Leadership to Promote Patient Safety
Culture and Learning in Critical Care

Deborah Tregunno, RN PhD
Lianne Jeffs, RN PhD (c)
G. Ross Baker, PhD
Diane Doran, RN PhD
Linda McGillis-Hall, RN PhD
Dyane Affonso, RN PhD

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**PRINCIPAL INVESTIGATOR**

Deborah Tregunno RN PhD  
Assistant Professor  
School of Nursing, Faculty of Health  
York University  

Telephone: 416-736-2100 ext. 22037  
Fax: 416-736-5714  
E-mail: tregunno@yorku.ca  

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For more information on the Canadian Health Services Research Foundation, contact the Foundation at:  

1565 Carling Avenue, Suite 700  
Ottawa, Ontario  
K1Z 8R1  

E-mail: communications@chsrf.ca  
Telephone: 613-728-2238  
Fax: 613-728-3527
**PRINCIPAL INVESTIGATOR**
Deborah Tregunno, RN PhD

**CO-INVESTIGATORS**
Lianne Jeffs, RN MScN
G. Ross Baker, PhD
Diane Doran, RN PhD
Linda McGillis-Hall, RN PhD

1 School of Nursing, Faculty of Health, York University,
2 St Michael’s Hospital, Toronto
3 Faculty of Medicine, University of Toronto
4 Faculty of Nursing, University of Toronto

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Leadership to Promote Patient Safety Culture and Learning in Critical Care
KEY IMPLICATIONS FOR DECISION MAKERS

- Hospital decision makers and policy developers can use the evidence from this study to develop a greater understanding of the complexities of the critical care environment, and to explore the ways in which safety culture and improved safety outcomes may be achieved through clinical leadership.

- The safety culture in critical care is described as a pervasive and uncomfortable tension between patient safety threats that are linked to provider knowledge and experience, and those linked to workplace conditions.

- The most commonly reported threats to patient safety in the critical care practice environment reported by all provider stakeholder groups include patient acuity, inadequate physical environment, and insufficient human and technological resources.

- Interdisciplinary teamwork and professional scope of practice are dynamic, and can be seen as either a threat to patient safety or an opportunity for improving safety outcomes.

- There is a need to balance deference to expertise with the burden experienced by senior nurses.

- Work is required to clarify scope of practice, practice standards, competencies, and skill base of team members in the context of professional accountability.

- Work is required to understand the support required by clinical leaders (i.e. expert nurses in charge on daily basis) to help them make decisions that promote the delivery of safe care.

- Work is required to help direct care providers develop a more comprehensive understanding of the dynamic nature of patient safety in their work environment and to manage the paradoxes of accountability in ways that will keep operations at a safe point.
EXECUTIVE SUMMARY

Creating practice environments in which nurses can engage in the delivery of “safe care” is a challenge for today’s nurse leaders. Moreover, recent evidence suggests that error and adverse events are especially common in critical care and that “good management” contributes to improved patient outcomes. Improvements in multidisciplinary teamwork and information technology are important strategies to improve patient safety; however, it has been suggested that these initiatives will fail in the absence of a safety culture.

Focusing attention on the relationship between the quality of the work environment (safety culture) and safety outcomes is important work of nursing leaders. While many have argued that the creation of a safety culture is the key to reducing error in health care, there is a lack of evidence to assist managers and policy makers in making important decisions about how to influence cultural change and how to link culture to improved patient outcomes. In addition, despite general agreement that health care leaders provide the infrastructure and momentum required to fuel cultural change in the practice setting so that patient safety issues are perceived and acted on throughout the organization, there is still limited systematic evidence about how leaders establish safety cultures.

The primary purpose of this study was to explore ways in which the safety culture of the critical care practice environment influences the delivery of safe patient care. This study was unique in that it explored the perceptions of multiple direct care providers (e.g. nurses, physicians, allied health and nurse leaders) simultaneously, as a means of maximizing knowledge about critical care teamwork and the role of nursing leaders in transforming the safety culture.

A grounded theory approach was used to develop and inductively derive a model of patient safety culture in critical care. The study was conducted in six acute care teaching hospitals in Ontario and took place in three phases. In phase 1, best practices and exemplary leader behaviors associated with the creation of safety culture were identified. In phase 2, current threats to the safety of patients and contextual factors that characterize patient safety culture in the critical care practice environment were identified. In phase 3, nurse leaders and other stakeholders identified and prioritized opportunities for leadership and improvement to influence critical care safety culture and improve safety outcomes.
Study findings indicate that the four provider groups have convergent and divergent perspectives of the culture of patient safety. The findings suggest substantial overlap between the four provider groups in their perceptions of the contextual factors that influence their ability to provide safe patient care. The most commonly reported threat to patient safety reported by all groups included inadequate physical space, lack of isolation capabilities, inappropriate hand washing facilities, the lack of equipment, equipment failure and non-standardized equipment, and medication shortages. In addition, a number of operational issues threaten patient safety, including: heavy workload; staff shortages; agency nurses; frequent rotation of residents; the presence of internationally educated physicians; the rapid rate of clinical innovations; administrative delays; challenges of keeping up with changing knowledge; and the challenge of balancing teaching and practice. A key issue is the rapid cycle of patients in and out of critical care and the pressure to discharge patients quickly, and potentially, prematurely.

Findings suggest divergent perspectives around the role of teamwork and scope of practice in relation to patient safety. The most notable difference relates to the role of Allied Health, who are “second string” players (as seen through the metaphor of a sports team). Concerns were expressed about the balance between professional accountability and professional scope of practice. In addition, teamwork and scope of practice are dynamic in nature, and can be seen as either a threat to patient safety or an opportunity for improving safety outcomes. Finally, a key issue is the need to balance deference to expertise with the burden experienced by senior nurses.

This project furthers our understanding of the complexities of the critical care environment and explores the ways in which safety culture and improved safety outcomes may be achieved through clinical leadership. A key theme emerging from this research is the pervasive and uncomfortable tension between patient safety threats that are linked to provider knowledge and experience, and those linked to workplace conditions. There was agreement among the provider groups that improvements were needed in interdisciplinary communication, increased respect and value for professional contribution, greater understanding of the roles and responsibilities of the team members, and shared mental models of patient goals. In addition, substantial work is required to clarify scope of practice, practice standards, competencies, and skill base of team members in the context of professional accountability.
This research focused uniquely on critical care practice in teaching hospitals, and findings may not apply to the same extent in community hospitals. More research is needed to determine whether the issues identified in this study also apply in other sectors. In addition, the perspectives of patients and families were not explored; further research is required to understand the perspectives of this stakeholder group.

Other questions to be explored through subsequent research include 1) What supports are needed for expert critical care nurses who are burdened by the need for them to support junior nurses and junior physicians? 2) What changes are needed to promote understanding of professional roles and interdisciplinary teamwork in critical care? 3) What information and supports do clinical leaders (i.e. expert nurses in charge on a daily basis) need to help them make decisions that promote the delivery of safe care? 4) How do direct care providers learn to develop a more comprehensive understanding of their work environment and manage the paradoxes of accountability in ways that will keep the operating point safe?