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Events of harm: Inpatient nurses' perceptions of peer, manager, and system response

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Twenty years ago, the Institute of Medicine (IOM) report *To Err is Human* challenged healthcare organizations to create safety systems using design principles adapted from other high-risk industries such as naval aviation.[1] One of these design principles, creating a learning environment, emphasizes the importance of encouraging the reporting of events of harm, errors, and hazardous conditions to find and fix system deficiencies before they result in patient harm. Fostering this type of environment requires a nonpunitive response to error reporting and a consistent feedback loop to staff about how reported issues are being addressed.[1]

Today, healthcare organizations conduct routine assessments of patient safety culture to understand progress toward creating a nonpunitive learning environment. The Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture (HSOPSC) is a valid and widely used tool to measure safety culture at the unit and hospital level.[2] The survey measures hospital staff opinions about patient safety issues and medical error and event reporting. It includes 42 items that measure 12 dimensions of patient safety culture.

Nonpunitive response to error is a consistently low-scoring dimension on the HSOPSC. In 2018, the nonpunitive response to error domain had the lowest percent positive response (47%) across all organizations who participated in the survey (630 hospitals).[2] This dimension assesses respondents' perception that reported errors are held against them and mistakes are kept in their personnel file.[2] Low scores on these items indicate nurses fear that reporting errors will result in punitive actions while the underlying problems remain.[3,4]

Although the link between nonpunitive response to events of harm and positive safety culture is well understood, little is known about how nurses experience the response to events of harm in their organizations. The purpose of this descriptive, qualitative study was to understand adult inpatient nurses' perceptions of peer, manager, and system response to events of harm in an academic medical center.

Methods

The study site employs over 2,000 nurses and conducts the AHRQ HSOPSC biannually. The organization has used a web-based event reporting system since 2007. The system is an anonymous, menu-driven tool to record event details, manager review, and follow-up.

A qualitative, descriptive design was used to understand the way nurses view peer, manager, and system response to events of harm. Qualitative description provides a structure for collecting and interpreting interview data that results in a comprehensive summary of nurses' perceptions.[5] Rigor was achieved through providing thick descriptions of participants' responses, peer review debriefings, and triangulation of data analysis by two of the researchers.[6] Institutional Review Board approval was obtained before the recruitment of participants.

A maximum variation sampling strategy was used to ensure variability in participants' gender, ethnicity, age, length of time in nursing, and degree type. A qualitative research expert who worked outside the study site was chosen to recruit participants and conduct interviews. Nurses were excluded if they were in orientation, in a leadership or management position, or an agency nurse. Informed consent was obtained before conducting interviews. A semistructured interview guide was developed through a literature review and consultation with the qualitative research expert. (See *Table 1.*) The interview guide encouraged participants to describe actions that peers, managers, and the system took in response to events of harm. The qualitative research expert conducted interviews until she determined that data saturation was achieved. Fifteen participants were interviewed in a setting of their choice between June 2017 and August 2017. Interviews were transcribed verbatim.

Two members of the research team analyzed verbatim transcripts using an inductive content analysis approach.[7] Transcripts were read multiple times to identify the participants' perceptions of peer, manager, and system response to events of harm. Descriptions were organized in a table using verbatim text. Each researcher used verbatim text to identify common words that participants used to describe peer, manager, and system response to events of harm. A reconciled list of code words was developed and categorized. After sorting and refining, abstraction of categories led to themes that described nurses' perceptions of peer, manager, and system response to events of harm.

Table 1: Semistructured interview guide

1. Please describe your understanding of or what you know about "just culture" (say nonpunitive working environment) in nursing.
2. How's "just culture" (substitute words of participant from the first question) carried out in your organization?
3. Do you ever have conversations with peers about "just culture" (substitute words of participant)?
4. What actions by this organization (such as policies and procedures) do you perceive as working in a "just culture" (substitute words of participant)?
5. What actions by your nurse manager or immediate supervisor do you perceive as working in a "just culture" (substitute words of participant)?
6. What actions by your peers (nurses you work with every day on the unit) do you perceive as working in a "just culture" (substitute words of participant)?
7. Can you describe a situation in your organization that didn't feel like "just culture" (substitute words of participant)?
8. Is there anything about "just culture" (substitute words of participant) that you would like to share that I haven't asked you about?

Results

Most of the 15 clinical nurse participants were White (60%, n = 9) and female (80%, n = 12), with greater than 6 years of experience as a nurse (67%, n = 10). (See *Table 2*.) Ages ranged from 25 to 57, with a mean age of 42. Most participants had a baccalaureate degree in nursing (53%, n = 8). All references to the web-based event reporting tool were changed to "[report]" for consistency.

Perceptions of peer response

Participants described peer responses to events of harm as either encouraging or discouraging. The encouraging response was exemplified by peers wanting to ensure that nurses felt safe approaching each other to discuss safety concerns to prevent harm from reaching a patient. RN L focused on nurses being able to express when they had a knowledge deficit, stating, "I want somebody to feel comfortable coming to me because I would rather them come to me and say 'I don't know what I'm doing'… I want them to know it's okay, you're learning." Opportunities for peers to encourage each other occurred during bedside shift report and unit huddles. The encouragement peers provided each other included inviting questions, providing reassurance, and reinforcing best practices.

RN H highlighted the reassurance that nurses provide their peers. She stated, "We just support each other. I mean whenever people have made mistakes, a lot of the more seasoned nurses will kind of come to them and just let them know that this could happen to anybody." Nurses in this study recognized that reporting events is critical to ensure a safe environment and peers have a role in encouraging the reporting of events. Encouraging reporting gives the team an opportunity to learn from past events and prevent future events. RN F stated, "With any incident, it's our responsibility as care providers to report any type of offense, whether it's harmful to the patient or could've been harmful to the patient. The staff isn't going to be penalized."

In contrast, a discouraging peer response to events of harm was described in relation to fear of the consequences of reporting. RN J stated, "I think when people talk about 'management is going to come down,' they're talking about it out of fear of 'I'm going to get fired' or 'Oh, I'm going to get written up.'" The act of reporting an event in the web-based event reporting system itself was viewed as a response to an event of harm and caused fear among peers. RN I stated, "If I told somebody…I'm going to have to fill out a [report], they're like you want to go and vomit because… your job could be on the line."

Further, there was a perception that peers use the web-based event reporting system as a tool for reprimand and a mechanism to threaten. RN B stated, "I just remember when one guy put it in on me. I've had two [reports] put in on me." Nurses also discussed their fears about what the consequences of error would be if an event was entered in the system. RN I stated, "Am I going to lose my job? Are they going to report me to the board of nursing?"

Table 2: Participants' demographics

Characteristic	N (%)
Gender	
Male	3 (20)
Female	12 (80)
Age	
≤30	3 (20)
31–40	3 (20)
41–50	5 (33)
>50	4 (27)
Ethnicity	
White	9 (60)
Non-White	6 (30)
Years as an RN	
2–3	3 (20)
4–5	2 (13)
6–10	3 (20)
>10	7 (47)
Years at organization	
1–3	4 (27)
4–7	4 (27)
8–10	2 (13)
>10	5 (33)
Nursing degree level	
Diploma	1 (7)
ADN	5 (33)
BSN	8 (53)
MSN	1 (7)

Perceptions of manager response

Participants described three typical manager responses to events of harm: supporting, disciplining, or ignoring. Feedback about manager response was the lengthiest in the study.

Managers showed support for nurses when they provided education on practice issues after events of harm occurred. For these nurses, their manager was an essential link in the feedback loop when events were reported on the unit. RN F stated, "They would educate me, and I could prevent future events. And not only for myself, but by obtaining that knowledge and passing it on

to others, it would help them." Further, manager communication about events was described as supporting learning, helping identify risks, and setting expectations regarding care practices that may prevent events of harm. RN H stated, "They kind of go over…why the actions that you took weren't appropriate and then they offer tips and suggestions of how you can do things going forward to prevent…it from happening again."

Nurses were aware of the discipline process steps and talked about coaching discussions with managers in which the managers balanced learning and "reprimand" by giving "tips and suggestions" to address the error that was made. Nurses discussed negative aspects of the discipline process. Nurse A stated, "Management will take a side of one person over another and maybe one gets written up or maybe they both get written up."

Ignoring as a manager response to events of harm was described as managers avoiding event follow-up and not listening to staff concerns. RN C stated, "I love my manager, but she doesn't listen really well to our concerns." Nurse F said, "It angered me… that I could come to her and tell her that 'Hey, I'm really concerned about this on multiple levels,' and I was totally dismissed and that really angered me." The lack of a consistent feedback loop about events was described. Nurse I stated, "I feel like we'll produce the [reports], produce and produce them… But then we never really know what happens after that. And I feel like…that's where they fail, honestly."

Perceptions of system response

Participants described two system responses to events of harm. Feedback about system response was the shortest in the study. First, the system provided resources to address safety issues and concerns. Medication bar coding and orientation and training were examples of the types of resources mentioned. Second, the system was viewed as being involved in cases with significant harm.

Disciplinary action at the system level was viewed as occurring when necessary and not for one mistake. RN N stated, "I guess people get disciplined appropriately and people have gotten fired for things they've done wrong." In response to events of harm, nurses in this study saw the system as a distant provider of resources for improving patient safety and the disciplinary decision-maker in the most serious events.

Discussion

Participants spoke more about peers and managers than the system when discussing response to events of harm. Both nonpunitive and punitive responses were described.

Nonpunitive response

Participants described events such as medication errors, incorrect use of equipment, and failure to rescue. The first person who nurses encounter after an event of harm occurs is most often a peer. If the peer is encouraging and supportive about reporting and human error, it promotes a nonpunitive environment. Peer support was described as inviting questions, providing reassurance, and fostering a culture where nurses feel comfortable sharing when they have a knowledge deficit. The importance of peer-to-peer interpersonal relationships and support is foundational for creating a positive patient safety culture and increasing staff comfort with reporting events of harm.[8,9] Although this study found that peer interactions are a factor shaping individual perceptions of patient safety culture and the propensity to report, interventions to impact peer relationships haven't been a major focus of safety culture development to date.[10]

Managers can positively influence perceptions of a nonpunitive environment by encouraging staff to report events of harm, supporting staff members when

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they do report events, communicating practice expectations or changes to prevent events of harm, and providing a consistent feedback loop regarding follow-up on events that have been reported.

System-level interventions to promote safety culture, such as medication bar coding and organization-wide safety huddles, may not have the desired impact on creating a nonpunitive environment when used alone.

The lack of a consistent feedback loop to nurses about outcomes of events or event reporting amplifies apprehension and fear.

Punitive response

Fear was rooted in nurses' apprehension about reporting events of harm because of witnessing or hearing about consequences that peers experienced when past events occurred. Some participants in this study referenced an event that occurred 15 years ago before they joined the organization, which continued to create fear about event reporting. Some participants described event reporting as a mechanism to instill fear. The lack of a consistent feedback loop to nurses about outcomes of events or event reporting amplified apprehension and fear. A passive response from the manager, described as "ignoring," fostered uncertainty related to patient safety on the unit.

In this study, participants spoke more about the manager's response to events of harm than the response of the system. This supports researchers who found that manager expectations, feedback, and communication about events are important factors in promoting a safe patient culture.[11-13] This finding informed a deeper investigation of the level of contribution peers and managers have in creating a nonpunitive response to error.[14]

Limitations

This qualitative, descriptive study was limited to one organization with individuals who volunteered to participate. Participants may have biased beliefs and perceptions that drove their willingness to participate in the study. The peer, manager, and system categories were used as a framework for this study and may not be the most important elements in understanding responses to events of harm. Additional research on this framework would be helpful to establish the validity of the approach. Although the interviews in this study were conducted in 2017, the topic and findings remain timely.

The importance of support

Over 20 years ago, the IOM challenged healthcare systems to create nonpunitive learning environments to improve patient safety. This study describes the importance of nurse peer and manager interpersonal relationships in creating a nonpunitive environment. Clinical nurses in this study reinforced the impact that the manager's response to events has in shaping their view of event reporting and patient safety. If a nonpunitive learning environment is to become a reality, future safety strategy deployment must emphasize the development of positive, supportive nurse peer and manager interpersonal relationships regarding response to events of harm and consistent feedback loops about the outcomes of event reporting. NM

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