



Creating a Culture of Safety: Improving Communication in Health Care

Presented by Cynthia Stinson, PhD, APRN, CNS, RN-BC, and

Ruthie Robinson, PhD, RN, CNS, FAEN, CEN, NEA-BC

During the 2019 Annual Convention

Summary: This presentation is the culmination of 10 years of legal research, using actual nursing malpractice cases to identify themes associated with errors or omissions that most likely lead to safety issues, with a discussion of how these problems can be alleviated or reduced. A culture of safety acknowledges that errors will/can occur and proactively seeks to identify latent threats. First and foremost, nurses must identify what the likely cause of nursing errors are and then work to prevent these errors from occurring through effective communication and person-centered care.

Nursing Implications:

- A root cause analysis of sentinel events has identified miscommunication as a leading cause of medical errors.
- Miscommunication occurs between healthcare providers and patients or among healthcare providers.
- A culture of safety acknowledges that errors will/can occur and proactively seeks to identify latent threats.
- Nurses must identify what the likely cause of nursing errors are and then work to prevent these errors from occurring through effective communication and person-centered care.

Key Takeaways:

- A culture of safety acknowledges that errors will/can occur and seeks to identify latent threats.
- The NPSF-reported errors included miscommunication resulting in medication errors, laboratory errors, misdiagnosis, and incorrect usage of equipment.
- 1 in 10 patients who experience a patient safety incident die as a result of the event.
- The number of patients affected by these events was unchanged from previous years creating a need for more research in this area.

Link: <https://library.amsn.org/amsn/sessions/5188/view>

Copyright ©2020, Academy of Medical-Surgical Nurses (AMSN). No materials, including graphics, may be reused, modified, or reproduced without written permission.





References:

American Hospital Association (2017). *Focusing on Teamwork and Communication to Improve Patient Safety*. Retrieved from: <https://www.aha.org/news/blog/2017-03-15-focusing-teamwork-and-communication-improve-patient-safety>

Nurse Professional Liability Exposures: 2015 Claim Report Update (2015). Retrieved from: <https://www.nso.com/Learning/Artifacts/Claim-Reports/Nurse-Professional-Liability-Exposures-2015-Claim>.

View a complete menu of REAL Briefs™ at amsn.org/real-briefs-convention.

Copyright ©2020, Academy of Medical-Surgical Nurses (AMS). No materials, including graphics, may be reused, modified, or reproduced without written permission.



PO Box 56 • Pitman, NJ 08071-0056 • (866) 877-2676 • amsn@amsn.org • amsn.org