A Culture of Safety—Whose Responsibility?

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WE KNEW AS EARLY as 1998 when the Institute of Medicine report, *To Err Is Human: Building a Safer Health System* was published that up to 98,000 patients die each year in the United States as the result of preventable medical error.[1] Fifteen years later, the National Patient Safety Foundation's report, *Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human*, found that despite some improvement in patient safety in the US, the improvement has been slow and limited. Unfortunately, patients continue to experience harm when interacting with the health care system.[2]

This finding has been brought home these past few weeks with two very visible, yet very different instances of patient harm. In a large university hospital in Tennessee, a nurse was indicted by a grand jury with charges of reckless homicide and impaired adult abuse in the death of a patient in 2017 due to medical error. The reports so far are that the nurse ignored safety precautions and administered vecuronium intravenously into a patient instead of Versed.[3] The 75-year-old patient who was undergoing treatment for a subdural hematoma was to receive a full body scan, but was ordered Versed because of claustrophobia. Allegedly, the nurse was using an electronic medicine cabinet, and when she could not find Versed, she used an override feature, typed in "VE", pulled out vecuronium and injected the patient. The patient was left alone for the scan, and later discovered as not breathing, and coded. She died the next day.[3]

This is a medical error with the worst possible outcome in terms of patient safety. Blogs and listserves about the error are mixed. Some nurses are very supportive because of the fact that all of us are human and make mistakes, though typically without such consequences, and others are critical of the fact that the nurse overrode the safety system and did not check the label before administration of the medication. What is true is that this seems to be a system failure with more than one cause for the error. The Institute for Safe Medication Practices (ISMP) disagrees with criminal action blaming "common, underlying system vulnerabilities that contributed to the error."[4] The details are not reported by the grand jury; we will only know those in the future. However, the fact that this nurse was charged with reckless homicide is chilling to many nurses and chilling to those who are supportive of a culture of "no blame" which requires accurate reporting from all who make errors or almost make errors ("near misses"). How will this affect those who make errors in the future? While it is easy to place blame, in reality don't most of us breathe a sigh of relief that our errors have not caused a patient's demise?

A second example of patient harm is from a large hospital in Ohio. A physician is under criminal investigation by the local homicide cold case unit and the County Prosecutor's office.[5] He is accused of ordering excessive doses of Fentanyl and other painkillers for at least 34 patient who were on ventilators near death. The medications are believed to have caused the deaths of 28 of those 34 patients. The hospital received formal complaints on October 25, November 19, and November 21, when he was pulled from patient care. He was subsequently fired on December 5 and the State Medical board and county prosecutor were notified. The hospital then notified The Joint Commission, State Nursing Board, and state Board of Pharmacy. The first family to sue has made the accusation that the patient received 1000 mcg of Fentanyl to hasten her death, and she died 18 minutes later. Apparently, the physician would issue the medication order as an emergency order to work-around the

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pharmacy department. He then talked the nurses into administering the medication. Twenty-three employees, nurses, pharmacists, and managers have been suspended pending investigation.[5-7]

This example shows an intentional administration of inappropriate medication dosage rather than an inadvertent error. For those of us who administer Fentanyl daily for acute pain in the postanesthesia care unit, it seems unimaginable that a nurse would open multiple vials of Fentanyl and administer to the patient. While we know details only from news and television reports, these two instances illustrate in a tragic way that preventable patient harm still occurs.

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Key features of organizations with inherently complex and hazardous work (such as the airline industry) that consistently reduce adverse events, include a "blame-free" environment where individuals are able to report errors or near misses without fear of reprimand or punishment and an organizational commitment to address safety concerns.[8] While reading about these two examples, you may have wondered where personal accountability fits into a culture of "no blame." The issue of distinguishing between errors that are appropriate for "no-blame" and errors that require appropriate accountability is complex and often a dilemma. The concept of "just culture" focuses on systems that lead persons to participate in unsafe actions, while maintaining personal accountability by establishing zero tolerance for irresponsible behavior.[8] In a just culture, the reaction to an error or near miss is based on the type of action associated with the error, not the severity of the event. For example, reckless behavior such as refusing to perform a "time-out" prior to surgery would warrant disciplinary action, even if patients were not harmed.[9] A systems approach, which replaces blame with a focus on identification of system flaws has been responsible for much progress of the patient safety movement. However, most leading experts agree that blame is "appropriate for individuals who make frequent, careless errors, who fail to keep up with their specialty, who come to work intoxicated, or who choose to ignore reasonable safety rules." Application of a just culture is a way to reconcile "no blame" when caring, competent personnel make errors with the need to hold individuals or institutions accountable for culpable and blameworthy errors.[9]

Evidence exists that a culture of safety results in better clinical outcomes including reduced infections and hospital readmission rates.[9] What defines a culture of safety can vary across hospitals, and can also vary among units within a hospital. Checklists can be used as a method to ensure adherence to safety processes. While checklists are not the only answer, they—and other safety-oriented activities such as standardization, simplification, forcing functions (forcing conscious attention and disrupting automatic actions), and double checks—can help deliver patient care that is safe and more reliable.[9]

Until we have more information, it will be hard to determine exactly what happened in each of the above circumstances. I have no answers and will cast no aspersions. I do think it is worth the discussion. As nurses, and as the most trusted profession in the US,[10] it is imperative that we do our part to keep our patients safe, and whether from our position at the bedside or providing leadership for the unit culture, our active participation is needed.

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