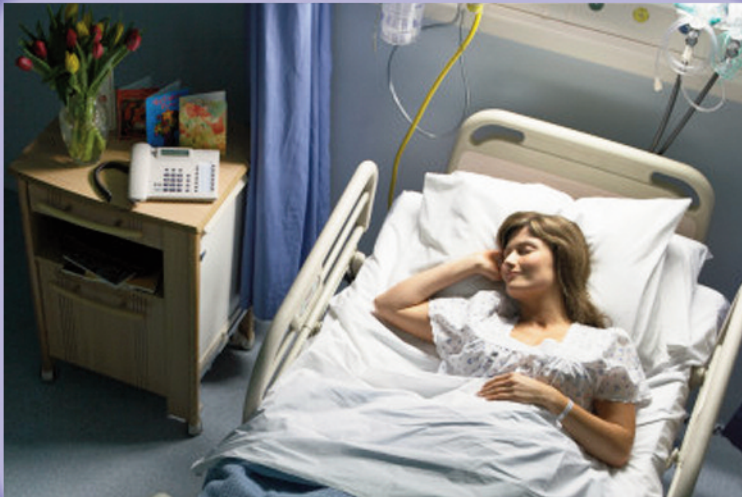


Ways to Improve Patient Safety: *How the Environment Plays a Critical Role*



Abstract

The patient environment of care plays a vital role in the discipline of patient safety for every hospital. Demonstrating that the hospital is a safe place for patients and for those that work there should be of the utmost importance for all health care personnel. This white paper outlines 5 important steps that will improve overall hospital safety and increase patient satisfaction.

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Patient safety is dependent upon both the caregiver and the environment in which care is provided.

Patients (and their families) look for visible, palpable evidence that demonstrates that a hospital is a safe haven and that those who care for them are skilled, involved, and, ultimately, will protect them. In their state of acuity, patients see and hear everything in relationship to themselves, looking and listening for signs and symbols that will offer hope and security as they navigate through the healthcare crisis.

Therefore, the environment of care can play a key role in providing appropriate visual and audio “safety” cues.

To a degree, the intention to promote safety is obvious and commonly visible. Common examples include the sign in the bathroom that reminds the staff to wash their hands, and the orange skull and crossbones warning on the stainless steel dirty needle container in every patient room. Furthermore, the nurse call button confirms that someone is within reach; the bars in the bathroom and along the corridors say that all efforts have been made to prevent patients from falling. Caregivers wearing gloves is another safety indicator. While these are ways of standardizing safety, the question remains as to why hospitals continually confront the unfortunate reality that they are not always safe nor perceived as safe.

The Risks

JCAHO identifies noise as a potential risk factor related to medical and nursing errors, stating that the ambient sound environments should not exceed the level that would prohibit clinicians from clearly understanding each other. An article in the *Journal of the Association of Operating Room Nurses* (November, 2003) reported a surgical episode in which the music was so loud that the surgeon's directions to the anesthesiologist regarding heparin levels were misunderstood by 8,000 units. Thus, beyond annoyance, within the sound environment lie potential safety risks that are often unidentified or ignored. (Mazer, 2003)

Clemenceau Medical Center, a facility in Beirut, Lebanon, managed by Johns Hopkins, designed their facility to be inherently safe and of the highest quality, believing that one cannot exist without the other. Hassan Fakh, Director of Engineering, defines active failures as those made by provider error. He defines latent conditions as conditions present in the system or environment that contribute to the errors made. Mr. Fakh includes the following in his list of latent conditions:

(1) poor facility design, (2) poor patient visibility and high noise levels, (3) lack of standardization, (4) excessive patient movement, and (5) inappropriate or complex processes. (Fakh, 2006)

What all of these conditions have in common is that they exist in the day-to-day environment. Habituation and complacency are the greatest contributing threats to both patients and staff. As Florence Nightingale stated, the sick room itself will interact with the disease and cause harm to the patient (Nightingale, 1860). The environment of care can become the place where safety is, itself, at risk.

Promoting patient safety from an environmental standpoint requires active attention to the daily circumstances that increase risks to both patients and staff.

Five Steps to Improve Patient Safety

Here are five steps that will improve overall hospital safety and lead to increasing patient satisfaction:

1. Remove stored equipment from public areas:

A common practice in hospitals is to make hallways a storage area for equipment in waiting. Risks can be high when unforeseen situations happen, such as when a visitor trips over a cart wheel that is protruding into the walkway, or a rushing staff member hurriedly comes around a corner, falling due to IV poles and monitors left in the pathway.

Creating Environments that Heal

If there is no alternative, only minimum equipment needed should be tolerated. Good planning and a commitment to safety must drive creative and effective storage options that are far safer than hallways.

2. Minimize hospital room clutter: In her *Notes on Nursing (1860)*, Florence Nightingale said that nothing in the patient's room should prevent the nurse from seeing dust and dirt for fear of insidious contamination. In the hospital room, this means keeping clutter away, properly storing or removing clothing, meals trays, and basically everything not immediately needed or being used. Maintaining a clean and un-encumbered patient room is essential to keep the patient safe. "Clean" in this case is not only about "cleaning," but, as stated, involves putting away or removing those things that are not serving the immediate patient needs. This may be challenging but should be mandatory. Patients and families will appreciate the need for keeping the room safe and will participate in order to minimize preventable risk.

3. Eliminate or organize area clutter: Nursing stations must be well managed so that everything that needs to be seen can be seen. Cluttered desks are layered, often with both essential and non-essential items; if there are layers, much of what is there cannot be seen. Organize the paperwork so that it can be found, but don't let piles of records hide themselves in plain view of everyone else. Trust in the confidentiality of individual medical records is threatened when desks are piled high with patient records or other paperwork.

4. Assure overall cleanliness of all areas: What is cluttered does not look clean; what is not clean, looks cluttered. A study in the UK showed hospitals that were perceived to be unclean had a 10% higher rate of infection. Perception confirms the otherwise invisible reality. Stains in carpets, privacy curtains, unkempt bathrooms, lingering meal trays and housekeeping carts tell a tale of sloppiness that cannot be tolerated. This includes public bathrooms as well as patient toileting areas.

5. Minimize auditory clutter: Considering unnecessary noise as auditory clutter puts into perspective the risks for patients and staff. Ambient noise in the hospital, regardless of source, has been associated with everything from sleep deprivation to medication errors, from patient falls to breaches in confidentiality. Because the general noise occurs in the same frequency range as

the spoken voice, it is easy for words to be misunderstood. Sound-alike drugs and sound-alike instructions spoken into a sea of babble, invite errors and subsequent mistakes in practice. If every individual paid attention to where they were and remembered what was at stake, noise would be far more manageable.

Within the hospital environment, noise can be a critical factor in the welfare and safety of both patients and staff. When there is a quieter environment and unnecessary sounds are minimized, patient stress will be reduced, anxiety will be minimized, and restfulness will be improved. Many hospitals today utilize various ways to mask or reduce noise. One of the most effective is providing relaxation programming like The C.A.R.E. Channel® in patient's rooms, staff lounges, and in hospital lobbies.

Conclusion

Improving the environment of care to improve patient safety is more than just about perception; rather it is a constant challenge for hospitals. Further, responsibility for safety resides in each department and individual. From administration to the clinical and nonclinical staff, to housekeeping and volunteers, the shared accountability for patient safety has no boundaries. It demands an open and honest evaluation of the norms, values and current environment of the hospital, prioritizing eliminating or minimizing unnecessary and often inadvertent risks to patients, families and staff. Furthermore, because outcomes are systemic, only the hospitals that commit to being a culture of safety will be successful over the long term. It is requisite that each individual be proactive in addressing patient safety which, in turn, will result in better patient and staff outcomes.



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