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Reading, Reflection, and application in Reality

By Shelley Jones

Talking about safe practice

A way to look after yourself, your colleagues, and your patients

LEARNING OBJECTIVES

Reading and reflecting on this article will enable you to:

- Discuss shifts in thinking about clinical error and adverse events prompted by the patient safety movement.
- Identify two types of process failures and the reasons why we generally fail to learn from each type.
- Reflect on your own role and actions in building a safety culture within your work team.

We like the good news – that nurses are consistently ranked by the public as one of the most trusted professions. But we are not so keen to embrace the bad news – that health care services harm patients at a surprising and unacceptable rate. We cannot assert that nursing is an integral and critical part of health care and have little to say about our share of responsibility for that harm, especially when we also claim that it's the closeness and continuity of the nurse-patient relationship that makes it distinctive. Ironically, the good news may be based on an inaccurate image of nursing, yet the bad news is based on hard evidence of reported incidents. In this learning activity, we'll look at how every day talk contributes – and could contribute more – to safety for patients.

WHAT IS PATIENT SAFETY?

The term patient safety can refer to:

- **a way of doing things** – an approach or philosophy with its own explanatory framework, ethical principles, and methods
- **a discipline** with a body of expertise, concerned with applying safety science methods to achieve a trustworthy health care system
- **an attribute or property** of a health care system that minimises the incidence or impact of adverse events and maximises recovery from them[1].

Patient safety as a discipline uses methods from cognitive psychology, human factors engineering, and organisational management. It applies principles of systems design and safety culture as found in high-reliability, high-risk organisations – such as in the aviation industry. But the discipline also accommodates the individualised and personal nature of health care that, for instance, requires confidentiality and privacy for patients[1].

Helping not harming

Medicine used to be simple and ineffective and relatively safe, but now it is complex, effective, and potentially dangerous[2].

Health care presents a challenging paradox by pairing the mandate to 'do no harm' with mounting evidence that much harm is done in the course of delivering care[3].

Patient safety and health literacy are relatively recent developments that shape – or should shape – everything we do in our increasingly complex, specialized, and fragmented health care services. We've discovered that the incidence (probably under-reported) of patients being harmed in the course of treatment is unacceptably high[1,4,5]. And in realising that health literacy helps patients self-manage and navigate the health system, we have recognised that information, treatment, and services could be better designed to reduce complexity and risk and thus increase safety[6]. Involving patients in safety practices, for instance, in a 'checking with' approach, brings health literacy and patient safety together by accepting that patients know that errors can occur, legitimising their right to ask questions, and reinforcing their right to receive safe care[7].

In the traditional view, which assumed that competent, committed clinicians do not make mistakes, those involved in adverse events were deemed to be incompetent and careless. According to a principle of individual accountability, clinicians admitting to an adverse event were subjected to 'blaming and shaming' intended to motivate them to be more careful[1,3]. An unintended but predictable consequence was reluctance to report errors for investigation. The resulting silence affords no learning, and the opportunity is lost for the organisation to discover and correct causes beyond individual practice[8,9].

Challenging the silence

Patient safety thinking challenges this silence in three ways that support clinicians.

Firstly, it reconciles the precept 'first, do no harm' with the insight that 'to err is human'[3]. Without abandoning clinicians' obligations to give safe and effective care, it recognises that the demands of normal clinical work (managing complexity and uncertainty in diagnosis and treatment for medically fragile patients under time pressure) can obscure the safest course of action[3]. Put another way, *'Errors are to be expected, even in the best organisations'*[8].

Secondly, viewing adverse events through a systems design and human factors 'lens' reveals that strategic decisions may create weaknesses in safety defences (e.g. unworkable procedures) or translate into error-provoking conditions (e.g. understaffing, time pressure, inadequate equipment and supplies, lack of training). These latent or 'blunt end' conditions can set up the circumstances in which the clinician at the 'sharp end' of care delivery actively makes a mistake (e.g. by taking their focus off patient care)[1,8]. Conversely, systems can be designed to make it more likely that the right thing will happen and more difficult for the wrong thing to happen. In other words, *'We cannot change the human condition, but we can change the conditions under which humans work'*[8].

Thirdly, threats to patient safety require a response from everyone involved in health care, but especially clinicians. Accountability for safe and competent care is integral to any professional role and code of conduct[10]. Patient safety requires that we realise our collective accountability for learning from not only near misses and errors but also look at what we need to do differently if the quality of care has been compromised[1]. The Health and Disability Commissioner's complaints process and

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decisions acknowledge that one of the motivations for patients and families bringing complaints about care is to ensure 'it doesn't happen again'[11]. As nurses, we need to shoulder our share of the responsibility for preventing adverse events and addressing poor care by learning what *we* need to do so that 'it doesn't happen again'[23].

DEFINITIONS: ERRORS AND ADVERSE EVENTS

Errors are failures of planned action. There are two types:

- when the action is correct but does not proceed as intended – **error of execution**
- when the intended action is not correct – **error of planning**

Adverse events are injuries caused by treatment interventions; they are not the result of the patient's health condition. A large proportion of adverse events are the result of errors, and are therefore considered **preventable adverse events**[4].

Learning from process failures

Organisations in which reliability is a more pressing issue than efficiency often have unique problems in learning and understanding, which, if unresolved, affect their performance adversely[12].

When small failures are neither identified widely, nor discussed and analysed, it is very difficult for larger failures to be prevented [13].

The small mistakes and problems that occur in care delivery processes are not seen as material for systematic shared learning in the same way that adverse events are. Yet these frequent, apparently inconsequential failures can be compounded by one failure too many, and the accident no one knew was waiting to happen finds its mark. If we are serious about safety, we have to pay attention to *'...these small failures or vulnerabilities are [which are often] present in the organisation long before an incident is triggered'*[14]. In other words, a shift from reactive to proactive risk management[8].

Edmondson, in her findings from an ethnographic study of teams in hospital wards, differentiates errors and problems as two types of process failure.

- **Errors** were defined as unnecessary or incorrectly executed actions that, with the right information, could have been avoided. But interpersonal relationships or the professional dynamic at the frontline often inhibits nurses speaking up to ask questions, express concerns, or directly challenge a colleague. Because drawing someone's attention to their error – even though it is unintentional and the person is not aware of it – is potentially threatening for both people, saying nothing may be easier. If it is difficult to talk about errors, then there is no shared learning.
- **Problems** were defined as disruptions to a worker's ability to complete a task because either an element needed for its completion was not available or some other thing interrupted or interfered with task completion. Problems mostly originated somewhere other than where they showed up, meaning they qualified as system issues. Problems made up the majority of the process failures observed (86 per cent), and managing them took on average 15 per cent of the nurses' time. Nurses' dominant responses to these obstacles were quick fixes and workarounds – rather than looking for root causes and applying systematic problem solving – not at all surprising given their incidence at one per nurse per hour. In contrast to errors, nurses were very aware of problems – they were obvious, frustrating, and disruptive to the smooth organisation of work. Even though one person's quick fix may create a problem in another department, these recurring disruptions were not discussed as failures with implications for patient safety[13].

The researchers found that nurses generally just quietly got on with it: they seamlessly corrected for someone else's error (without bringing it to their attention), and faced with obstacles to patient care, made adjustments and improvised without asking their colleagues for help or bothering their managers. Describing the nurses doing this as 'adaptive conformers', Edmondson acknowledges that this behaviour is valued but argues that the opportunity to address unrecognised threats to patient safety is lost. To make the most of the safety lessons in these undramatic process failures, Edmondson says we need 'observant questioners' who manage the error or problem and also escalate it to their managers[13]. Then, rather than finding this annoying, managers need to welcome and act on staff questions and complaints as part of being serious about patient safety[9,13].

Making it safe to say what needs to be said

...a new role for health care leaders and managers is envisioned. It is one that places high value on understanding system complexity and does not take comfort in organizational silence [9].

...there are at least two ways in which leaders enable safer practices on the front line: first, by directing attention to safety, and second, by creating contexts where practitioners feel safe to speak up and act in ways that improve safety [9].

Adverse events in health care often have communication issues at the heart [15].

Safety tools are designed to address the honest mistakes that humans will inevitably make, but even well-designed systems need supportive dialogue between the staff using them. A safety tool may highlight a problem, but if the interpersonal climate makes it unsafe to speak up or get others to pay attention, it undercuts good design and compromises patient safety, according to two linked studies with the hard hitting titles: 'Silence Kills' and 'Why safety tools and checklists aren't enough to save lives'[16,17].

Findings were that health workers had often seen their colleagues make mistakes, flout rules, or demonstrate incompetence that threatened patient safety (and staff morale), but most didn't speak up. However, about ten per cent did, and the critical difference between them and the silent 90 per cent was their confidence in being able to say the thing that needed to be said[16,17]. There were common patterns in these crucial conversations – the nurses who talked with their colleagues:

- explained their positive intent to help the colleague and the patient
- assumed a good response would be forthcoming
- did their homework on the problem – used facts and data as much as possible
- avoided creating defensiveness in the colleague by making it safe for them
- avoided negative stories and accusations, and
- defused or deflected anger and emotion.

The researchers concluded: *"If every caregiver has these skills, it will go a long way toward resolving the problem of organisational silence"*[17]. It could be argued that all nurses already possess a set of highly refined and sensitive interpersonal communication skills – those we bring to our encounters with patients are nearly sufficient to equip us for this task[18,19].

A key theme in the patient safety literature is the critical importance of developing a safety culture in which everyone is clear that safety is central to 'how we do things around here', and which attends to building high-quality relationships within the team so that it is safe to take the interpersonal risk involved in raising a question or concern about practice. Making it safe to speak up can be as simple as a team leader or manager asking "Was everything as safe as it could have been for our patients this week?" and being prepared to fight whatever battles are needed to overcome the routine organisational failures that otherwise take focus and time away from patient care[13].

Talking amongst ourselves

But it's not just what leaders do. If all team members are open to the possibility that they may make a mistake (for any reason), then having one's human error brought to awareness is true colleagueship. What is needed are trusting and respectful relationships amongst team members and time given to talking about safe practice, whether the informal learning and debriefing with each other in course of the day[21], or in peer learning partnerships[22] or purposeful discussion in team meetings. If trust and time are not there at first, finding even small amounts of each will help develop a commitment to a process of shared learning.

Let's not forget the part of safety we hold dear in the nursing role – that our patients and their families feel safe with us. We are committed to helping, not harming. Bringing

a colleague to an awareness of how aspects of their approach with patients may be less than helpful, supports them in developing the insight that their practice could be safer and prompts their learning different approaches. Talking amongst ourselves – at all levels, as a personal and professional imperative – about safe nursing practice is what Philip Darbyshire means when he says, *'We do, indeed, need to talk about nursing'*[23]. When you think about how many lives we touch every day[24] – in ways great and small - we should have no difficulty in saying something as simple as 'Have you washed your hands?' to a colleague.

QUESTIONS THIS ARTICLE MIGHT PROMPT YOU TO ASK YOURSELF

- How would I feel if a colleague said something that stopped me from making a mistake?
- What are the workarounds that we take for granted in our team? What would it take to address these 'workarounds' as potential sources of failure or learning?
- How would I react if a colleague said something that made me rethink how I was interacting with a patient or family?

Recommended reading and resources

Articles

FIRTH-COZENS J (2001) Cultures for improving patient safety through learning: the role of teamwork. *Quality in Health Care*10(suppl 2):ii26-ii31.

HENRIKSEN K & DAYTON E (2006) Organizational silence and hidden threats to patient safety. *Health services research* 41(4p2):1539-1554.

Web resources

The United States based Agency for health care Research and Quality covers more than 20 topics in a comprehensive set of 'Patient Safety Primers': http://psnet.ahrq.gov/primerHome.aspx

The principles of assertive communication are a good basis for raising an issue with a colleague or manager:

http://www.mindtools.com/pages/article/Assertiveness.htm

Kupperschmidt et al's online article about skilled communication styles in relation to healthy work environments is useful in relation to making it safe to say what needs to be said: bit.ly/YXqvs6

The Johari window is a useful model for looking at self-awareness

http://www.businessballs.com/johariwindowmodel.htm

The text of Darbyshire's 2011 article is at a link from his blog: bit.ly/S5MVV2

More on the topic of getting feedback from peers at my blog at www.learn-ability.co.nz

About the author:

Shelley Jones RN BA MPhil has been working in nursing professional development for 30 years.

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I would like to thank my colleagues at Bowen Hospital for an ongoing dialogue about whether and how peer feedback processes can foster mutually supportive professional development.

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Erratum

In the RRR Change management: A classic theory revisited, *Nursing Review* 13(1), at page 15, under the heading Change competencies, the second dot point should read "The rate of quality improvement implementation in health care is less than 50% [14]".

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2 CHANTLER C (1999) The role and education of doctors in the delivery of health care. *The Lancet* 353 (9159):1178–81

3 VOGUS TJ, SUTCLIFFE KM & WEICK KE (2010) Doing no harm: Enabling, enacting, and elaborating a culture of safety in health care. *The Academy of Management Perspectives* 24(4):60-77.

4 KOHN LT, CORRIGAN JM & DONALDSON MS (1999). *To err is human. Building a safer health system (Executive summary).* Washington: National Academy Press.

5 HEALTH QUALITY AND SAFETY COMMISSION (2012) *Making our Hospitals Safer: Serious and Sentinel Events reported by District Health Boards in 2011/12.* Health Quality and Safety Commission: Wellington.

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7 JOINT COMMISSION (2007) *"What Did the Doctor Say?" Improving Health Literacy to Protect Patient Safety.* Retrieved from www.jointcommission.org/NR/rdonlyres/D5248B2E-E7E6-4121-8874-99C7B4888301/0/improving_health_literacy.pdf.

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15 DuPREE E, ANDERSON R, McEVOY MD & BRODMAN M (2011) Professionalism: a necessary ingredient in a culture of safety. *Joint Commission Journal on Quality and Patient Safety* 37(10):447-455.

16 MAXFIELD D, GRENNY J, McMILLAN R, PATTERSON K & SWITZLER A (2005) *Silence kills: The seven crucial conversations for health care.* Retrieved from http://www.silenttreatmentstudy.com/silencekills/

17 MAXFIELD D, GRENNY J, LAVANDERO R & GROAH L (2011) *The silent treatment: Why safety tools and checklists aren't enough to save lives.* Retrieved from http://www.silenttreatmentstudy.com/index.html

18 I am grateful to my colleague Teresa Shapleski for her comment that the patterns in these conversations amounted to "good intent - a genuine caring approach for their colleague and positive patient outcomes. Core nursing attributes".

19 KUPPERSCHMIDT B, KIENTZ E, WARD J, REINHOLZ B (2010) A healthy work environment: It begins with you. *OJIN: The Online Journal of Issues in Nursing* 15(1): Manuscript 3.

20 NEMBHARD IM & EDMONDSON AC (2006) Making it safe: The effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behavior* 27(7):941-966.

21 BAUER J & MULDER RH (2007) Modelling learning from errors in daily work. *Learning in Health and Social Care* 6(3):121-133.

22 MANTESSO J, PETRUCKA P & BASSENDOWSKI S (2008) Continuing professional competence: Peer feedback success from determination of nurse locus of control. *The Journal of Continuing Education in Nursing* 39(5):200-205.

23 DARBYSHIRE P (2011) We do, indeed, need to talk about nursing. *Australian Nursing Review* August 2011:14-15

24 The question of how many lives a nurse might touch in the course of a year occurred to me whilst attending a workshop run by the Health Quality and Safety Commission. Discussing the idea with the Commission's General Manager Karen Orsborn in the break, she suggested the calculation apply to the course of a day.

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DOWNLOAD THE INTERACTIVE PDF WORKSHEET AND ANSWERS AT: www.nursingreview.co.nz

NAME: _____ DESIGNATION:_____

DATE:_____ NURSING COUNCIL ID:_____ WORKPLACE:_____

Undertaking this learning activity is equivalent to 45 minutes of professional development. It contributes to maintaining competence by helping you reflect on your responsibilities to provide safe care (including clinical and cultural safety) and manage threats to patient safety, and your involvement in quality activities that address safety issues and improve care for patients and their families/whānau.

See the Nursing Council defined competencies related to ensuring that patients receive safe care for RNs, ENs, and NPs at www.nursingcouncil.org.nz/index.cfm/1,55,0,0,html/Competencies

This learning activity also helps you explore the values underpinning professional conduct – especially integrity – as outlined in Nursing Council's *Code of Conduct for Nurses* at www.nursingcouncil.org.nz/index.cfm/1,255,html/Code-of-Conduct-and-Guidelines

A The questions in this section are designed to help you read the article attentively.

Reading

1 Amongst other insights, the patient safety movement supports the idea that:

Tick one ❑ professional training means clinicians never make errors

❑ poorly designed systems can cause clinicians to make errors.

2 Which of these is not given in the article as an explanation for silence around errors?

Tick one ❑ avoiding 'blaming and shaming' as punishment ❑ no compelling reasons to change established practice

❑ team members may feel it is not safe to speak up.

3 Adverse events are defined in this article as:

Tick one ❑ injuries caused by treatment ❑ idiosyncratic responses to treatment

4 Reasons given in this article for analysing and addressing recurring but seemingly inconsequential disruptions in daily work include:

Tick one ❑ workarounds take time away from patient care ❑ they can compound to cause a larger failure

❑ they offer safety learning opportunities ❑ all of these factors ❑ none of these factors

B This section helps you reflect on your learning from reading and relate it to your experience.

Reflection

Think about a time when you were aware that patient safety was compromised. Which points in the article explain what helped you or others to speak up or take action? Which points in the article explain what inhibited speaking up or taking action?

What are your 'take home' learnings? List 3 points from the article

1

2

3

C The notes you make in this section show how you intend to apply your learning in practice

Reality

Please select from 'Questions this article might prompt...' the one of most relevance and interest to you. Outline your responses and then make brief notes on what would be most likely to help you and/or your team be open to reconsidering your practice. Note two or three specific attitudes or actions you can take to make it safe for yourself and others to speak up and raise issues in your work team.

Verification by a colleague of your completion of this activity: *(Signature)*

COLLEAGUE NAME: _____ DESIGNATION:_____ DATE: _____

NURSING COUNCIL ID:_____ WORK ADDRESS:_____ CONTACT #:_____