

Dialogue for Quality Improvement and “Just Culture”

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Received date: Jul 11, 2016, Accepted date: Nov 22, 2016, Published date: Nov 29, 2016

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Short Communication

Being a nursing faculty member at a university, weekly clinical teaching and supervision with undergraduate nursing students were included in my responsibilities. Students were placed on the medical-surgical units with the juniors in the adult nursing course, while the seniors were in nursing leadership and management course. At the end of the rotation, they were evaluated both theoretically and clinically.

One day while conducting clinical teaching and supervision, I observed a patient with renal impairment with a peritoneal dialysis catheter in-situ carrying the boxes with peritoneal dialyze to his bedside. He was being accompanied by a nurse during this activity. Based on my clinical judgment, I went to a staff nurse on the unit to express specific patient safety and legal concerns. The junior staff nurse was very polite and denied that she routinely utilized the patients to do such activity, but appeared timid to address the matter. Also, she reported that the patient was being accompanied by a senior nursing staff from the renal unit. I could sense the apprehension in her voice as she expressed concerns about how she would address this matter.

At that moment, I empathized with being a junior staff and wondered how I would have acted if I were in her place. Three weeks later, when meeting with a senior nursing administrator at the hospital, I shared the incident noting that I had not seen the prior interaction with him and the senior nurse. What I reported, was that the client was carrying boxes with dialyze to his bedside while in her presence. I wondered whether he was asked to help or offered to assist in this process.

Issues, Questions and Reflections

Should a nurse ask or accept an offer of physical assistance from a client? Contextually, it is not uncommon for clients to offer to give assistance to nurses. This may occur during care delivery as they may feel appreciative of the services received. Also, as an attempt to retain some level of autonomy by participating in their care. Whatever your answer might be, this may pose safety, ethical and legal concerns. The International Council of Nurses (ICN) code of ethics and Benner's From Novice to Expert Theory [1] will be utilized to guide the discussion and recommendations as they address nursing practice issues.

Specialist Renal Nurse and Patient with Chronic Condition

Nurse and practice: In healthcare settings, patient guardianship and safety are paramount during institutionalization. Unfortunately, the power dynamics that exist within an institution among healthcare teams, consumers, institutional procedures and policies all has a potential to remove certain rights and privileges. Thus having the

potential to make the client feel vulnerable. As an observer, I took into consideration the pathophysiological changes in chronic renal disease. I was concerned that renal patients often have low haemoglobin and reduced oxygenation. During periods of exertion, the ventilation perfusion mismatch that exists may adversely affect cerebral oxygenation and could result in syncope and falls. If such as event were to occur during this activity, the nurse would be liable as the client was in custody of the unit. Unfortunately in this case example, the accompanying nurse does not work on the unit, therefore, whose responsibility would it be to write an incident report if such an event were to occur? Also, the undue patient stress that would result from such as event could have been avoided if this act had not occurred.

Should Nurse Faculty Utilize a Teachable Moment with Clinical Staff?

The ICN code section on nurse and co-workers, identifies that the nurse should take action to protect the patient, families and communities by speaking out when their health is at risk [2]. In this exemplar, there were three nurses: one being the junior staff, a renal dialysis senior nurse and the external nursing faculty. At that moment, I felt justified to intervene and communicate my safety and legal concerns in a timely manner. Seeing that she did not act may indicate the constraint of the junior staff by speaking up to protect the patient, especially when a senior member and nurse expert is involved.

Benner's Novice to Expert Theory [1] identifies that novices have had little experience in situations they are expected to perform. Therefore, it is necessary to have strong nursing leadership in clinical settings who are mentors and have advocacy skills. In areas where this does not exist, how can faculty members empower the clinical staff in an environment that is diverse and transitioning? However, I had to be prudent as the faculty's role in this setting is primarily to guide and critique students, but may have to do the same for the clinical staff. This ambiguous role may create strained relationships with clinical staff and nursing faculty if not done in a caring and thoughtful manner.

Nurses have had a long and proud history of advocating for clients [3]. I was convinced that whistle blowing on my colleague was an act of advocacy. Wherever and whenever nurses see vulnerable groups, they step to the calling. It is no wonder nursing is rated as the most trusted profession for the last 14 years [4]. Arguably, whistle blowing is a difficult act that requires institutional support in order to protect the whistle blower and help change attitudes and promote quality care [5]. Fortunately in some countries like the United States of America (USA), whistle blowers have constitutional protection [6] this is not so many developing countries.

When it is Sharing, Reporting or Whistleblowing?

Another thought struck me about my decision, was it whistle blowing? There are several definitions for the concept. Ahern and McDonald [7] defined it as any reporting of misconduct in the workplace. Interestingly, Boatright [8] gave a more detailed definition of whistleblowing, as "voluntary release of non-public information, as a moral protest, by a member or former member of an organization outside the normal channels of communication to an appropriate audience about illegal and or immoral conduct in the organization or conduct in the organization that is opposed in some significant way to the public interest". The latter more extensive definition did not fully explain my action as I had not reported the matter to any external agency; nevertheless, I made a report.

As hard as it was to admit, it was easier for me because I am more confident than I was 21 years ago when I was a junior nurse. Also, I did not feel vulnerable because I was not employed to that institution. Then I thought about which theory was applicable to explain my action and the junior staff's inaction? Once again, Benner came to mind. Galer-Unti, Tappe and Lachenmayr identified numerous barriers to advocacy, these included lack of training and education about advocacy skills and victimization [9,10]. Experience has taught me that organizational culture can enable or inhibits whistle blowing and advocacy. Is it possible that advocacy is less likely with junior staff as they are less confident and more vulnerable to victimization? I believe yes!

The nurse, profession and practice: Nurses should maintain a practice culture that is supported by research evidence [2]. This should be a personal commitment for all nurses and should be supported at the institutional level. In clinical settings, nurse leaders have a significant role to play in enhancing care. This could be done by several initiatives such as journal clubs and collaborating with nursing faculties with research to strengthen knowledge translation. Faculty can also partner with nurse leaders by conducting grand-rounds with clinical staff among others. Such skills building activities could be used to build confidence and strengthen decision-making skills for novices.

How can we Utilize Safety, Quality, and Ethical Exemplars to Open a Door for Just Culture?

Two weeks after meeting with the nursing administrator, I shared the events with my nursing mentor in the United States of America (USA) when I visited as a nursing scholar. The discussion surrounded the concept of "just culture" and how nursing faculty can champion the cause for institutional change towards a culture of safety. Reason [11] argued that a just culture creates an atmosphere of trust, encouraging and rewarding people for providing essential safety-related information [4]. References for "just culture" go back more than 10 years, however the discussion and implementation is just beginning to

take hold in clinical settings [4,12-14], even though it has been practiced in aviation and the automotive industries [16]. Environments that support "just culture" have a shift in focus from a blame culture that reprimands, to one that is restorative and proactively find ways to prevent errors, thus enhancing safety.

Nurse leaders have a role to play in creating and supporting a safety environment and just culture [14-16,17]. However, dialogue with faculty and administrators needs to be strengthened as both can be champions for a just culture for students, novice to expert nurses, and among inter-professional teams. There is no one right answer that is contextually appropriate in every situation or setting, but a just culture is an avenue that is supportive in enhancing patient quality care and safety in a complex health care environment.

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