

Oncology nurses are tasked with developing skills that enable vigilant risk surveillance through situational awareness. However, care distractions, task interruptions, increased workloads, and time constraints are common challenges that compete with the ability to provide optimal safe care. A commitment to safety is a professional and organizational expectation, and being empowered to overcome safety-related challenges necessitates multilevel and interprofessional accountability.

AT A GLANCE

- Error prevention requires interprofessional collaboration, trust, and accountability.
- Continual risk assessment should involve both professional vigilance and patient engagement.
- Oncology nurses can develop critical behaviors that promote a safe and just culture.

KEYWORDS

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Safety Culture

Establishing processes to support trust and accountability for risk reduction

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Regardless of the phase of care, many patients being treated for cancer have complex needs related to the effects of high-risk drug regimens with inherent toxicities and narrow therapeutic indexes. Two key aspects of quality cancer care are safe handling of agents with hazardous characteristics and verification of regimen dosing. Just as an incremental overdosing error may result in life-threatening patient harm, underdosing errors may lead to substandard treatment outcomes (American Society of Clinical Oncology, 2017; Edwards & Bencheikh, 2016). With the additional consideration of coexisting conditions and diverse psychosocial needs, safety risks are ever-present. A significant safety event may diminish patient outcomes, cause undesirable public attention and financial effects, increase insurance costs, and affect the psychosocial status of staff and patients. Therefore, strategies that result in interprofessional collaboration and accountability through a systems approach are needed to reduce risk and recognize safety concerns before they affect patients (Lennes et al., 2016; Shulman, 2015).

Accountability

Without prioritizing a culture of safety, a system is highly vulnerable to adverse events. At the system level, leaders must demonstrate a commitment to ensuring safety above all else. Safety goals should encompass error reduction with the understanding that safety-related events likely will never be eliminated (Benzer, Charns,

Hamdan, & Afable, 2017). The integral components needed to transform practice and facilitate safe cancer care are grounded in an environment and culture that cultivate excellence, support staff needs, and mitigate risk and harm (Institute of Medicine, 2013; Joint Commission, 2017). Infrastructure, processes, and clinical decision tools must demonstrate a proactive approach to event recognition and reporting, with policies and procedures that support safe care. Responsive and evaluative processes that outline a nonpunitive investigative process aimed at reducing the chance for repetitive events should also be in place (Fyhr, Ternov, & Ek, 2017; Surbone & Rowe, 2015).

The context of the care environment may influence the safety of medication administration. Work cultures may be prohibitive to event reporting, sometimes evoking fear of retribution and punitive action (Brady, Malone, & Fleming, 2009; Farag, Tullai-McGuinness, Anthony, & Burant, 2017). The context of each oncology care setting varies because staff characteristics, patient demographics, and care delivery models differ. However, pharmacovigilance and safety reporting are likely to be easier in a culture that is respectful, that does not cast blame, and where training and experience in event-prevention strategies are prioritized (Joint Commission, 2017; McNab, Bowie, Ross, & Morrison, 2016). A lack of unit-based safety goals may contribute to undesirable patient events through personal attitudes and perceptions, care distractions and interruptions, lack of resources and education, poor collaboration and communication, inadequate care transitions,