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Patient safety in nursing education: Contexts, tensions and feeling safe to learn

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SUMMARY

Education is crucial to how nurses practice, talk and write about keeping patients safe. The aim of this multisite study was to explore the formal and informal ways the pre-registration medical, nursing, pharmacy and physiotherapy students learn about patient safety. This paper focuses on findings from nursing.

A multi-method design underpinned by the concept of knowledge contexts and illuminative evaluation was employed. Scoping of nursing curricula from four UK university programmes was followed by in-depth case studies of two programmes.

Scoping involved analysing curriculum documents and interviews with 8 programme leaders. Case-study data collection included focus groups (24 students, 12 qualified nurses, 6 service users); practice placement observation (4 episodes = 19 hrs) and interviews (4 Health Service managers).

Within academic contexts patient safety was not visible as a curricular theme: programme leaders struggled to define it and some felt labelling to be problematic. Litigation and the risk of losing authorisation to practise were drivers to update safety in the programmes. Students reported being taught idealised skills in university with an emphasis on 'what not to do'.

In organisational contexts patient safety was conceptualised as a complicated problem, addressed via strategies, systems and procedures. A tension emerged between creating a 'no blame' culture and performance management. Few formal mechanisms appeared to exist for students to learn about organisational systems and procedures.

In practice, students learnt by observing staff who acted as variable role models; challenging practice was problematic, since they needed to 'fit in' and mentors were viewed as deciding whether they passed or failed their placements. The study highlights tensions both between and across contexts, which link to formal and informal patient safety education and impact negatively on students' feelings of emotional safety in their learning.

Introduction

Improving patient safety is a global concern. In 2001 the UK National Patient Safety Agency (NPSA) was established followed by the World Alliance for Patient Safety in 2004 (WHO, 2004). However UK inquiries continue to highlight safety issues; children's heart surgery at Bristol (Kennedy, 2001); the Maidstone and Tonbridge Wells investigation into *Clostridium difficile* (Healthcare Commission, 2007); and the recent inquiry into care provided by Mid Staffordshire National Health Service (NHS) Foundation Trust (Francis, 2013; Hornett, 2012). Issues included: teamwork, workplace culture, leadership, communication, staffing levels, training, difficulties in reporting concerns; and information monitoring. The increased profile of patient safety resulted in numerous campaigns and collaborations across UK universities, the NHS and beyond (Slater et al., 2012; Burston et al., 2011). Developments include the Safer Patients' Initiative (Health Foundation, 2011a), Scottish patient safety programme and research network (Haraden and Leitch, 2011), and patient safety research centres. Thus considerable research and development have been stimulated in areas including, adverse events (Jordan, 2011), medication issues (Wulff et al, 2011), non-technical skills (Gordon et al, 2012; White, 2012), organisational factors (Dodds and Kodate, 2011) and human factors (WHO, 2009). Despite some progress, unnecessary patient harm remains a key issue for nursing and health care (Health foundation, 2011b; Jordan, 2011). Education is recognised as playing a major role in developing safe, high quality, nursing and health care (Francis, 2013; Mansour, 2012; Slater et al, 2012; Pearson and Steven, 2009). However a recent review of evidence on perceptions of patient safety in pre-registration and

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undergraduate education revealed a continued lack of research and the need for 'patient-safety-friendly nursing curricula' (Mansour, 2012, p.536).

Background

In 1994 Leape argued the most fundamental change needed if health care was to make meaningful progress in error reduction was cultural. Progress was seen to lie in addressing underlying conceptual models of, and attitudes towards, error, and in the establishment of learning cultures that enable systematic error reporting and continuous practice improvement (Lester and Tritter, 2001).

In 2004 the NPSA placed education at the centre of their *Seven Steps to Patient Safety* document (National Patient Safety Agency, 2004). In 2006 the Department of Health (DoH, 2006) suggested education providers ensure advances in healthcare education and training to support patient safety, highlighting the need for a patient safety curriculum promoting appropriate attitudes, behaviours and skills. Milligan (2007) argued that shifting UK healthcare towards a patient safety culture required changes to healthcare professional education and training. However concern was expressed regarding a focus on individual errors in nurse education (Gregory et al., 2007) with claims that nursing curricular competencies urgently needed changing to match the needs of the practice environment (Sherwood and Drenkard, 2007). Thus the place of learning, education and training in promoting and supporting a safety culture has long been recognised (Pearson et al., 2010; Sammer et al., 2010).

In 2009 the WHO produced a patient safety curriculum for medical schools, and a multi-professional edition in 2011. Howard (2010) and Gantt and Webb-Corbett (2010) describe educational frameworks for learning and teaching about patient safety, yet it is unclear how much behaviour is driven by hidden curriculum or practice culture (Bradley et al., 2011), or which educational strategies are effective in creating change. A strong evidence base does not yet exist about how patient safety is understood and applied during training, or ways that it can be effectively incorporated in health care curricula (Mansour, 2012; Pearson and Steven, 2009; Attree et al., 2008). Few studies systematically explore patient safety in pre-registration nursing (Mansour, 2012). At a time of transition this is a critical area for investigation.

Aim

The study from which the findings of this paper are drawn aimed to investigate the formal and informal ways pre-qualification students from a range of healthcare professions learn about keeping patients safe from errors, mishaps and other adverse events. Findings from the nursing programmes are presented while other findings are reported elsewhere (Pearson and Steven, 2009).

Methods

Design

The methodological approach drew on 'illuminative evaluation' (Parlett and Hamilton, 1977) which focuses on exploring, describing and interpreting. A two stage theoretically based design was employed (see Fig. 1) underpinned by Eraut's theoretical framework (Eraut, 1994, 2000) which suggests that we learn from (i) formal planned education (undertaken in university or college); and (ii) informal education (in all settings) which includes common ideas, ways of thinking, traditions, and beliefs that are unwritten but form a part of our daily life. Stewart (2008) re-conceptualised Eraut's work into three knowledge contexts (Fig. 2), which formed the basis of the study design (Fig. 1).

Ethics

Ethical approval was granted by the Local National Health Service Research Ethics Committee. Site-specific approval was obtained at each site and from university committees. Ethical issues included: potentially 'discovering' threats to patients' safety (none emerged), power dynamics (between researchers/practice staff/students) and anxiety regarding the 'safety' focus of the study. Protocols were implemented to deal with potential safety issues; informed consent was obtained; researchers stressed throughout that no judgements of educational or clinical practice were being made and that decisions regarding participation would not affect future education or employment.

Data Collection and Participants

Data were collected between 2006 and 2008. Stage one explored the formal curricula of four pre-registration degree level nursing programmes in four UK universities (Table 1). Programme documents were collected (Table 2) and analysed alongside semi-structured interviews with programme leaders/equivalents ($n = 8$). To enhance transferability a range of programmes were included (Table 1). Variations included programmes based in England and Scotland (different policy contexts and health care systems), differing university histories, geographical locations and course characteristics.

Documents were analysed for how patient safety was represented in curricula, the programmes' formal intentions, and to develop an understanding of 'education as planned'. Interviews examined programme information, identified where participants felt patient safety lay within the curriculum and obtained views about how or what patient safety education is or should be. Two programmes employing diverse curricula in different types of university, and located in differing geographical areas were selected for in-depth case study in stage 2 (Stake, 1995). Three teaching sessions (each up to 3 hrs) were observed for each programme. Researchers used an agreed observation framework covering: implicit and explicit content; verbal comments; staff and student behaviours; and explicit and implicit messages regarding patient safety. Observations of clinical areas (four episodes/19 hrs) during student placements obtained snapshots of practice culture and influences on students.

Focus groups (FG) were held with second and final year students ($n = 24$), newly qualified nurses ($n = 4$), practice staff who taught or supervised students ($n = 8$) and service users involved in curriculum development or delivery ($n = 6$). Interviews were undertaken with nurse and risk managers ($n = 4$) in NHS trusts providing student placements. Interviews covered the organisation's views of, and approach to patient safety, links with education and organisational ethos/culture.

Documents concerning patient safety, i.e. policies and protocols ($n = 9$) were also requested. Analysis aimed to provide an overview of the organisations' formal approach to patient safety, and develop an understanding of their ethos.

Analysis and Rigour

The team developed analytic frameworks and coding. Documents were content analysed, interviews and focus groups analysed via a thematic approach and observations condensed using vignettes. Topics important to participants, and unanticipated themes were allowed to emerge. Findings from one research stage informed the next. Two researchers analysed data independently and then compared findings. After completion of the project the authors continued to refine the analysis during the writing process and conference presentations.

Findings

The findings are presented by context and theme, and draw on all nursing data sets, integrating results of the scoping exercise (stage 1) and case studies (stage 2).