

2016: Creating a Culture of Safety in Oncology

Nurses play vital roles in preventing errors and improving the quality of care for patients. However, in the breakthrough Institute of Medicine (IOM) reports, *To Err Is Human: Building a Safer Health System* (IOM, 1999) and *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001), it was estimated that about 44,000–98,000 Americans die each year as a result of medical errors. Gibson and Singh's (2003) book, *Wall of Silence: The Untold Story of the Medical Mistakes That Kill and Injure Millions of Americans*, shared real-life stories of medical mistakes to help raise awareness and create a sense of urgency for the issues surrounding healthcare errors. Gibson and Singh (2003) also included aspects of the human side of errors—the perceptions of the healthcare providers regarding their errors and the responses of patients who had been harmed.

Many actions to improve the safety of the healthcare environment and reduce adverse events for patients have been taken since the publication of those three reports (Gibson & Singh, 2003; IOM, 1999, 2001). Nurses have been instrumental in many of the initiatives to improve patient safety and the quality of care. For example, in 2011, the American Nurses Association (ANA) partnered with the Centers for Medicare and Medicaid Services (CMS) to form the Partnership for Patients (PfP) (<http://1.usa.gov/1oYECMJ>). The focus of PfP is quality improvement, patient safety, and cost-effective patient care (CMS, n.d.). The three key elements of this partnership have been widely implemented: hospital engagement networks (currently 17 contracts), community-based care transitions programs (in 46 sites), and patient and family engagement to improve the relationship between healthcare professionals and patients and their families.

A specific initiative of PfP is to reduce hospital-acquired conditions, such as

catheter-associated urinary tract infections (CAUTI). In response, the ANA (n.d.) developed the CAUTI prevention tool using an expert panel, evidence, and previously published guidelines from the Centers for Disease Control and Prevention (2009). The tool is a nurse-driven protocol to decrease urinary tract infections in hospitalized patients.

In addition, the ANA has launched the 2016 Culture of Safety campaign (<http://bit.ly/ITSOLYD>). This year-long campaign is the result of the sustained commitment of organizations, such as the ANA, and leaders, managers, and healthcare workers in clinical care to emphasize safety over competing goals.

Other national organizations are involved in defining the role of healthcare institutions in creating a culture of safety. The Agency for Healthcare Research and Quality (2014) has outlined the key features for establishing a culture of safety:

- Acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations
- A blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment
- Encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems
- Organizational commitment of resources to address safety concerns.

Across healthcare organizations, settings, and professions, there has been an impetus to share evidence from research

and practice settings and improve reporting of errors and near misses to enhance safety in health care (Leonard, Frankel, Federico, Frush, & Haraden, 2013) (see Figure 1).

Cancer care is complex and sometimes hazardous work that requires extra vigilance to maintain safety in care delivery for patients and providers. Oncology nurses work hard to increase the quality of care from chemotherapy and radiation therapy delivery to minimize adverse events for patients. Oncology nurses also understand that a blame-free environment is needed so that clinicians report errors or near misses to help identify problem areas and adjust and improve care-delivery systems.

The *Clinical Journal of Oncology Nursing* has historically addressed the issues of safety with two key columns: *Safety*, which debuted in 2008, and *Quality*, which debuted in 2013.

The *Safety* column, edited by associate editor David Glenn, RN, MS, examines potential hazards such as medications, falls, radiation risks, oncologic emergencies, and other safety concerns that may affect patients with cancer and the nurses and family caregivers who care for them. The *Quality* column, edited by associate editor Anne Gross, PhD, RN, FAAN, disseminates quality improvement work in oncology care that has improved cancer care. More information about these two columns can be found at <https://cjon.ons.org/content/columns-and-editorial-board>.

Creating a safe environment is everyone's job—oncology nurses, managers, administrators, national organizations,

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American Nurses Association

The American Nurses Association, as part of the Culture of Safety campaign, is providing monthly topics, such as Emerging Infections and Transitions in Care, on their website, <http://bit.ly/1TS0LYd>. ANA is also promoting the health and safety of nurses at Healthy Nurse™. www.anahealthynurse.org

American Society of Clinical Oncology

The Institute for Quality and the Quality Oncology Practice Initiative (QOPI®) provide tools for oncology practices to assess care and improve outcomes. Three QOPI measures were started in 2015 that are relevant to nursing practice: assessment of pain, assessment of emotional well-being by second visit, and review of advance directives by the third visit. <http://bit.ly/1RnYkrA>

Centers for Disease Control and Prevention

The National Healthcare Safety Network tracks healthcare-associated infections to identify problem areas and track progress toward prevention and elimination of healthcare-associated infections. www.cdc.gov/nhsn/about-nhsn/index.html

National Comprehensive Cancer Network

Oncology nurse experts were included on the Expert Panel for Distress Management. www.nccn.org/professionals/physician_gls/pdf/distress.pdf

Oncology Nursing Society

The Oncology Nursing Society has developed evidence-based guidelines for pain, anxiety, and depression with the Putting Evidence Into Practice initiative. www.ons.org/practice-resources/pep

Oncology Nursing Society/American Society of Clinical Oncology

The Oncology Nursing Society and American Society of Clinical Oncology have collaborated on the development of the Oncology Nursing Society and American Society of Clinical Oncology Chemotherapy Administration Safety Standards, which now include safe administration of oral chemotherapy, a growing concern in cancer care. www.ons.org/sites/default/files/2013chemostandards.pdf

FIGURE 1. Organizations Promoting a Culture of Safety in Health Care

and family members and caregivers. Working together, we can create a culture of safety that improves the quality of care for patients with cancer, decreases

adverse events for patients and health-care workers, and integrates a humane system for reporting errors to help identify areas for quality improvement.

References

- Agency for Healthcare Research and Quality. (2014). Safety culture. Retrieved from <https://psnet.ahrq.gov/primers/primer/5/safety-culture>
- American Nurses Association. (n.d.). ANA CAUTI prevention tool. Retrieved from <http://nursingworld.org/ANA-CAUTI-Prevention-Tool>
- Centers for Disease Control and Prevention. (2009). Guideline for prevention of catheter-associated urinary tract infections, 2009. Retrieved from http://www.cdc.gov/hicpac/cauti/001_cauti.html
- Centers for Medicare and Medicaid Services. (n.d.). About the Partnership for Patients. Retrieved from <http://1.usa.gov/1oYECMJ>
- Gibson, R., & Singh, J.P. (2003). *Wall of silence: The untold story of the medical mistakes that kill and injure millions of Americans*. Jackson, TN: Perseus Distribution Services.
- Institute of Medicine. (1999). *To err is human: Building a safer health system*. Washington, DC: National Academies Press.
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press.
- Leonard, M., Frankel, A., Federico, F., Frush, K., & Haraden, C. (Eds.). (2013). *The essential guide for patient safety officers* (2nd ed.). Oakbrook Terrace, IL: Joint Commission Resources.