

8-2020

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Whether medical errors will occur is not the question. When and to what degree of harm will the patient, nursing staff, and organization experience is a more valid question. The nurse leader's ability to navigate staff through the aftermath of a negative patient event has far-reaching consequences. Errors impact the organization financially and reputationally, and can have devastating results for the nursing staff. This paper explores the use of AONL's 9 elements of a healthful practice environment. These elements offer structure and guidance for the nurse leader to mindfully lead the nursing staff through a difficult situation while enhancing staff resilience and organizational success.

Everything is moving along as planned in the career of Caroline, the chief nursing officer (CNO) of an acute care hospital. Staff seem happy, morale is high. Then the unthinkable happens. On a day with adequate staffing, a skilled 18-year tenure nurse makes a mistake. A human error. A slip in judgment. A patient has paid the ultimate price. A sentinel event. Root cause analysis, fishbone diagrams, reports, action plans, and institutional reviews will follow. But what about the staff? Navigating the next few months can be career-defining or devolving; can upend the culture of the organization, and can impact the hospital's reputation for years to come.

Nurse leaders have an obligation to lead staff through difficult times. Core to leadership are the leader's values, ethics, sense of justice, and moral centeredness.¹ Successful nurse leaders build a culture within the nursing team that ensures the provision of high-quality nursing care. However, what happens

when a devastating error occurs? The future of the organization can very well be dependent on the resilience of the nursing staff and the skill of the nurse leader.

Mistakes in health care occur every day. If you believe the numbers based on the landmark report *To Err Is Human*² (2000) by the Institute of Medicine, 44,000 to 98,000 die of preventable medical error each year. Behind each of these "mistakes" is a care provider who can become a target for the consequences of the error. On a larger scale, the overall healthiness of the work environment can also suffer. A healthy work environment is an ongoing challenge for nurse leaders. The more the leader anticipates and understands the potential costs of an error, the more he or she will be able to minimize the impact on the work environment. A mistake or error produces quantifiable hard costs. The soft costs, although harder to grasp, have the potential for deep and impactful consequences for the nursing team and organization. The American Organization of Nursing Leadership (AONL)³ identifies 9 elements that lead to healthy work environments. By understanding these essential elements, a nurse leader can excel and strengthen the nursing team through the outcomes of a costly error.

COSTS OF ERRORS

Transparency in hospital ratings offer avenues for consumers to learn about a hospital's performance. Pay for performance (P4P) initiatives may have initially intended to stimulate quality improvement; however,

KEY POINTS

- Nurse leaders prepared for unintended patient errors will lessen the consequences related to the second victim.
- AONL's 9 essential principals of a healthful environment serve as a framework for resilient staff during the recovery period after an error.
- Perseverance of the nursing staff is a direct result of the leader's anticipation and response to adverse events.

the penalties of this system related to errors have been felt by many organizations. In an analysis done by Figueroa et al,⁴ organizations most likely to be penalized in US P4P programs include large hospitals, major teaching hospitals, and hospitals with safety net status. These findings make us question whether the P4P programs are able to identify high-quality facilities. Although this may be true, the impact of an error on a hospital's reputation should not be to marginalize.

The financial landscape for health care has changed. Nurse managers' skill in developing financial expertise is the only mechanism that is successful in determining how scores from quality, patient satisfaction measures, mortality, and readmission rates relate directly to reimbursement rates and the costs of patient care.⁵ Value-based financial models and P4P have become the mainstay of determining quality of care. Although this may be the tipping point for some hospitals to invest in quality initiatives, thus improving overall quality, it may not prevent the incidental error that can lead to potential reputational decay. Examples of this can be found in the news when the consequences of the errors have been deemed significant to be reported by the press. Often this leads to decreasing admissions and visits for the affected facilities. An analysis of the economic impact of medication errors by Walsh et al⁶ concluded that the true economic impact of medication errors has been underestimated. Financial costs are hard costs that are felt; however, another cost just as tangible is the impact on nursing staff.

Previously called the second victim syndrome, nurses experience feelings of blame and burnout resultant from superimposed or relational perceptions. The organizational impact of the second victim can be seen in outcomes such as decreasing staff morale and turnover, and a lack of staff engagement.⁷ Fallout from the second victim syndrome is difficult to measure. Links from this syndrome to decreasing patient satisfaction scores, increased errors, high-cost turnover, and decreasing admissions are seen but often not measured or reported. After an adverse error occurs, nurses must continue forward, caring for other patients as if nothing has occurred. There is no time to grieve, and debriefing, if available, is often delayed. The situation continues to haunt the staff. Once organizational impact is realized, other staff begin to internalize feelings of blame, guilt, and doubt. This can quickly turn a positive culture into one that devolves quickly if the nurse leader does not take action.

AONL'S 9 PRINCIPLES IN PRACTICE

The 9 essential elements of a healthful practice environment by AONL provide the nurse leader scaffolding on which to build a strategy that moves the nursing staff through the negative impact of the error and enhances learning from the error. The first

essential element of a healthful practice environment is the demonstration of a collaborative practice culture.³ A collaborative practice culture requires trust, respect, and strong team contributions. This develops over time in an environment where the nurse leader is transformational, encourages shared governance, and values transparency. Collaboration is evident both within the nursing structure and in interactions with interprofessional colleagues. If this element is not evident at the time of the negative patient outcome, struggles will ensue, but it is possible to implement strategies of transparency and shared decision making that will reach beyond the initial reaction to the error.

The second essential element of AONL's healthful practice environment is a communication-rich culture.³ Core to leadership is learning good communication skills and recognizing how this communication can impact the organization.⁸ When harmful errors occur, leaders need to select words carefully. Mindful messaging in the context of the situation will build relationships versus destroying trust and respect. Communication should reflect a leader that is acting on values. Building a solid ground for communication, if not already in place, will prove vital in moving forward. Consistent and predictable values act as ground builders for professional relationships with staff. Although the first thought may be to defend, become angry, and express frustration, staff will recognize leader resilience and self-control.⁹

A culture of accountability is the third essential element.³ Building a positive culture is difficult. Without a strong, supportive culture, patient errors can divide staff and negatively impact trust in an organization. Accountability is a fundamental concept in high performing organizations. Accounting for our actions is a part of a functioning society.¹⁰ Nurses expect to be held accountable and expect this to be done in a fair and thoughtful manner. A just culture supports the premise that errors occur and focus should be on encouraging truth, speaking up, transparency, and process improvement. There is no overarching-blame free approach, in contrast, there is a focus on identifying and fixing system issues and not on blaming or shaming.¹¹ Responding to an error may be an ethical and/or a legal matter. Whether or not the error reaches the status of a legal matter, the professional mistake is put on trial in the court of public and professional opinion. The leader managing and navigating the court of opinion will need to ensure that the error is acknowledged, learning occurs, and improvements are made. The focus is not on the error or the nurse, but the opportunities that arise for improvement. A leader that has a forward-oriented focus uses this opportunity to enhance patient safety and staff relationships.

The fourth element is the presence of adequate numbers of qualified nurses.³ Often when a negative

patient outcome occurs, the finger is pointed at staffing levels or staff competencies. The benefits of adequate and engaged staff cannot be argued. One of the foundational roles of the nurse leader is to ensure safe staffing levels and engaged staff. However, fluctuating staffing levels are an ongoing phenomena in nursing. The Bureau of Labor Statistics¹² predicts a 15% growth in registered nursing jobs, outpacing the growth for many other occupations. With this known, increasing attention to hiring, retaining, and training should be the focus of an organization's human resource department in combination with the nurse leader. The meaningful implementation of all elements of a healthful environment will lead to a decrease in turnover and an increase in retention.

Visible leadership is the fifth element.³ Clearly, a positive presence can foster relationships and healing, whereas; negative responses such as anger and blaming are the unraveling of these relationships. Blame and shame require looking backward, moving forward takes monumental efforts and meaningful actions. The first step in moving forward will be empowering staff. Refusing to allow the error to define nursing care in the organization relies on the leader's ability to empower staff through connections to quality and safe patient care. Research by Hassmiller and Bilazarian¹³ found that staff who engage compassionately with consumers must first feel valued and heard by management. Connecting and building relationships cannot occur via e-mail or through notices and postings. Direct contact with the nurse leader, with meaningful and purposeful dialogue, increases staff performance.¹⁴

Shared decision making and encouragement of professional practice development are the sixth and seventh essential element respectively.³ Shared decision making will play a vital role in the learning and practice outcomes driven by the error. Nursing staff who manage their own practice will develop practice standards and learning outcomes that far exceed expectations of management if given the opportunity. Three key values staff need to demonstrate are shared responsibility, accountability, and authority. Authority is the key element of the three that the leader must share with staff in ensuring workable solutions to prevent errors and promote patient safety. A sense of responsibility and accountability are evident in functioning professional nursing staff. Kutney-Lee et al¹⁵ studied the relationship between engagement, shared governance, and outcomes. The study concluded that shared governance can be a valuable intervention for promoting optimal patient outcomes.¹⁵ Allowing staff to grow through shared practices and professional development ensures the organization's ability to flourish through shared decision making.

The last 2 elements are recognition of the value of nursing's contributions and recognizing specific nurses

for their meaningful contributions to practice.³ As nurses, our sense of value is derived from positive experiences with patients. Our buoyancy is tied to patient outcomes and appreciation. However, organizational recognition can lead to enhanced organizational commitment. Recognizing nursing and specific nurses reaffirms that the care provided is extraordinary, builds and nourishes teamwork, motivates, reinforces a culture that values nursing and promotes pride.¹⁶ Appreciation is perceived as being respected for the contributions made to the organization and to the profession. The act of appreciation and recognition of staff should be ongoing. The potential impact of a negative patient outcome on morale should signal the leader to increase efforts for staff appreciation and recognition.

IMPLICATIONS FOR NURSE LEADERS

All organizations attempt to minimize or greatly reduce the chance that an adverse event will occur. Errors are unfortunately unavoidable, it is not a matter of if they will occur, but when. Sustainable and resilient cultures are the goals of any nurse leader. Behaviors directed at achieving this goal will set the leader up for enduring and flourishing in the face of a negative patient outcome. The degree of error may vary; however, nurse leader's preparation and anticipation of adverse events can positively influence how the organizations will preserve.

Mindfully navigating through AONL's elements of a healthful practice environment offers a structured mechanism ensuring the nurse leader has covered all the bases to enhance staff resilience during this stressful time. Many of the essential elements need continual attending from the nurse leader and should be in place to ensure a healthy environment prior to any negative patient outcome or adverse event. The goal of approaching incident recovery using this structure is to ensure learning from the incidence and thriving through the struggle. A re-examination of the elements can strengthen the organization and the nursing staff's resilience. Prompt and thoughtful action from the leader will ensure the organization's survival.

Recovery from a harmful error will also require the nurse leader to be acquainted with the principles of the second victim theory and recovery process. Subsequent to an error, nurses experience an array of symptoms that impact them emotionally, spiritually, psychologically, physically, and professionally.^{7,17,18} Each second victim may cope in a different individual manner, yet all will need support to move through the recovery process. The second victim is not always a single individual, it can be coworkers, a team, or a department. The recovery process is not quick, it can last months or even years.^{17,18} However, time is essential. A quick response can minimize the impact on the second victim(s). The leader's quick response and support will be

essential during the recovery process. Staff's ability to move on and thrive is essential for a healthy work environment.

SUMMARY

Stressful situations when the staff are emotionally vulnerable is not the time to shy away from exposing humanness. Strong leaders exhibiting emotional agility will lead staff to become stronger and more resilient. Psychological and emotional distress are common occurrences when our actions could have potentially caused patient harm. Nurse leaders are human and can be prone to emotional hiccups. Overreact, taking issues personally, being on the attack, getting defensive, and whining are a few examples of what emotional hiccups can look like.⁹ These actions can prove detrimental to the nursing culture and organizational reputation. Costs of mistakes can only be quantified to an extent. Staff disillusionment, lack of engagement, a decrease in staff and patient satisfaction are organizational time bombs and can be career ending for nurse leaders.

Anticipating errors in a human-led and human-served service is the only sustainable action the nurse leader can take. Insight into the second victim concept and recovery process can enhance nurse leader efforts to support a resilient nursing staff. Rather than recreating and brainstorming specific activities, supporting a healthful work environment is the quintessential approach in safeguarding the culture of an organization while navigating through the outcomes of an adverse patient outcome related to a nurse mistake. Revisiting the 9 essential elements of a healthful environment by AONL provides the scaffolding of action for the nurse leader. The 9 essential elements allow the nurse leader to readdress the focus on processes, vision, and strategies for improving patient safety while maintaining a healthy, engaged nursing staff, thereby ensuring organizational success.

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1541-4612/2020/\$ See front matter
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<https://doi.org/10.1016/j.mnl.2019.04.007>