Lessons learned: Nurses' experiences with errors in nursing

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ABSTRACT

Background: Health care organizations seek to maximize the reporting of medical errors to improve patient safety.
Purpose: This study explored licensed nurses' decision-making with regard to reporting medical errors.
Methods: Grounded theory methods guided the study. Thirty nurses from adult intensive care units were interviewed, and qualitative analysis was used to develop a theoretical framework based on their narratives.
Discussion: The theoretical model was titled "Learning Lessons from the Error." The concept of learning lessons was central to the theoretical model. The model included five stages: Being Off-Kilter, Living the Error, Reporting or Telling About the Error, Living the Aftermath, and Lurking in Your Mind.
Conclusion: This study illuminates the unique experiences of licensed nurses' who have made medical errors. The findings can inform initiatives to improve error reporting and to support nurses who have made errors.

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Introduction

A 2000 Institute of Medicine (IOM) report *To Err Is Human* provided estimates of the number of medical errors that occur nationwide and concluded that 44,000 to 98,000 patients die annually as a result of preventable medical errors (Kohn, Corrigan, & Donaldson, 2000). Goodman, Villarreal, and Jones (2011) multiplied the IOM estimates of patient deaths by the median social cost of injury as described by Viscusi (2003) and estimated the cost of preventable inpatient injuries at $6.7 billion. This value of a statistical life is an important parameter in assigning monetary value to health risks (Doucouliagos, Stanley, & Viscusi, 2014).

Although in 2000 the IOM called for a 50% reduction in medical errors within 5 years, this decrease has not occurred despite the development of several error-reduction interventions (Leape et al., 2009). The lack of demonstrable reduction in errors has been attributed to several factors including inconsistencies in reporting mechanisms across organizations, variations in how errors are measured in research, and the inability to accurately identify the percentage of actual errors reported by health care providers. High rates of medical errors persist within health care systems despite efforts to develop a culture of safety within hospitals and a push to make health care systems high reliability organizations (HROs) (Hershey, 2015). HROs are characterized by attention to failure, the reluctance

to simplify understanding of systems and processes, and a focus on what happens at the point where real work is completed and reliance on the expertise of those who perform the real work (Weick & Sutcliffe, 2007). To move health care toward more reliable performance and outcomes, detailed understanding of the work of nursing, the processes and systems that touch their work, and learning about what happens when these processes and systems fail is critical. The ultimate goal of reporting is for increased learning about why things go wrong and to improve systems and outcomes.

Determining rates of medical errors in health care systems in the United States have been problematic due in part to the lack of systematic reporting procedures (Agency for Healthcare Research and Quality [AHRQ], 2010; Pham, Frick, & Pronovost, 2013; Pronovost, Miller, & Wachter, 2006). Accurate counts of deaths or injuries attributed to medical errors are also hard to obtain due to variations in legal, cultural, and administrative approaches to reporting errors (Anderson, Kodate, Walters, & Dodds, 2013; Loeb & O'Leary, 2004). James (2013) reviewed four studies which used the Global Trigger Tool (Griffin & Resar, 2009) to track patient adverse events and estimated that 210,000 to 400,000 of these adverse events occur yearly. Subsequent studies have reinforced these findings and the utility of the Global Trigger Tool (Harkanen et al., 2015; Mull et al., 2015). The failure to demonstrate reduction of errors also may be a result of differences in research methodology, such as variations in the way error reporting is measured, rather than lack of safety in hospitals (Goodman et al., 2011). Accurate determination of error reporting is needed to determine the efficacy of error-reduction interventions.

The Patient Safety and Quality Improvement Act of 2005 was designed "to improve patient safety by encouraging voluntary and confidential reporting of events that adversely affect patients" (AHRQ, 2010). This legislation prompted the creation of patient safety organizations (PSOs) charged with identifying error patterns by analyzing large numbers of error reports from diverse sources so that threats to patient safety could be identified and interventions could be developed to reduce risks to patients (Clancy, 2008; Kachalia, Mello, Nallamothu, & Studdert, 2016). Licensed nurses (registered nurses [RNs] and licensed practical nurses) and unlicensed nursing assistants comprise 54% of the health care workers in the United States (Page, 2004). Complete information given to PSOs by licensed nurses is critical to the accuracy and dependability of patient safety databases.

When nurses make, discover, or observe an error during the course of their practice, they must decide whether or not to make a formal report. Although nurses are the health care professionals who most frequently report errors, many continue to harbor fears about reporting them (Bayazidi, Zraezadeh, Zamanzadeh, & Parvan, 2012; Cook, Hoas, Guttmannova, & Joyner, 2004; Espin, Lingard, Baker, & Regehr, 2006; Hartnell MacKinnon, Sketris, & Fleming, 2012; Osmon et al., 2004; Prang & Jelsness-Jorgensen, 2014; Rowin et al., 2008; Uribe, Schweikhart, Pathak, Dow, & Marsh, 2002). In many institutions, the workplace culture regarding error reporting remains one of blame, and nurses are often concerned about personal repercussions associated with reporting errors (Blair, Kable, Courtney-Pratt, & Doran, 2015; Castel, Ginsburg, Zaheer, & Tamin, 2015; Cook et al., 2004; Espin et al., 2006; Jeffe et al., 2004; Stratton, Blegen, Pepper, & Vaughn, 2004; Taylor et al., 2004; Uribe et al., 2002). A better understanding of nurses' decision-making regarding error reporting and workplace factors that influence their decisions can inform the development of strategies to improve the frequency and accuracy of error reporting by nurses. The purpose of this study, therefore, was to explore nurses' decision-making processes regarding reporting errors.

Methods

Grounded theory (GT) methods guided this study. GT is an approach used to develop a theoretical framework that describes a psychosocial process shared by a group of individuals that faces a common challenge and is influenced by a sociocultural context that affects the collective (Charmaz, 2014; Glaser & Strauss, 1967). Through an iterative process of data collection and analysis, participant narratives about the phenomenon of interest served as the basis for the development of a theoretical framework (Charmaz, 2014).

Sample

Licensed RNs who worked in an adult intensive care unit (ICU) as direct patient caregivers comprised the study sample. ICUs were chosen because high rates of errors are reported on nursing units that provide acute care for critically ill patients, such as ICUs (Brunsveld-Reinders, Arbous, De Vos, & De Jonge, 2016; Landrigan et al., 2004), and critically ill patients experience higher rates of adverse events and errors than other patient populations (Balas, Scott, & Rogers, 2006; Kiekkas, Karga, Lemonidou, Aretha, & Karanikolas, 2011).

Convenience sampling was used to recruit licensed nurses from eight ICUs within an urban university-affiliated hospital organization between November 2012 and June 2013. Following approval from the university institutional review board, which was honored by the hospital organizations in lieu of separate approvals, emails explaining the study were sent to three chief nursing officers (CNOs).

The CNOs provided access to department directors and unit managers. Following approval from each unit manager, the researcher spent time on each unit to observe and be present with the nurses. During these visits, the researcher initiated discussions regarding the study, provided details for those who appeared