



PRACTICE MANAGEMENT

Developing a Culture of Safety in Your Practice

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It is widely recognized and extensively documented that errors can manifest within the realm of health care.¹ As caregivers, veterinary nurses shoulder a significant responsibility for the wellbeing and safety of patients. While we do our very best to prevent mistakes, they occasionally still occur. Sometimes it is human error; other times a series of events can occur that lead up to error. These errors can range from close calls to catastrophic or even fatal events. In order to create the safest possible work environment for both the healthcare team and patients, it is essential to establish a culture of safety in the veterinary practice.



So, what exactly does safety culture entail? It encompasses an array of values, behaviors, and norms singularly devoted to the safeguarding of patient wellbeing.²

WHY DOES SAFETY CULTURE MATTER TO MY PRACTICE?

Studies have shown that facilities with a positive safety culture have fewer medical errors.³ Research also shows that when employees feel comfortable discussing safety issues, they are more likely to perform better, learn from their mistakes, and fix problems before they cause harm.⁴ This safety culture improves morale, productivity, and overall organizational success.⁵

HOW CAN I IMPROVE SAFETY CULTURE AT MY OWN PRACTICE?

Numerous avenues exist for fostering and enhancing a safety culture within the veterinary workplace. However, it is imperative that all stakeholders wholeheartedly embrace this culture shift to truly effect meaningful change. Initiating a transformation in culture may pose challenges in terms of its magnitude and time requirements, yet the benefits are substantial for patients, personnel, and the overall practice.

Standards of Care and Protocols

Having established standards of care and protocols to follow will allow the veterinary team the ability to reference procedures. It also provides a basis for conducting assessments within the practice, allowing for structured evaluation of hospital performance and compliance. These assessments can identify areas of improvement and therefore improve quality of care.⁶ Many practices already have these, but it is key to assign someone the task of making sure these procedures and standards are kept current and constantly reviewed using evidence-based practices.

As veterinary medicine evolves, so should our standards. Just because something has always been done a certain way doesn't mean it is the best for patients. The great thing about veterinary medicine is that we are always learning. The hard thing about veterinary medicine is that we are always learning. Standards of care will always continue to evolve and change; we must adapt and change with them.



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Training Programs

Start from the ground up by instituting a training program for new hires. Creating a standardized program creates consistency and will improve quality of care.⁷ Staff retention in veterinary medicine can be challenging, and new team members are especially vulnerable.⁸ These individuals should be supported and mentored during the critical first months of transition.

Prevent Team Strain

While having seasoned team members—with proper utilization and education—can generate increased profit for a practice, high turnover creates an added financial burden (e.g., time invested to train new team members) and may cause emotional strain.⁹ Protect team members from burnout and compassion fatigue by ensuring lunch breaks are taken and patient care ratios are maintained. Allow the team opportunities to grow by attending continuing education lectures and conferences. Trust your seasoned veterinary nurses and utilize them to their fullest potential.

Maintain Records

There is power in documentation. Make sure everyone is trained on the legalities of proper medical record keeping and is performing consistent and thorough record maintenance. Since patients cannot verbally advocate for themselves and clients are not medically trained, detailed comprehensive records are often the lifeline of information between clinicians, veterinary nurses, and differing practices (e.g., referrals to specialists, transfers to different hospitals). These records can also potentially protect you and the team from litigation.



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Talk About Mistakes

Establishing a culture of safety in the veterinary workplace heavily relies on ensuring that team members feel capable and confident in acknowledging their own mistakes or reporting observed errors. We must first assume the good intentions of caregivers. After over 20 years of working in veterinary medicine, I have rarely found an example of someone who is purposefully attempting to cause harm to a patient. When errors do occur, my first reaction is, “Is the patient okay?” My next concern is for the caregiver who made the error. When errors occur, the focus should be on understanding the underlying cause of the error rather than placing blame. For example, a veterinary nurse getting out the wrong drug from a dispensing machine may on the surface look like they just weren’t paying attention. Further investigation often leads to a greater understanding of the event and reveals areas where preventable measures can be implemented. In this instance, another colleague was asking a question while the drugs were being removed, leading to distraction of the individual performing the task. The creation of a simple “no interruptions during medication dispensation” policy could help prevent similar future errors. Our shared goal is to ensure the wellbeing of our patients, and frequently, the individual responsible for the mistake is already experiencing distress. A culture of safety can provide professionals with the necessary assistance to navigate mistakes and emerge even more resilient.

Respond to Errors With Grace

Sometimes it takes a failure to realize that the procedures you have in place are inadequate. These can be opportunities to grow for both the individual (who will probably never make the same mistake again) and the practice. Remember to support those who are experiencing grief from making a mistake. Stop the

office gossip. “Did you hear what they did yesterday?!” Don’t engage in this toxic behavior. I usually respond with, “Yeah, I bet they feel really badly right now. I hope they are OK.” In my experience, it has helped to share a story about an error I have made in the past, especially if I am in a more senior position. Seeing that senior team members are also capable of error can help encourage open communication in the future and create a safer work environment. Think ahead about how you might handle your own recovery if you make a mistake. Your coworkers will still respect you and your patients will still need you.

Supplying self-reporting instruments, such as a standard form, can aid in systematically documenting errors. This approach assists in structuring the different aspects of the incident and supplies the hospital with information regarding the frequency of errors and the occurrence of recurring errors in particular areas. This data can subsequently be employed to develop enhanced protocols and offer targeted education or training for specific occurrences. Utilizing self-reporting tools presents a chance to recognize instances of effective error interception and offer positive encouragement to the team members involved. Speak up when you have caught your own errors before they have gotten to the patient. “Oh! I calculated that dose wrong. Good thing I double checked it!” Open dialogue about errors will foster an environment where employees feel safe speaking up, recognizing their own mistakes, and responding to others and themselves with grace.

Communication Is Key

It is estimated that approximately 80% of serious medical errors are directly related to failures in communication.¹⁰ For this reason, many tools have been developed to help improve communication and decrease medical errors. Closed-loop communication, or “check-backs,” is often used in emergent situations to prevent error when time is of the essence. This is where the receiver of information repeats the order back to the sender for confirmation to ensure accuracy prior to carrying them out.¹¹ An example of this might take place around the crash cart, as illustrated here:

CLINICIAN: “Give 2 mLs of epinephrine.”

VETERINARY NURSE: “OK, getting 2 mLs of epinephrine now.”

CLINICIAN: “Great.”



This type of communication can feel like it might take longer, but in reality, it can save time by eliminating the need to interrupt and ask for clarity.

The Mighty Checklist

Employing checklists can reduce medical errors by guaranteeing that procedures adhere to distinct steps in the process, simultaneously lowering the likelihood of omitting those steps.¹² One study found that the utilization of checklists helped decrease the incidence of central line–related infections by 66%, which resulted in the saving of an estimated 1500 human lives.¹² Learn more about the evidence for checklists and patient care bundles at bit.ly/3F1qriT.

Make Space for Difficult Conversations

Raising questions about a colleague's or clinician's instructions can feel intimidating. It is not unusual for veterinary professionals to experience unease when faced with potential confrontation, especially if their apprehensions are met with resistance. This is especially difficult when it is a new hire having to question a seasoned colleague's plans or actions. Often, new hires, or those that fear confrontation, either stay quiet about their concerns or complain to a coworker, both of which can lead to mistrust, anxiety, and continued unsafe/incorrect behavior. Safety culture helps ensure everyone feels secure asking questions and engaging in difficult, uncomfortable conversations in a productive way. It is crucial to bear in mind that whether you're posing the question or receiving it, everyone is ultimately focused on the wellbeing of the patient.

Utilize Communication Tools

When you find yourself needing to draw a team member's attention to a possible issue, utilizing easy-to-remember mnemonic devices can aid in effective communication.

CUS

Designed by TeamSTEPPS, "CUS" is an evidence-based teamwork system that can be a valuable approach to in-clinic communication.¹³ As Steinbinder wrote in *American Nurse Journal*, "When you speak the signal words of the CUS tool—concern, uncomfortable, safety—you alert team members and cue them to clearly understand not just the issue but also its magnitude or severity."¹³ These are the steps in CUS¹³:

1. State that you are **Concerned**.
2. State your reason for feeling **Uncomfortable**.
3. Identify why this is a **Safety** issue as well as what actions should be taken.

In the following example of how CUS could be used on the clinic floor, coworkers Jordan and Jarica discuss patient care concerns.

JORDAN: "I have some **concerns** about the amount of insulin you're giving Buster."

JARICA: "What's making you think that?"

JORDAN: "Given that Buster's a Pomeranian, I think the dose might be too high for his size. Can you tell me his current blood glucose level? I'm feeling **uncomfortable** because 6 units could potentially lead to severe hypoglycemia."

JARICA: "It's fine."

JORDAN: "This is actually a **safety** concern. Could you please pause for a moment and verify the dosage?"

Jarica sets down the syringe, heads to the computer, and accesses Buster's electronic medical record, while Jordan double-checks the insulin vial.

PACE

Another tool is the PACE acronym, which encompasses "Probe, Alert, Challenge, and Escalate."¹⁴ Similar to the CUS model, PACE shows a gradual increase in assertiveness but also points out the potential for consequences should the actions continue.¹⁴

Probe: Pose a question, and use subsequent inquiries to illustrate your concern. For instance, you might ask, "Are you confident that the trach tube is properly positioned?" This essentially gives the coworker the opportunity to correct the behavior.

Alert: Indicate your disagreement with an action or assessment. It is beneficial to provide additional statements explaining your viewpoint. For example: "I'm uncertain about the trach tube positioning. I've noticed the stomach is distended with air."

Challenge: Present evidence to support your perspective and encourage them to reevaluate or consider alternative actions. For instance: "I believe the



trach tube is in the wrong place. The chest movement is minimal and the end tidal CO₂ is at 2. We should consider reintubating.”

Escalate: Communicate the potential consequences of the perceived error. An example might be: “If this patient is esophageally intubated it could lead to worsening hypoxia and cardiac arrest.” If necessary, proceed to escalate by saying, “I’m contacting the senior clinician.”

Encourage Open Dialogue

Nurturing a setting in which questioning or challenging orders is encouraged can substantially reduce errors.¹⁵ When veterinary nurses feel comfortable expressing their thoughts and asking questions, they are more inclined to raise awareness about potential issues. In 2010, a study conducted with over 6500 human nurses and nurse managers delved into the intriguing aspect of communication breakdown: “undiscussables.”¹⁵ These are essentially widely recognized risks that often go unmentioned. The study found that 84% of these nurses experienced a situation where they felt unable to speak out while witnessing inappropriate short-cuts or lack of proper care.^{15,16} Establishing such an environment is strongly dependent on our reactions when faced with challenges or questions, as well as how we choose to respond.

For the more timid or nonconfrontational individuals, “I need clarity” badges can be used to ask for information without having to actually interrupt or

speak up. Flashing the badge to signal the need for clarity can alert the person delivering the information that further explanation is needed. Think about how you will react if a colleague questions you.

In conclusion, while there are many tools and techniques veterinary professionals can employ in the workplace, it is up to each member of the veterinary practice team to play their role in developing a culture of safety to reduce patient harm. **TVN**

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