AEE Risk Management Webinar Case Study Homework: *Organizational Culture*

In order to be best prepared for the risk management webinar this week, please review the following case studies and consider them as examples of organizational culture.

Case Study #1: Drowning on geology field trip

Background (short video): https://www.youtube.com/watch?v=Bhw4lBzHl2U&feature=youtu.be

Study Questions:

1. If an incident like this occurred in your organization, what would the next steps be?
2. What steps would you take to encourage your organization to prevent this kind of incident from recurring in the future?

Case Study #2: Disagreement between doctor and nurse about patient care in a hospital

Background: A great deal of attention has been placed on ensuring our end stage renal patients get the "right" central line placed in order to preserve vasculature if they are/or will soon become dialysis patients. Placing a central line in a sub optimal location (e.g. a blood vessel in their arm) may render that vasculature useless when it comes time for dialysis. Not having access can literally lead to their death once they are dialysis dependent. Nurses and PAs/MDs have been educated about this…a lot.

Our hospital has also placed energy into developing a culture around safety that empowers anyone to "stop the line" (call "time out") when a patient safety concern arises. We have been to multiple trainings, done online modules, and been given concrete tools to use when situations arise so that people feel comfortable speaking up. As part of this education, we have all learned that communication is often the key factor when root cause analyses are performed on sentinel events. We are taught to use an escalating series of phrases in order to respectfully voice our concerns about safety, even when doing so to other employees who are above us in the hierarchy of the hospital.

Situation: A dialysis patient was admitted to the ICU and needed a central line. The admitting MD wanted to place one "as quickly as possible" and assumed that the "best option" would take too long. The patient did need the central line, but was stable, so we had time and the situation wasn't as urgent as she described. She also had not checked with the department that could place the correct line, had told the consulting physicians who were advocating for the correct line placement that this was not possible, so they had agreed to the alternative line placement given the situation as they understood it. The admitting physician was pressuring two nurses to place the sub-optimal line in the patient. Those providers approached me and told me they were not comfortable placing the line and that they had told the physician as much. They felt they were being bullied into doing the wrong thing for the patient. The patient's nurse had also spoken with the physician who was also pressuring him to get the incorrect line placed "to be done with it." I consulted with another physician who agreed with us that our understanding was correct, but he did not want to get involved because it wasn't his patient. I called the department who could place the correct line and verified that they were available; they were, and said, "We are standing by and can be there in 5 minutes." None of the other providers were comfortable calling the attending physician to revisit this topic because of the hostile manner in which she had communicated. As the Charge Nurse, I said I was happy to call her, called the attending physician and informed her of all this. She yelled at me, told me I didn't know what I was talking about, and that I just "needed to listen to her and do what she told me," and, "none of those nurses know what they are talking about anyways." I continued to advocate for correct line to be placed and told her the team could be there in 5 minutes; she again told me, "No, you are wrong – they can't." I replied that this was a patient safety concern, the right thing could indeed be done in a timely fashion for this patient, and if she wasn't going to agree to it I would be calling the administrator on call to facilitate the right line getting placed in the patient." She said, "Fine, do what you want" and hung up on me.

The correct line was placed in the patient shortly after this last phone call. I filled out a patient safety event record and four weeks later was recognized by the VP of Quality with a "Patient Safety Advocate" award.

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Study Questions:

1. What steps did the organization take to positively create and reinforce the culture of safety they desired?
2. Why do you think the Charge Nurse was the only one willing to speak up, and how could the organization encourage others to do the same?