



RNAO

Registered Nurses
Association
of Ontario

L'Association des infirmières
et infirmiers autorisés de
l'Ontario

Policy Statement on Patient Safety

Introduction

The Registered Nurses Association of Ontario (RNAO) believes patient safety is a priority in public accountability for individual nurses, administrators, organizations, professional associations and all levels of government. In striving for excellence and optimal outcomes of care, registered nurses (RNs), as a key link in the health care system, protect and enhance the health of patients/clients whether the client is an individual, family, or community. In so doing, nurses create environments that support patient safety. Patient safety has emerged as a priority national and provincial issue in health care. The evidence suggests many errors can be prevented. It is therefore incumbent on all health care providers, organizations, and governments to create cultures of safety that support safe practice for both patients and staff.

Background

Numerous initiatives (national, provincial, territorial and local levels) including research activities, coalitions, and national reports have repeatedly pointed to the gaps in safety and outcomes associated with adverse events within the healthcare system. Recently, the release of the Canadian Adverse Events Study (Baker, Norton et al. 2004) indicated 36.9% of adverse events were

preventable.ⁱ Adverse events in hospitals have been reported in several countries with as many as two-thirds of all errors considered to be preventableⁱⁱ.

Collectively, these key documents have heightened pressures to improve patient safety within our health care system.

Currently, many patient safety outcomes linked to nursing practice are discussed in negative terms and include medication errors, nosocomial infections, patient falls, and pressure ulcers.ⁱⁱⁱ Patient safety has been defined as preventing and mitigating unsafe acts by protecting people from harm (real or potential)^{iv}. A more comprehensive view however, builds on protection to “nurture the human capacity for sustaining life through processes that assist, heal, and revitalize responses toward health and well being”^v

RNAO supports a broader perspective of patient safety that moves beyond error and physical safety of patients to one that includes psychological safety (e.g. verbal threats or intimidation) and the creation of safe environments. This broader patient safety perspective is supported by recommendations from reports and research studies that emphasize moving from a culture of blame to a focus on the systemic challenges^{vi}. One important initiative at

the national level has been the creation of the Canadian Patient Safety Institute (CPSI) by the federal government in 2003 which is mandated to provide leadership and coordination building quality improvement throughout the health care system.^{vii} Two key nurse leaders are founding CPSI Board of Director members.

Considerations in Patient Safety

Three key aspects of patient safety have particular relevance for nursing. These are quality care and nursing; quality work environments; and multi-level accountability.

Quality Care and Nursing

Patient safety must be viewed within the context of excellence in nursing care and an outcome of quality care in all sectors. RNs view patient safety as a moral and ethical imperative in caring for others^{viii}. RNs as the care provider overseeing and coordinating care 24 hours a day, seven days a week have a vital contribution to improving patient safety through assessment and clinical decision-making. The nurse's ability to influence decisions that positively impact patient care and the ability to provide continuity of care grows out of knowledge of the patient as well as skill, educational preparation, and experience. It is therefore critical that nursing practice be supported and strengthened.

While patient safety is a cornerstone in all domains of practice, nurses are also challenged in their ability to deliver safer processes of care and to be accountable for patient safety^{ix}. Factors such as workload, staff shortages, and increased complexity of patients contribute to increased risk to patients and increase the likelihood of adverse events within

the health care environment.^x Moving beyond error reduction and risk management to a broader perspective of the complexities in the processes of care is fundamental in building a safe health care system.^{xi} As such, effective and safe systems are required to promote optimal health and minimize harmful effects of treatment and care.^{xii}

Quality Work Environments

Quality outcomes of care are fostered in quality work environments. A safe environment for patients/clients must also be safe for staff. Not only must the physical environment be safe, but staff must also feel confident to question practices and challenge assumptions in order to learn and grow. Traditional approaches to dealing with error have focused on individual responsibility,^{xiii} limiting open dialogue and sharing of concerns^{xiv}. In organizations where there is a culture of blame, staff is discouraged from speaking out about structures and policies that contribute to adverse events. Whistleblower protection is a key strategy in promoting a culture of disclosure that enables staff to speak out, without fear of retribution, when they believe patient or staff safety is being compromised.

Practice environments enable or disable nurses and other health care professionals in their ability to provide safe care. Quality of care is jeopardized with current levels of part time, casual, and agency employment. The research is replete with evidence documenting an association between a richer skill mix of registered nurses and shorter length of stay in hospital, mortality, and failure to rescue.^{xv} It is therefore essential that 70% of registered nurses work fulltime, an attainable and sustainable target if all

RNs were provided with their choice of employment status ^{xvi}. Clearly, quality work environments are linked to quality patient outcomes.

Multilevel Accountability

As with most aspects of care, responsibility for safe practice resides at multiple levels: that of the individual nurse, organization, profession, and government ^{xvii}. System improvement requires a collaborative approach with the citizens, health professionals, employers, and governments at all levels. Partnerships are required to ensure effective and safe systems are in place by bringing together the collective expertise and perspective of each health discipline in developing workable strategies for optimal health. ^{xviii}

If health care leaders truly view patient safety as a priority, then they must be prepared to address the systemic issues within organizations that enable learning and change to occur to create and sustain work environments conducive to patient safety ^{xix}. Accountability can be strengthened within organizations such as through reporting practices and disclosure policies that foster a culture of openness and ability to share concerns.

A Call for Action

RNAO believes that in spite of challenging work environments, action can be taken to provide an environment that supports excellence and consequently, a safe environment for patients and caregivers. Specifically, structures to support cultures of safety are required. In this context, RNAO recommends the following strategies that cross-cut the 3 key aspects of patient safety for nursing and health care.

- Amend legislation to have a senior nurse administrator in all sectors responsible for nursing practice who reports to the chief executive officer.
- Require that when nurses are the principal care providers, the manager to whom they report must be a registered nurse.
- Put structures in place for meaningful participation by registered nurses in decision making related to patient care.
- Introduce whistle blower protection at the provincial level to enable health care providers to speak out when safety is being compromised.
- Administrators share in the responsibility along with individual nurses in patient safety.
- Implement 70% fulltime employment for registered nurses in all sectors. Minimize use of agencies and multiple employers.
- Create a blame free organizational culture.
- Introduce structures within organizations to re-engineer systems for standardization and checks to intercept errors before they reach the patient ^{xx}.
- Promote collaborative team practice in work settings.
- Support and conduct research on nursing's contribution to patient safety science and quality health care.

All individuals have a right to safe effective care in all sectors in all practice settings. The Registered Nurses Association of Ontario asserts that collective action at all levels to address

system issues and supporting registered nurses in providing optimal patient will create a safer health care system, evident by quality outcomes to patients/clients, organizations/communities, the system and the nursing profession. September 2004.

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