Many nurses at ambulatory surgery centers managed by Addison, Texas-based United Surgical Partners International (USPI) are sporting a new badge. It says, “We Care,” followed by a promise to speak up if they see an error or potential error in treatment. It is a promise to patients and physicians.

It is also a promise to nurses that if they point out a potential error or safety concern, they will be listened to.

How has it come to this? Doesn’t everyone naturally call attention to a problem in the course of treatment?

Not necessarily, according to USPI’s quality manager Clint Chain, RN, BSN. Even today, in an era of quality awareness and professionalism, nurses often are hesitant to speak up, he says. They may have been ignored or scolded in the past, or they may be reluctant to trust their own perceptions over those of a surgeon or a more seasoned peer. They may simply be unsure whether they are seeing an error.

In addition, though the medical culture historically may have fostered an unspoken agreement to not admit errors, organizations are changing, Chain says.

Creating a culture of safety

Chain, who rose through the nursing ranks as a naval officer, has confidence in the reliability of a nurse’s opinion. “Nurses work with doctors, and know what they [the doctors] are supposed to do.”

The badge, he stresses, is just one piece of an initiative to create what he calls “a culture of safety.” Other components feature research, education, and staff feedback.

The USPI Clinical Services Department introduced the program in late 2007 at a company conference. In a follow-up e-mail to USPI’s facility administrators and clinical managers, Chain reminded them, “Communication breakdown among the health care team providing care to the patient continues to play a significant role as a contributing factor in medical errors. The primary purpose of the We Care badge is to provide staff with a scripted communication process that can empower the staff member to ‘speak up’ when they become aware of an actual or potential safety risk to a patient.”

Adoption of the badge is optional, and Chain notes that several USPI facilities opted not to participate, underscoring the sensitivity of the issue. (Some prefer to display a poster with the We Care message.) He developed instructional materials to help OR managers explain the program and provided survey forms to be completed following pre- and postoperative briefings.

Finally, he asked participants to report back to him concerning staff reaction and how the process was implemented in their facilities. Chain told OR Manager he is compiling results, which will offer clues to how the program could be modified or gain further participation.

A badge of distinction

The blue-and-red badge is an acronym that spells “CARE”:

- I am Concerned…
- About the safety of the patient related to…
- Can we Review the…
- In order to Eliminate…

The nurse fills in the blanks depending on the situation. The point is to empow-
er the staff, educate them, and give them a tool to address error prevention. It means, he says, “They’re not going to yell at me for speaking up.”

Often, he says, a patient will notice the badge and ask about it. That gives the nurse an opportunity to assure the patient he or she is committed to safety.

While nurses are on the front lines in this safety effort, the badge is provided to all staff at participating surgery centers. The purpose, Chain says, is to “create an environment where staff freely share information about safety issues and speak up without fear of reprisal from other staff members, physicians, or managers.”

The badge script is useful in any situation where in the past there has been hesitation to speak up. One example is to let a physician know a medication order is not clear and to ask for verification.

**Briefing and debriefing**

Under the We Care program, staff members meet briefly to review the badge script and report their experiences in a 5-minute debriefing following each shift. The follow-up allows management to collect statistics and reinforces the behavior of communicating problems.

Recommended questions include:

- asking how many people had to comment on a safety issue and then have them explain and discuss each event
- focusing on the most serious events by asking how many had a “good catch” and reinforcing such reporting with praise
- considering safety issues staff have identified and discuss how the process could be changed to improve patient safety.

Information from the briefings becomes the basis for what Chain calls the “model for improvement.” In his instructions to USPI managers, he asks, “How will we know that a change is an improvement?” He answers with a series of benchmarks, or measures of success:

- the number of safety issues employees have identified
- how much information was shared among staff related to safety issues
- how many errors were caught before reaching the patient because staff feel more empowered to speak up
- how many patients have asked questions related to safety due to increased education
- the number of staff members who say they consider the safety briefings to be valuable.

**Speaking up is ‘brave’**

Chain is not unsympathetic to many physicians’ resistance to being questioned. “A doctor needs confidence in all members of the operative team,” he says, given the intense nature of their work and responsibilities.

“Doctors are trained to be assertive and confident. It is impossible for the doctor to focus on everything going on in the entire OR. Because they focus so closely on the operative procedure itself, they must rely on the entire OR team for complete patient safety.”

Stopping to listen to staff concerns might mean delaying the schedule. It is inconvenient. “The person that speaks up—they’re brave,” Chain says.

Surveys show, however, that when it comes to preventing errors, physicians overwhelmingly say, “Yes, we would like the nurse to speak up,” he notes. “An error is horrible for everyone.”

While the We Care program will not eliminate resistance, he says, it empowers nurses to bring up concerns later. It means nurses will not be disciplined for raising questions to ensure safe care.

That is why bringing physicians on board is crucial to any error-prevention program. Following the Joint Commission’s Universal Protocol, OR teams hold a timeout before each invasive procedure. Staff members stop and confer to verify the patient identification, correct surgical site, correct procedure, and other details.

“That is the time for the circulating nurse or other member of the operative team to say, ‘This is not right. Something’s amiss.’” Chain says.

At USPI facilities, the timeout takes place before all invasive procedures and requires the surgeon to be present.
The Joint Commission will notice

Another incentive for management to adopt a We Care-type program is that the Joint Commission’s 2008 National Patient Safety Goal 2 for ambulatory care mandates improving communication among caregivers to prevent errors. In addition, Goal 13 requires facilities to encourage patients’ active involvement in their care as a patient safety strategy.

The Joint Commission’s Speak Up program, launched in March 2002, is a national campaign directed at patients. It offers promotional materials to encourage patients to ask questions and voice concerns about their treatment. The program advises patients to use a hospital, clinic, surgery center, or other type of facility that has undergone “a rigorous on-site evaluation” against established quality and safety standards such as those of the Joint Commission.

We Care, Chain says, can be used to demonstrate that a facility has such safety standards in place. “Accreditation surveyors notice the badges,” he says.

Chain presented the We Care badge concept at the 2008 Perioperative Care Symposium in Chicago in April sponsored by Joint Commission Resources. He was asked to share safety measures in ambulatory surgery centers that have contributed to promoting a culture of safety and eliminating medical error.

The subject “is fraught with fear,” he admits. Often the first response is denial—“We don’t have errors.” One USPI facility noted nurses already wear other badges. “It’s not about the badge—it’s about the process,” he advised them.

Posters and other materials also educate staff about efforts to achieve the goal of eliminating health care errors. “The point,” he says, “is to be proactive and stop the error from ever happening.”

—Paula DeJohn

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A nurse speaks up

Dawna Jennings, RN, was one of the first to sign up for the United Surgical Partners International (USPI) We Care program. She is administrator of Doctors Surgery Center at Huguley in Burleson, Texas. She ordered the badges in December 2007 after attending the USPI conference where they were introduced.

“The team here at our center was given the in-service, badges, and permission to use the process anytime they needed,” she says. “As the administrator of the facility, I also encouraged staff to call me directly if the questionable action was not addressed by the team members involved.”

Soon enough, a nurse found it necessary to invoke the badge and its script. A circulating nurse felt overwhelmed by a series of rapid-fire orders from a physician. She realized rushing on her part could compromise the patient’s safety. Before the We Care program began, she would not have dreamed of complaining.

Jennings explains that the nurse might not have questioned a physician and “might have just kept going without the feeling of empowerment and backup that our new We Care process encouraged. Failure to speak up and alert the team could have potentially put the patient at risk. [However,] not only did the surgeon listen to her concerns but thanked her for speaking up.”

It turned out the surgeon simply did not realize the impact of his demands on the rest of the staff. The nurse, Jennings recalls, was “elated.”

Others have used the badge with similar results. According to Jennings, “The We Care badges can be worn so even the newest or most quiet team member can read straight off the card and plug in the words that apply to the situation.

“The doctors know it came from the top and is approved and backed by facility leadership.”