura identifies a potential error that could happen if the oral syringe was mistaken for IV use. Ms. Brown seeks out her preceptor to tell her about her observation.

**Response in a Culture of Blame:** When Laura speaks with her preceptor about the incident, Sally incredulously responds by saying, “I cannot believe you could think such an error could occur. What are you thinking?” Sally then proceeds to lecture Laura that she works in a busy unit, and that she is responsible for any medication errors that she causes and that she must pay attention and be vigilant; after all, errors occur when nurses don’t do their jobs well. Sally then continues warning Laura that “you could cause serious harm to patients if you are not
careful.” Ms. Brown feels like she has failed and is concerned that if this is the reaction when a potential problem is identified, then what would happen if an error actually occurred?

**Response in a Culture of Safety:** After Laura relates the incident to her preceptor, Sally commends Laura for raising the concern that oral medication could mistakenly be administered intravenously because the syringes look almost identical. Sally contacts the pharmacy to discuss the concern. Together, the pharmacy and nursing teams meet to conduct an analysis of the “near miss” incident. The multidisciplinary team uses a root cause analysis (RCA) approach (VA National Center for Patient Safety, 2005b, 2005c) to identify contributing factors to the “near miss” incident. The team reviews current practice to determine what happened, why it happened, and what to do to prevent it from recurring (VA National Center for Patient Safety, 2005c). In assessing what happened, the team realizes that the type of syringe dispensed with the oral medication could potentially contribute to the medication being administered incorrectly because both the oral and IV syringes do look very similar. After completing the analysis, the team developed a customized action plan for its organization to help prevent such incidents from occurring. Based on its unique organization, the team developed the following action plan:

1. Obtain specific syringes for oral use that look different than intravenous/parenteral syringes (Institute for Healthcare Improvement, Paparella, 2004) and that are “designed to be incompatible with IV ports and needles” (Woods, 2003, p. 6).

2. Ensure that all oral syringes dispensed from the pharmacy are clearly labeled “for oral use only” to alert healthcare providers.

3. “Store oral syringes separately” (Institute for Healthcare Improvement) from intravenous/parenteral syringes.
4. Revise policy and procedures to reflect the need to use oral syringes “only” for oral medication and other safety interventions related to safe administration of medication.

5. Provide education programs for nursing, pharmacy, medical staff, and ancillary staff to communicate changes and reasons for change in the policy and procedures.

6. Monitor compliance with newly revised policy and procedures in units. Determine if the changes are adequately addressing the original problem. Encourage vigilance in use of new syringes to identify any unanticipated problems. Be prepared to address additional concerns.

7. Personally thank pharmacy and nursing staff members that identified the safety concerns, and the team that conducted the root cause analysis and developed the recommendations to improve safety within the organization.

8. Reinforce using the seven rights when administering medication to avoid errors (right patient, right medication, right dose, right time, right route, right reason, and right documentation) (Pape, 2003).

9. The action plan will include tasks to be completed, persons responsible, and due dates.

In this example, the key aspect of a culture of safety is an effort to analyze incidents in a nonbiased, interdisciplinary manner and ultimately improve patient care through an analysis process. Unlike a culture of safety, the response in a culture of blame did not explore other factors (e.g., the design of the syringe) or influences that could have contributed to the situation.
In a culture of blame, there was not an attempt to analyze the situation to prevent recurrences or report the concern. Further, the atmosphere is punitive with a lack of supportive communication. Because Sally reacted to Laura’s actions in a punitive way, Laura will most likely be reluctant to share such concerns in the future. As a result, there is a missed opportunity to improve patient care in this organization with this type of environment.

As illustrated in the case example, a culture of safety is beneficial because the reasons for the “near miss” or “error” are analyzed and discussed in a supportive way. Potential solutions and approaches are identified by interdisciplinary teams in a collaborative atmosphere (VA National Center for Patient Safety, 2005c). Open, honest communication is encouraged, (Page, 2004) and input is sought from the staff. Once a viable strategy is identified, the solution will be implemented and disseminated throughout the organization. Once disseminated, follow-up is essential. An evaluation of the solution should be completed and revisions should be instituted to alleviate gaps or problems identified with the proposed solution. This is a continuous cycle of assessment, planning, implementation, and evaluation familiar to nurses. In a culture of safety, those that report “near misses” are recognized positively for identifying a potential patient safety concern and for calling attention to a system problem, thereby improving the quality of care delivered at this organization. A culture of safety supports the reporting of “near misses” and errors to improve the delivery of care (VA National Center for Patient Safety, 2005a).

Moving Toward a Culture of Safety

Nurses are an integral part of the healthcare delivery system, being in a unique position to make patient care as safe as possible. The development of a culture of safety has three stages:
Stage 1: Emphasis is on complying with regulatory standards and meeting technical requirements.

Stage 2: Good safety performance is seen as an organizational goal and valued as being important.

Stage 3: The culture of safety permeates the organization and there is an emphasis on continuous improvement. (Page, 2004).

To move from a culture of blame toward a culture of safety, change is necessary. Elements in a change process include leadership, effective communication, redesign to support the change, training and education programs, and an ongoing measurement of progress that incorporates reward and recognition strategies (Vestal & Spreier, 1997). The culture of safety as described by the IOM includes leaders and managers committed to promoting a culture of safety at all levels of the organization, and empowers employees to be attentive to and observant of potential problems that need to be addressed (Page, 2004). Open communication is emphasized and encouraged among all staff members and management (Page, 2004). A culture of safety recognizes that safety is not an accident. It requires all staff to be properly trained and educated with regard to patient safety and prevention. It requires that the requisite supply of resources and infrastructure is present and available so staff can function efficiently and effectively within the workplace.

Where Do We Go from Here?

Despite the many patient safety efforts undertaken since the release of the IOM report, there is still much work to be done. A recent national survey of consumers highlighted continuing concerns about patient safety and healthcare quality. Fifty-five percent of those surveyed reported dissatisfaction with the quality of care received, and 34 percent reported that
they or a family member had experienced a medical error (Kaiser Family Foundation, 2004). There is a perception that healthcare suffers from a culture gap when it comes to safety: “the healthcare industry is a laggard behind virtually all other sectors of our economy in allowing unsafe service to proliferate” (Gibson & Singh, 2003, p. xix). More action needs to be taken to instill a greater sense of confidence in the healthcare system. Healthcare needs to acculturate the best practices from other industries, such as the nuclear and aviation industry, to best implement the axiom of “first do no harm.” According to the IOM, an adequate healthcare delivery system must possess the capabilities to ensure services that are safe, effective, patient-centered, timely, efficient, and equitable (Institute of Medicine, 2001).

Nurses are committed professionals in a unique role to advocate for patient safety and contribute to the overall efforts to reform healthcare. Nurses are the largest group of healthcare providers in the nation and are regarded by the public as the most highly ethical and honest group of professionals (Moore, 2004). Thus, nurses and the nursing profession play a distinctive role in promoting positive change that will ultimately benefit patients.

**Tools to Improve Safety**

One way of improving the quality of care and preventing medical errors is to learn from medical errors (Leape, 2002). There are several error-reporting tools that can help practitioners develop a supportive culture of safety, so that they can learn from errors to improve care delivery. One such tool, from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), utilizes a voluntary reporting system to capture serious adverse events (O'Leary, 2000). Serious adverse events are termed “sentinel events” and are defined as “any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof” (Joint Commission on Accreditation of Healthcare Organizations, 2002). The purpose
of this type of voluntary reporting is to identify and respond to such events to improve the 
quality of care delivered (Joint Commission on Accreditation of Healthcare Organizations, 
2002). Healthcare organizations are required to respond to sentinel events and conduct root cause 
analysis. The JCAHO developed a framework for conducting root cause analysis to educate and 
assist healthcare organizations in analyzing sentinel events (Joint Commission on Accreditation 
of Healthcare Organizations, 2005b). Between 1995 and 2004, there were 2,966 sentinel events 
reviewed and analyzed by JCAHO (Joint Commission on Accreditation of Healthcare 
Organizations, 2005d), and more than 60 percent of sentinel events reported to JCAHO 
identified communication as a root cause of the event (Joint Commission on Accreditation of 
Healthcare Organizations, 2004).

In addition to the sentinel events program, the JCAHO began requiring compliance with 
its National Patient Safety Goals for organizations seeking accreditation, thus ensuring a greater 
focus on patient safety. The JCAHO has developed safety goals for ambulatory care, assisted 
living, behavioral health, home care, hospitals, and long-term care organizations (Joint 
Commission on Accreditation of Healthcare Organizations, 2005c). These goals are reviewed 
and revised each year, and apply to various accreditation programs offered by JCAHO. Some of 
the 2005 goals include:

- Improve the accuracy of patient/client/resident identification
- Improve the effectiveness of communication among caregivers
- Reduce the risk for healthcare-associated infections (Joint Commission on 
  Accreditation of Healthcare Organizations, 2005a).

The complete list of safety goals, including the new 2006 Patient Safety Goals are available at 
the JCAHO website (www.jcaho.org/accredited+organizations/patient+safety/npsg.htm).
Another program addressing patient safety is the United States Pharmacopoeia, which operates the Medication Errors Reporting Program with the Institute for Safe Medication Practice (ISMP). This program utilizes a voluntary reporting mechanism to track medication incidents (Institute for Safe Medication Practices, 2005). Through its voluntary approach, this program promotes a systems approach to medication error analysis, and preventive strategies and recommendations can be shared with healthcare providers to avoid reoccurrences (Institute for Safe Medication Practices, 2005).

A safety culture assessment can be a useful tool for improving patient safety, diagnosing the safety culture of an organization, raising safety awareness, and identifying opportunities for improvement (Nieva & Sorra, 2003). The IOM recommends “conducting an annual, confidential survey of nursing and other healthcare workers to assess the extent to which a culture of safety exists” (Page, 2004, p. 15). The Hospital Survey on Patient Safety Culture measures various dimensions of the culture, including both hospital and unit level aspects. The unit level aspects that are measured include:

- Supervisor/manager expectations and actions promoting safety;
- Organizational learning—continuous improvement;
- Teamwork within units;
- Communication openness;
- Feedback and communication about error;
- Nonpunitive response to error; and
- Staffing (Sorra & Nieva, 2004, p. 3).

This survey, funded by AHRQ, can be found at [www.ahrq.gov](http://www.ahrq.gov) along with guidance for administration and reporting the results. There are other initiatives that address the issues of
patient safety and error prevention, too numerous to mention here. However, nurses are encouraged to research the following selected websites to enhance their expertise in patient safety. (See Patient Safety Websites **Table 2**)

**What Can Nurses Do?**

The culture of safety is essential to the efficient, competent delivery of quality care. Fortunately, there are several nursing organizations that are addressing patient safety issues. One group is the Center for American Nurses (CAN), which has developed educational material for nurses discussing the role of the environment in promoting patient safety in its publications; *Transforming Nursing Work Environments to Enhance Safety and Quality: What CMAs and Nursing Leaders Can Do* and *The Nation’s Quality Problem and Why Nurses Must Step Up to the Plate* (Greiner). In January 2005, the American Association of Critical-Care Nurses (AACN) embarked on an ambitious effort to promote patient safety and healthy work environments for nurses. The AACN developed standards for healthy work environments (American Association of Critical-Care Nurses, 2005), described in **Table 3**. These six new standards are congruent with developing a culture of safety within healthcare environments.

These are just a few of the nursing initiatives that are underway to address the patient safety problem. Nurses can contribute to the culture of safety by acknowledging deficiencies and working to resolve them. In one study of medication errors, nurses were noted to be “the ones most likely to intercept errors” (Leape et al., 1995 p. 37) and responsible for an 86 percent interception rate of medication errors prior to medication being administered.

The problems facing healthcare are so varied and complex that it will take a multifaceted approach from nurses and others to solve the problems and improve patient safety. Healthcare
environments need to be respectful of all members of the healthcare team, support honest communication and a culture of safety, and empower all to “do the right thing.”

**Table 1: Comparisons of Cultures**

<table>
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<tr>
<th>Characteristics of a Culture of Safety</th>
<th>Characteristics of a Culture of Blame</th>
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<tr>
<td><strong>Leadership and Support</strong></td>
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<tr>
<td>• The leaders promote a culture of safety (Kohn, Corrigan, &amp; Donaldson, 2000; Larson, 2000)</td>
<td>• Leadership not visible in supporting safety</td>
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<tr>
<td>• Leadership provides the resources needed to promote patient safety (Institute for Healthcare Improvement, 2005)</td>
<td>• Leadership does not provide resources needed to promote patient safety</td>
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<tr>
<td><strong>Event Analysis</strong></td>
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<tr>
<td>• Root Cause Analysis approach “what happened, why did it happen, what to do to prevent from happening again” (VA National Center for Patient Safety, 2005b)</td>
<td>• Punitive approach to “near misses” and errors (Hughes, 2004)</td>
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<td><strong>Reporting</strong></td>
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<td>• Learn from reported medical errors to prevent reoccurrence (Leape, 2002)</td>
<td>• There is a reluctance to report errors because of fear of punitive response and suppression of open discussion related to medical errors (Simpson &amp; Berry, 2001)</td>
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<td>• More reports being generated is perceived positively by the organization as opportunities to make improvements in the system are identified (Dotan, November 2003)</td>
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<td><strong>Communication</strong></td>
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<tr>
<td>• Effective open communication (Page, 2004)</td>
<td>• Lack of effective communication</td>
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<tr>
<td>• Recognition of importance of communication and collaboration among all team players (American Association of Critical-Care Nurses, 2005)</td>
<td>• Hierarchical communication (Page, 2004).</td>
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<tr>
<td><strong>Emphasis</strong></td>
<td></td>
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<tr>
<td>• Emphasis on prevention, not punishment (VA National Center for Patient Safety, 2005a)</td>
<td>• Emphasis on punishment, not prevention</td>
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<tr>
<th>Organization</th>
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<td>American Nurses Association</td>
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<tr>
<td>Association of PeriOperative Registered Nurses</td>
<td><a href="http://www.patientsafetyfirst.org">www.patientsafetyfirst.org</a></td>
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<td>Agency for Healthcare Research and Quality</td>
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<td>American Association of Critical-Care Nurses</td>
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<td>Institute for Healthcare Improvement</td>
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<td>Institute for Safe Medication Practices</td>
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<td>National Center for Patient Safety</td>
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<td>National Patient Safety Foundation</td>
<td><a href="http://www.npsf.org">www.npsf.org</a></td>
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<td>U.S. Food And Drug Administration</td>
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**Table 3: American Association of Critical-Care Nurses’ Standards for Establishing and Sustaining Healthy Work Environments***

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<tr>
<th>Standards</th>
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<tbody>
<tr>
<td>1. Skilled Communication</td>
<td>Nurses must be as proficient in communication skills as they are in clinical skills.</td>
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<tr>
<td>2. True Collaboration</td>
<td>Nurses must be relentless in pursuing and fostering true collaboration.</td>
</tr>
<tr>
<td>3. Effective Decision Making</td>
<td>Nurses must be valued and committed partners in making policy, directing and evaluating clinical care, and leading organizational operations.</td>
</tr>
<tr>
<td>4. Appropriate Staffing</td>
<td>Staffing must ensure the effective match between patient needs and nurse competencies.</td>
</tr>
<tr>
<td>5. Meaningful Recognition</td>
<td>Nurses must be recognized and must recognize others for the value each brings to the work of the organization.</td>
</tr>
<tr>
<td>6. Authentic Leadership</td>
<td>Nurse leaders must fully embrace the imperative of a healthy work environment, authentically live it, and engage others in its achievement.</td>
</tr>
</tbody>
</table>


References


