Creating Healthy Work Environments 2019

Work Environment and Error Reporting by Nurses

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Error reporting is one of the primary ways that hospitals learn from errors and near misses (Institute of Medicine [IOM], 2000; Kusano et al., 2015). However, it is widely recognized that errors in hospitals are significantly underreported (Hamilton et al., 2018; Levinson 2012; Sari, Sheldon, Cracknell, & Turnbull, 2006). Consequently, countless opportunities to learn from mistakes are missed by healthcare organizations.

Past research indicates that error reporting is a multifaceted phenomenon in hospitals, with multiple diverse and complicated reasons for error-reporting process breakdowns. While much of the past research on error reporting has sought to identify facilitators and barriers to error reporting, these studies have not fully explained how more complex factors in organizations may affect error reporting by clinicians. In this study, we used the model of work-team learning (Edmondson, 1999) to examine factors that affect error reporting by nurses, namely work environment and teamwork dynamics on nursing units. Specifically, the safety climate on the nursing unit, nurses' perceptions of nurse managers' leadership qualities, and the psychological safety of nurses on the unit were examined.

This study used a cross-sectional descriptive design. Self-administered surveys were used to collect data from nurses and nurse managers in an 805-bed academic medical center in the southeastern United States. There were 1,922 RNs employed on 50 nursing units at the study site who were recruited to participate in this study. Of those nurses, 924 completed the survey, for a response rate of 48.1%. Data analysis was conducted using linear mixed models with random effects to account for within unit correlations. Bootstrap confidence intervals with bias correction were used for mediation analysis.

The results of the study demonstrated that the safety climate of the nursing unit, the leader inclusiveness of the nurse manager, and the degree to which nurses felt psychologically safe positively affected error reporting. Furthermore, the results showed that psychological safety mediated the relationship between aspects of safety climate and error reporting as well as the relationship between leader inclusiveness of the nurse manager and error reporting.

For organizational learning to occur in response to errors and near misses, awareness of those events is essential. Organizational awareness of errors and near misses can only happen if nurses, physicians, or other clinicians report that an error or near miss happened. The findings of this study emphasize the important relationship between the work environment and error reporting. The safety climate of the nursing unit, leadership behaviors demonstrated by the nurse manager, and nurses' perceptions of psychological safety are all significant factors that influence nurses' reporting of errors. The study findings also emphasize the importance of healthy work environments to the psychological safety of nurses. As hospital leaders seek to improve the quality and safety of care for patients by learning from errors, the findings from this study can help guide the development and implementation of strategies that foster a positive safety climate of nursing units, build leader inclusiveness of nurse managers, and promote positive perceptions of psychological safety among nurses.

Title:
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Leader Inclusiveness, Psychological safety and Safety Climate

References:

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Abstract Summary:
Error reporting is essential to organizational learning and safety improvement in hospitals. This study examined the effect of safety climate, nurse manager leader inclusiveness, and the psychological safety of nurses on nurses' willingness to report errors. The findings are important for administrators seeking to make hospitals a safer.

Content Outline:

1. Introduction
    1. Patient safety in hospitals is an important issue
    2. Error reporting is a primary way that hospitals learn from errors
    3. Widely recognized that errors and near misses are significantly underreported
    4. Summary of past research
2. Body
    1. Theoretical Framework of study
        1. Amy Edmondson’s (1999) model of Work-Team Learning
    2. Study design
        1. Cross-sectional descriptive design
        2. Completed by 924 nurses
    3. Statistical methods
        1. Linear mixed models with random effects
        2. Bootstrap confidence intervals with bias correction for mediation analysis
    4. Major findings
        1. Safety climate, nurse manager leader inclusiveness, and psychological safety positively affected error reporting by nurses
        2. Psychological safety was a mediator
            1. psychological safety mediated the relationship between aspects of safety climate and error reporting

2. psychological safety mediated the relationship between leader inclusiveness of the nurse manager and error reporting

3. Conclusion
    1. the important relationship between the work environment and error reporting.
    2. the importance of healthy work environments to the psychological safety of nurses.

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Professional Experience: Cheryl B. Jones, PhD, RN, FAAN, has expertise in studying micro- and macro-level issues in the nurse workforce to inform executive practice, improve the work environment, and evaluate the costs and quality of health care. She has studied nurse turnover and other related nurse workforce issues, including nurse retention, transition programs, and nurse employment patterns. Dr. Jones has taught health policy, health economics, administration and management at undergraduate and graduate levels, and is co-author (with Finkler, Kovner, Mose) of one of the most highly regarded financial management texts for nurse and healthcare leaders, Financial Management for Nurse Managers and Executives. She is a Fellow in the American Academy of Nursing (2005), and an alumni of the RWJF Executive Nurse Fellows Program. She received her BSN from the University of Florida in 1985, and her MSN and PhD degrees at the University of South Carolina in 1989 and 1993, respectively.
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