PATIENT SAFETY

Canadian Nurses Association (CNA) and Canadian Federation of Nurses Unions (CFNU)

CNA & CFNU POSITION

- Optimal patient safety requires collaboration, competence and accountability at many levels. Nurses and nurse leaders should be participants in all decision-making so that they can contribute their unique knowledge and skill to the achievement of a culture of safety and safe staffing.
- Systemic factors related to change, technology, fast-paced work environments and restricted resources have a crucial bearing on nurses' ability to prevent or minimize harm.
- Quality professional practice environments, safe nurse staffing and organizational models of nursing care that are appropriately matched to patient/client/resident needs are essential to providing safe and ethical care.
- Promoting the disclosure of hazards, adverse events, near misses and harm requires a culture of safety rather than a culture of blame. Nurses and other health-care workers require adequate support when intervening to address unsafe or incompetent practice.

CNA & CFNU BELIEFS

CNA and CFNU believe that safe, compassionate, competent and ethical care is a responsibility shared by all health-care providers, health-care organizations and governments.

Public involvement is an essential component of safe, compassionate, competent and ethical care.

CNA and CFNU believe that providing patient safety involves a wide range of policies, strategies and actions at the level of the individual nurse, the profession, the interprofessional team, the health-care organization and the health system (International Council of Nurses, 2012).

CNA and CFNU recognize that:

- Nursing shortages, understaffing and inappropriate staffing pose a significant threat to patient safety (Aiken et al., 2014; Ellis, Priest, MacPhee, & Sanchez

McCutcheon, 2006; McGillis-Hall, & Pink, 2004; Needleman et al. 2011; Shang et al., 2019).

- To ensure safe staffing, base staffing must be established using evidence-informed determinations of the needs of the patients/clients/residents who are regularly being cared for in the unit or program. Staffing decisions must also be matched with the knowledge, competencies and formal education of nursing care providers. If a nursing staff member needs to be replaced because of illness or other factors, that individual should be replaced by someone with the same formal qualifications and experience (MacPhee, 2014).
- Changes and increases in the number, acuity or complexity of patient/clients/residents will require corresponding changes to nurse staffing as they occur. "Patient needs assessment tools … must be used to make evidence-based determinations of patient needs, and to support collaborative staffing decisions between nurses and nurse managers on a real-time, shift-by-shift basis" (MacPhee, 2014, p. 53).
- To assure continuity and integration of care, staffing levels must allow for the time needed to:
  - Make necessary comprehensive assessments and re-assessments
  - Develop therapeutic relationships
  - Consult or collaborate with other nurses or health-care professionals, as well as family members, as required
- Appropriate organizational models of nursing care that are responsive to patient needs should be implemented to advance care continuity and avoid fragmented care (CNA, 2012; Harris & McGillis Hall, 2012; Tiedeman & Lookinland, 2004).
- "Scope of practice clarity avoids role confusion, fragmentation of care, and inappropriate use of nurses" (MacPhee, 2014, xvi).

CNA and CFNU believe that achieving patient safety requires accountability and competence at a system level.

- Voluntary patient safety reporting and learning systems must be in place to capture information about hazards, adverse events, near misses, harm, and other patient safety concerns and are intended to facilitate learning and improvement (Canadian Patient Safety Institute [CPSI], 2017). Clear policies on reporting patient safety incidents and on disclosing harm to the patient and family must be implemented to support good clinical practice and improve patient safety in the system. Individuals must have confidence and feel safe in reporting safety concerns without the fear of blame, and they must trust that their concerns will be acted upon (CPSI, 2017).

- System-level solutions are necessary because hazards, adverse events, near misses and harms[1] are most effectively reduced when seen as system failures. Such an approach shifts the health-care culture away from individual blame and toward a culture of safety in which disclosing patient safety concerns can be expected and promoted (CPSI, 2011; Auer, Schwendimann, Koch, De Geest, & Ausserhofer, 2014).
- To ensure organizational transparency and public accountability, "[d]ata related to nursing care delivery, such as staffing levels and staff mix, must be publicly available" (MacPhee, 2014, p. 54).
- As the health system provides more chronic care and acute care in community and long-term care settings, CNA and CFNU believe that patient needs and safety are the key criteria for decisions on staffing to ensure appropriate health outcomes. The provision of care must also be based on the best available evidence.
- It is important that every health-care worker is treated with respect and support when raising questions or intervening to address unsafe or incompetent practice (CNA, 2017). CNA and CFNU support nurses in advocating for environments in which nurses' advocacy on behalf of patients is encouraged and protected. This support may include whistle-blower protection and apology legislation[2] in all jurisdictions. Nurses should also be aware of disclosure procedures and their appropriate documentation (Canadian Nurses Protective Society, 2008; CPSI, 2011).

CNA and CFNU believe that the environment in which patients, clients and residents receive care and in which nurses practise can support or hinder nurses' capacity to provide safe care.

- While the responsibility of developing and supporting quality professional practice is shared by all health system leaders, nurse leaders play a particularly important role in fostering and maintaining them (Regan et al., 2017; Merrill, 2015).

CNA and CFNU believe that nurse leaders (i.e., those with education and credentials in the nursing discipline) must be involved at all levels of decision-making, including having sufficient autonomy and control over the budget and deployment of the nursing workforce. There must be an opportunity for, and the engagement of, nurses involved in direct patient care to select and implement innovations that are essential for

[1] While previously referred to as *incidents*, *adverse events*, *unsafe acts* or *errors*, these threats are better understood as *harm*. This shift in language is part of a movement away from a culture of blame, which reflects a patient's understanding of potential harm, and is in keeping with definitions used by the World Health Organization and the Institute for Healthcare Improvement.

[2] Apology legislation states that an apology is an expression of sympathy and regret, not an admission of guilt or liability.

achieving cultural reform in practice environments to enable and advance a culture of patient safety and improved quality of care. Nurses also require adequate resources and equipment to provide quality care.

BACKGROUND

Patient safety has been defined as the "pursuit of the reduction and mitigation of unsafe acts within the health care system, as well as the use of best practices shown to lead to optimal patient outcomes" (CPSI, 2016). Within nursing practice, patient safety also means being under the care of a professional health-care provider who assists the patient to achieve optimal health while ensuring that all necessary actions are taken to prevent or minimize harm.

Between 2014 and 2015, one in 18 patient safety events in hospitals in Canada resulted in patient harm that could have been avoided. Of this group of patients, 20 per cent experienced more than one harmful event[3] (Canadian Institute for Health Information [CIHI] & CPSI, 2016). To put this another way, "on any given day more than 1,600 hospital beds, the equivalent of four large hospitals, are occupied by patients who suffered harm that extended their stays. CIHI estimates this additional care costs the health system $685 million in 2014-15, not including payments to physicians for their services" (Vogel, 2016, p. E427).

In one year alone (2009-2010), the total economic burden associated with such harm was estimated at $1.1 billion (CPSI, 2012). Future projections suggest that, over the next three decades, 400,000 annual incidents of patient harm in home and community settings could occur (on average), for a projected annual burden of $2.75 billion (Risk Analytica, 2017).

Problems with patient safety are seen as being driven by systemic factors such as rapid changes in the health-care system, increased use of technology, the complexity of care, the quickening pace of work, and restricted resources, including shortages of qualified professionals. Therefore, "issues of integration, quality and patient safety cannot be resolved within the health care system without meaningful collaboration and coordination at all levels" (CFNU, 2012, p. 45). Generally, patient safety issues do not stem from the actions of a single care provider but rather from larger, systems-based problems (Fagan, 2012). Organizational factors, equipment, work environments and staffing all play a role in safeguarding patient safety. To better understand these issues,

[3] Four types of hospital harm were considered: (1) health-care or medication-related conditions, (2) health-care related infections, (3) patient accidents and (4) procedure-related conditions.

data collection and interpretation at the national level (e.g., the C-HOBIC project) is critical (Canada Health Infoway & CNA, 2015).

Canadian nurses have increasingly expressed concern about the ability to deliver safe care in today's health-care system. Nurses are deeply commited to providing patient care that is safe, compassionate, competent and ethical, as expressed in the *Code of Ethics for Registered Nurses* (CNA, 2017). However, nurses are experiencing increasing moral distress as they continue to work in environments that are not able to support quality professional practice. Much work has been done by nurses to address concerns for patient safety, as evidenced by the growing body of research on best practices and by the promotion by CNA and CFNU of quality practice environments and appropriate human resources planning in the health-care system. Much more remains to be done (CNA & CFNU, 2014).

Provincial and territorial nursing associations and colleges regulate the practice of nurses. They continually develop and maintain standards of practice within their jurisdictions through many programs, including licensure, disciplinary procedures and requirements for quality assurance, often with the involvement of other health-care professionals and public representatives.

Provincial and territorial nursing unions have incorporated specific language around workloads and safe staffing in their collective agreements. In every province, nurses are encouraged to complete workload report forms if they are concerned that the safety of the patients/clients/residents is being compromised, making it challenging for them to meet their professional practice standards.

The work of CNA and CFNU in promoting quality, professional practice environments is one of their most important initiatives for patient safety. CNA is a member of the Canadian Patient Safety Institute and supports other groups' patient safety initiatives, such as the dissemination of drug safety information, medication reconciliation and research on quality work-life indicators.

To promote safe staffing for patient safety, CNA and CFNU partnered to create an online toolkit.[4]

Approved by the CNA Board of Directors
June 2019

Replaces: Patient Safety (2009)

[4] CNA/CFNU Evidence-based Safe Nurse Staffing Toolkit: https://www.cna-aiic.ca/en/nursing-practice/tools-for-practice/safe-staffing-toolkit

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