Patient safety improves when leaders walk the safety talk

September 26 2012

(Medical Xpress)—When nurses feel safe admitting to their supervisors that they've made a mistake regarding a patient, they are more likely to report the error, which ultimately leads to a stronger commitment to safe practices and a reduction in the error rate, according to an international team of researchers. In addition, when nurse leaders safety actions mirror their spoken words—when they practice what they preach—unit nurses do not feel caught between adhering to safety protocols and speaking up about mistakes against protocols.

"Patient errors remain a major source of avoidable patient harm in the United States," said Deirdre McCaughey, assistant professor of health policy and administration at Penn State. "The Institute of Medicine report, 'To Err is Human: Building a Safer Health System,' charged that avoidable medical errors in U.S. hospitals kill at least 44,000 patients a year. Feeling comfortable reporting errors also leads to a stronger commitment to safe practices, which ultimately reduces error rate.

McCaughey and her colleagues examined the notion that care providers may experience a conflict between the strong enforcement of safety procedures on the one hand, and the reporting of safety/patient errors on the other hand.

"Despite this conflict, prior research indicates that a climate of safety requires both prioritizing existing safety protocols and constructive responses to errors," said the research team leader, Hannes Leroy of Katholieke Universiteit Leuven and the University of Calgary.

"Achieving this balance highlights the importance of leadership to foster team priority of safety."

The researchers surveyed 54 nursing teams in four hospitals in Belgium to determine if the leadership actions of head nurses were aligned with the verbal expectations they had given to staff nurses, as well as to examine the effect of that congruence on nurse/employee commitment to following safe work protocols and willingness to report a patient treatment error.

Six months later, the team then examined the relationship between fostering safety and reporting patient errors to determine if they were related to a reduction in errors regarding patients.

In their study, the researchers considered a team to be composed of one head nurse and a minimum of three nurses who reported directly to the head nurse. They distributed paper surveys to nurses and head nurses within the different nursing departments, and asked the nurses to deposit the surveys in a sealed box or envelope to assure anonymity.

The surveys examined the behavioral integrity of head nurses, the psychological safety felt by staff nurses, and team priority of safety using a variety of statements that participants ranked on a scale ranging from "completely disagree" to "completely agree." To examine the behavioral integrity of head nurses, the surveys included such statements as "My head nurse always practices the safety protocols he/she preaches."

To examine the psychological safety felt by staff nurses, the surveys included such statements as "If you make a mistake in this team, it is often held against you." To examine team priority of safety, the surveys included such statements as "In order to get the work done, one must ignore some safety aspects." The researchers then analyzed the data

using structural equation modeling.

The results appeared online this week in the *Journal of Applied Psychology*.

The researchers found that when nurse managers' spoken expectations regarding safety aligned with their commitment to safety, their teams had a stronger commitment to acting safely while carrying out work duties, as well as a greater rate of reporting errors. In addition, this greater emphasis on safety resulted in a reduction in patient treatment errors.

"The study offers support for the efficacy of leaders' behavioral integrity—walking the talk, if you will—and it demonstrates the importance of leadership in promoting a work environment in which employees feel it is safe to reveal performance errors," said McCaughey.

"This benefits patients because work environments in which error is identified offer employees the opportunity to learn from those errors and, ultimately, prevent similar errors from occurring."

According to Leroy, the researchers' findings suggest that by staying true to the safety values they espouse, leaders can start to solve the managerial dilemma of providing clear safety directives while encouraging employees to report errors.

"This is important as the results of our study indicate that the combination of both a high priority of safety and a psychologically safe working environment predicts the number of reported patient errors in hospitals," Leroy said.

Provided by Pennsylvania State University