



A Healthy Work Environment

What's in it for you?

22nd Annual Barbara Proctor Memorial
Education Day

Updates for Emergency Nurses

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Patient Safety in American Hospitals

- 1 in 20 patients at hospitals will be given the wrong medication
- 3.5 million will get an infection from someone who failed to wash their hands or take other appropriate precautions
- 195,000 patients will die because of preventable mistakes made during their hospitalization (Health Grades, Inc Quality Study, July 2004)

Personality Traits of Patients Likely to File Suits Against Nurses

- Persistently criticize all aspects of the nursing care provided
- Purposely not follow the care plan
- Overreact to any perceived slight or negative comment, real or imagined
- Unjustifiably depend on nurses for all aspects of care
- Refuse to accept any responsibility for care
- Openly express hostility to nurses and other personnel
- Project anxiety and anger onto staff and attribute blame for all negative events
- Previously filed lawsuits (Nurses Legal Handbook, 2004)

Characteristics of Nurses More Likely to Be Named as Defendants

- Insensitive to patient's complaints or fail to take them seriously
- Fail to identify and meet patient's emotional and physical needs
- Refuse to recognize the limits of nursing skills, personal competency, and scope of practice
- Lack sufficient education and training for tasks associated with a specific clinical setting
- Display authoritarian and inflexible attitudes
- Inappropriately delegate responsibilities
- Fail to advocate for the patient (Nurse Legal Handbook, 2004)

Characteristics of Health Care Environments that Threaten Patient Safety

Organizational culture/practices

- Failure to adhere to policies (deliberate deviations)
- Lack of trust in hospital administration
- Reduced clinical nursing leadership
- Diminished empowerment/involvement of clinical nurse
- Punitive cultures that hinder reporting and prevention of errors
- Top down communication patterns

Characteristics of Health Care Environments that Threaten Patient Safety

Workforce deployment practices

- Unsafe work force deployment
- Wide variation in nurse staffing levels
- Available means for achieving safer staffing levels are not employed uniformly
- Scaled back/abbreviated orientation programs
- Cut backs for nursing education and training
- Violations of safe scheduling practices

Diminished Workforce Engagement

- Not engaged:
 - Put time in at work
 - Intellectually and emotionally checked out
 - Not overtly positive or negative about employer
 - Wait and see attitude re: job and co-workers
 - Work without energy or drive
- Actively disengaged:
 - Dislike most everything at work
 - Act out displeasure regularly
 - Undermine co-workers

Lateral Violence and Bullying in Nursing

- Lateral – acts that occur between peers
- Bullying – perpetrated by one in a position of authority
- Overt or covert acts of verbal or nonverbal aggression
- Victims: students, new or experienced staff
- Behaviors undermining, sabotage, scape goating, infighting and withholding information
- Incidence 38% of all healthcare workers have suffered one or more types of bullying behaviors
 - 48% have experienced verbal abuse

Impact

- Physical – headaches, GI upset, fatigue
- Psychological – fear, depression, anxiety
- Adverse Patients Events – poor morale, impaired productivity, decreased critical thinking, increased errors of omission and commission, high turnover and absenteeism (Center for American Nurses Fact Sheet, 2008)

Root Causes

- Root causes of unhealthy work environments are dysfunctional relationships among providers
- An organizational culture that lacks open and honest communication, integrity and transparency will lead to an atmosphere that results in:
 - Aggression and violence
 - Dissatisfaction and burnout
 - Low retention, high turnover
 - Increased adverse patient events

Increased Frequency of Adverse Events in Poor Care Environments

- Medication Errors
 - Falls with Injuries
 - Nosocomial Infections
- 73% more likely
 - 90% more likely
 - 55% more likely

Dr. Linda Aiken
University of Penn.
Research in Nursing and
Health, 2002

Barriers for Nurses that Impact Safety

- Unclear unit values
- Fear of punishment for errors
- Lack of systematic analysis of mistakes
- Complexity of the work
- Inadequate teamwork and dysfunctional communication (Kalisch & Aebersold Nursing Economics, 2006)



“Our lives begin to end the day we become silent about things that matter.”

- Martin Luther King, Jr.

Organizations that fail to recognize communication as a major component of the work environment are not addressing issues that threaten patient safety.

Silence Kills

- Research study sponsored by AACN and Vital Smarts in 2005
- Identified Seven Crucial Conversations for Healthcare
 - Broken rules
 - Mistakes
 - Lack of support
 - Incompetence
 - Poor teamwork
 - Disrespect
 - Micromanagement

Silence Kills cont.

Conclusion

- People see others make mistakes, violate rules, demonstrate dangerous levels of incompetence
 - Repeatedly
 - Over long periods of time
 - In ways that jeopardize patient safety and demoralize employers
- Failure to speak up R/T their confidence in the ability to confront
- Only 5-15% of respondents engaged in a crucial conversation directly with the person(s) involved. The inability of others to confront created an information bottleneck.

Organizational System Dynamics

- Organizational System Dynamics that inhibit System Change prevent HCS from learning from mistakes
- Nurses are highly skilled dedicated workforce expected to compensate for operational/process failures under adverse conditions
 - Time pressure
 - Unpredictable work load
 - Reliance on others for supplies and information

Tucker and Edmonson, 2003

Compensation

- First order problem solving
 - Short term remedies “patch” – no action to prevent reoccurrence (supplies, information)
- Second order problem solving
 - In addition to patching the problem, also takes action to correct the problem – takes conscious effort

ED Nurses

- ED Nurses – Most notorious for first order problem solvers
- Drift into “at risk” behavior because of complicated systems and chaotic environment
- Unaddressed variations (volume and acuity) provide opportunities to create more risk or error and harm because safety checks circumvented
 - Ignore/turn off alarms
 - Unnecessary use of verbal orders
 - Not documenting meds immediately after administration

Recognizing Behaviors

- Recognizing behaviors that undermine a culture of safety can be an initial step in transforming an unhealthy work environment that contributes to medical errors
- Where your transformation begins depends on what areas are identified for improvement
- Progression from first to second order problem solving is influenced by managerial and organizational responses

Transformation

- Transformation to Healthy Work Environment might begin with reducing tolerance for at risk behavior
 - Identify at risk behavior
 - Move backward to remove incentives that encourage risky behaviors
 - Clarify values to motivate and align behavior change
 - Reward safe choices to encourage group acceptance and decrease variability in practice

Improving Work Environment

- Improving work environment can involve adoption of Just Culture
 - Shared accountability and learning
 - Emphasis on systems thinking and preoccupation with failure avoidance
 - Not blame free, provides guidance for individuals who willfully make unsafe behavioral choices

AACN 2001 – Healthy Work Environment

Healthy Work Environment

HWE one in which people are valued and priority is given to the multiple aspects of the workplace that affect the employees' ability to function well in order to accomplish the goals of the organization

First Order Problem Solving – Fix that Fails?

- Can be counterproductive, time consuming, tiring
- Isolates the problem rather than providing system change to improve operation, frustration
- Avoid asking for help or having unpleasant interactions
- Over time less likely to engage in second order

Second Order Problem Solving

- Effects real change – addresses the why of the problem
- Higher productivity, efficiency, patient and work satisfaction
- Interpersonal risk

Lack of Organizational Learning from Failures

- Individual resilience solve problems as they arise
- Maximize unit efficiency – not solve system problems
- Ltd empowerment of bedside nurses – removes managers and non-direct providers from non-clinical activities