To Err Is Human, Just Culture, Practice, and Liability in the Face of Nursing Error

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More than 2 decades have passed since the launch of the modern patient safety movement. Despite this, medical errors continue to be a serious public health threat and leading cause of death. Leaders should continually commit to the safe reporting of errors, especially in light of the criminal trial, conviction, and sentencing of a former Tennessee nurse involved in a fatal medication error. The purpose of this paper is to highlight a systematic approach addressing just culture and error reporting by revisiting *Err Is Human: Building a Safer Health System*, just culture principles, practice considerations, and liability potentials.

More than 20 years have passed since the landmark publication *To Err Is Human: Building a Safer Health System* was published by the Institute of Medicine, launching the modern patient safety movement.[1] This seminal work was the first in a series of publications from the National Academies addressing the nearly 100,000 Americans dying as a result of medical errors and the subsequent need to build safer health care systems.[1] Despite this advancement, in 2015, the National Patient Safety Foundation found that attempts to accelerate nationwide patient safety movements were tempered by the complexity of health care delivery systems, as well as issues in clearly defining medical errors directly contributing to morbidity and mortality.[2] As such, errors, whether by omission or commission, continue to be a serious public health threat and the third leading cause of death in the United States at a cost of $20 billion annually.[3-5]

Mistakes or medical errors, including those committed by nurses, are considered an inevitable part of professional practice and the human condition. As the largest group of health care professionals in the United States, nurses are the primary providers of care in inpatient settings and are most likely to be involved in errors associated with medication administration, patient falls, infections, documentation, and equipment-related patient injuries.[6,7] In order to promote a culture of safety, the ethical reporting of errors by nurses should remain a priority. Demonstrating a commitment to prevention, error reduction, and unnecessary patient harm is paramount. To improve organizational reliability and safety, some national health care leaders are challenging providers to double the number of voluntary safety event reports.[8] Voluntary error reporting is a critical component of sustaining a just culture of safety. More specifically, error reports are a crucial component of quality improvement processes and root cause analyses driving positive patient outcomes, system change, and safety movements.

Despite notable strides, evidence continues to suggest that nurses underreport errors.[9] Underreporting is attributed to fear of negative consequences, beliefs surrounding a perceived "blame culture," lack of incident report training, and the need for ongoing

KEY POINTS

- **Despite strides in patient safety, medical errors continue to be underreported.**
- **The recent criminal conviction of a nurse involved in a fatal error may have unintended consequences in the patient safety movement.**
- **Essential that nursing leaders maintain a culture of safety, safe error reporting, while integrating just culture principles, thus assuring a safe practice environment and improved nurse well-being.**

education and organizational support when errors occur.[10-12] Building and sustaining trust between health care leaders and frontline nurses in a just culture environment is imperative. Just culture principles maintain that most often, medical errors are the result of failures in error-proofing organizational systems and structures rather than a mistake made by a well-intentioned person, directly involved in an incident.[13] Just culture is vastly different than blame culture, where an individual is singled out and criticized when errors occur.[14] However, just culture ensures balanced approaches to accountability because some errors do warrant disciplinary action.[15] The lines between just and blame culture, systems failure, misconduct, and neglect were blurred as nationwide, nurses and health care leaders watched the criminal trial, conviction, and sentencing of a former Tennessee nurse involved in a fatal medication error.

In response to the onslaught of news and social media coverage of the Tennessee case, frontline nurses across the nation engaged in an outpouring of support for the Vanderbilt nurse, ultimately personalizing the experience and questioning their role, personal liability, and ethical obligations when disclosing errors in the face of possible criminal charges. Unfortunately, the conviction of the Tennessee nurse occurred at a time when organizational leaders are facing serious and unprecedented workforce issues with nurse well-being at the forefront. Since 2016, health care organizations have experienced a 90% turnover in workforce.[16] In 2020 alone, turnover was 19.5% with nurses at 18.7%, an almost 3% increase since 2019.[17] On average, hospitals lose between $3.6 million and $6.5 million annually, directly attributed to turnover.[17] In a 2021 nationwide survey of hospital nurses, 90% expressed that they were considering leaving the profession within the next year.[17] This is coupled with the negative long-term impact of the pandemic, including stress and burnout of the nursing worforce.[18,19] In a recent systematic review examining nurse burnout, the prevalence of emotional exhaustion was 34.1%.[20]

Medical errors have been linked to nurse well-being. In a recent study examining critical care nurses' physical and mental health, nurses in poor health report significantly more errors.[21] Nurses who perceived that their worksite is supportive of their well-being were twice as likely to have better physical health.[21] Findings further suggest that nurse wellness programming may increase the quality of patient care, subsequently reducing the incidence of preventable errors.[21] The health and well-being of nurses was recently addressed in the *Future of Nursing Report (2020-2030)* with a call to advocate for resources supporting nurse well-being.[22]

In an effort to share our collective commitment to frontline nurses, and in response to the national dialogue and implications of the Tennessee case, nurse leaders in our health care system made a quick and concerted effort to address just culture and error reporting by revisiting *Err Is Human: Building a Safer Health System*, just culture principles, practice considerations, and liability potentials. The purpose of this paper is to highlight our approach, including rapid communication, development and deployment of a system-wide nursing forum (To Err Is Human: Just Culture, Practice and Liability in the Face of Nursing Error), and a subsequent presentation and ongoing communications to nurse leaders. Of note, our organization spans 2 states employing more than 22,000 nurses and serving nearly 3 million people across 500 sites of care.

NURSE COMMUNICATION

To immediately address the conviction, in March 2022, an email communication was sent to employees, including nurses, recognizing the Tennessee verdict and loss of life under tragic circumstances. In this communication, the importance of our organization's reliability journey and commitment to a fair and just culture were highlighted. The leadership team reinforced that human errors lead to an examination of system processes and improvements if warranted, rather than punitive action. This communication included information about additional employee support, including immediate and ongoing access to our employee assistance program and mission and spiritual care for emotional (and spiritual) support if needed, a reminder regarding legal protection of safety reports and investigations from discovery through membership in a Patient Safety Organization (Institute for Healthcare Improvement, Press Ganey, etc.) and state Medical Studies Acts (Illinois and Wisconsin) protection, reiteration of our commitment to identifying and correcting system processes contributing to errors and harm, and assurances surrounding supporting nurses in litigation, including legal resources and representation. The communication highlighted that criminal prosecution and punishment is the wrong approach to errors.

To more directly address nurses' concerns stemming from the fatal error and criminal conviction of the Tennessee nurse, our nursing leadership team determined that an emergency forum structured in the format of our Nursing Grand Rounds was warranted. As such, the forum was developed. Email reminders, as well as other internal communication venues, were used inviting nurses to attend the Nursing Forum—To Err Is Human.

NURSING FORUM—TO ERR IS HUMAN

For several years, our organization has formally used Nursing Grand Rounds as a component of Magnet® nursing excellence. In our system, Nursing Grand

Rounds is a well-established conduit for sharing nursing research, evidenced-based practice and quality improvement initiatives, with continuing education credits typically available. The Nursing Forum—To Err Is Human was developed using this format.

First, a panel was formed including experts from risk management, compliance, safety, and nursing quality and practice, and a system attorney to develop content addressing concerns voiced by our nurses in shared governance meetings and other communication venues. Via consensus agreement from the expert panel, topics addressed and presented to nurses attending the forum included reviewing Reason's Swiss Cheese Model, professional practice standards and support, as well as individual professional accountability. Based on widely available public information from the Tennessee case, our expert panel collaborated examining, exploring, and deconstructing the fatal medication error and the response from the Tennessee hospital where the mistake occurred. While deconstructing the Tennessee case, attention to identifying gaps in standards of practice from a system and nurse perspective were targeted, described, and compared to our own system safety and practice standards.

Second, our Just Culture Decision Guide, based on the work of Reason,[13] was presented to attendees as a reference point and touchstone for how error reporting and subsequent assessments in our system occur. Our Just Culture Guide contains a series of post-error questions clarifying whether a nurse requires added training and support, or if there is a wider system issue contributing to the error. The decision guide does not replace patient safety reporting or nursing manager/human resources investigations, rather it ensures equity and shared accountability when examining errors. System error reporting was reviewed, and data were provided on how safety reports lead to root-cause analyses and peer review. Disclosure, including the serious safety event response plan, was presented. Third, legal considerations were explored describing differences between criminal prosecution and civil litigation, including negligence suits secondary to medical errors and insurance coverage for civil actions. Finally, the nurses' scope and standards of practice, medication safety, and avoidance of work-arounds were defined and described.

Audience questions were solicited prior to the forum. Questions informed the forum content and were specifically addressed in a frequently asked questions provided on the Grand Rounds website housed in our Nursing SharePoint Hub. One continuing education hour was offered. Forum results indicate that nearly 700 nurses (N = 691) attended the live session with an additional n = 100 views of the recording. Three hundred sixty-eight (n = 368) nurses submitted for continuing education credit. A paired samples *t*-test examining self-reported levels of confidence in knowledge on 1 item addressing just culture, and nursing practice accountability and liability shows a statistically significant increase in scores (1 = not confident, 5 = very confident) before (M = 3.62, SD = 1.07) and after ([M = 4.69, SD = 0.525], $t(369) = -21.35$, $p < 0.001$ [2-tailed]) the forum. In addition, after the Tennessee nurse was sentenced, leadership immediately sent an additional email communication reiterating that prosecution and punishment is the wrong approach to errors.

LEADERSHIP PRESENTATION

Nurse leaders are responsible for establishing and sustaining a culture of safety. This includes understanding what is and is not in a nurse's scope of practice, professional accountability and codes of conduct, when to apply just culture decision guides, and when to involve external regulatory agencies, including boards of nursing. As such, frontline nursing leaders (directors/managers) were invited to attend the forum because they provide nurses with the tools necessary to achieve safety goals.

Senior leaders, including chief nursing officers (CNOs) are considered key in the journey to high reliability and are called to focus on preoccupation with failure, reluctance to simplify, sensitivity to operations, deference to expertise, and commitment to resilience.[23] More specifically, CNOs are responsible for consistently maintaining safe operations and driving patient safety changes. Often, this means performing rapid assessments when errors occur and responding by integrating safety changes through the domains of shared governance, practice, education, and research. Leaders are responsible for reporting serious safety events to external regulatory bodies including the Centers for Medicare & Medicaid Services, state boards of nursing, and law enforcement. This is balanced with ensuring the informational and emotional needs of those impacted by errors are addressed within the confines of legal and confidentiality constraints.

In an effort to support CNOs, and other executive-level nursing leaders responsible for sustaining a culture of safety, a brief presentation was given to the Senior Nursing Leadership Council revisiting the system just culture decision guide, as well as introducing the nursing scope of practice decision-making framework and regulatory decision pathways.[24,25] The nursing scope of practice decision-making framework was developed by a team of national leaders and serves as a tool for determining what duties a nurse can safely perform within the scope and accountability of practice as defined by laws, regulations, evidence, scope, policies/procedures, education, training, and competence.[25] Similarly, and in an effort to support an understanding of how boards of nursing address violations of state practice acts and subsequent discipline,

the Regulatory Decision Pathway was examined.[26] This pathway assists board of nursing members in determining disciplinary decisions (education, reprimand, suspension of license, etc.) when practice errors, unprofessional acts, or misconduct occurs. The pathway addresses any system failures (or what role the system may have played), as well as nurse behavioral choices possibly contributing to the error. Finally, CNO and safety leaders were provided with communication (rounding) tools if additional questions arose. Over 40 nursing executives were in attendance for the presentation. Our patient safety team is currently developing a Just Culture offering via our Leadership Development Institute.

RESPONDING JUST IN TIME

In light of the Tennessee nurse recently convicted of criminally negligent homicide and gross neglect of an impaired adult,[26] leaders must recognize that nurses in their systems may have been personally impacted in untoward ways. As a result, leaders should remain nimble and prepared—quickly responding when contemporary issues arise. Addressing safety principles including just culture and liability, error disclosure and reporting, near misses, and adverse events, all fundamental components of the patient safety movement, ensures a safe work environment—an essential component of nurse well-being. Nurse well-being should remain a priority, especially when medical errors occur. The moral and emotional impact of medication errors is devastating for nurses, only contributing to further burnout.[27,28]

In conclusion, the flow of communication to frontline nurses and subsequent development and delivery of the forum To Err Is Human was a planned effort to assure our nurses that they practice in a safe and just culture and that their well-being matters. The presentation and communications described above were in alignment with our other high reliability organizational tools including huddling, purposeful rounding, crosscheck and coach, positive feedback and accountability, and STAR (stop think, act, review), etc. Nurse leaders are a stabilizing force and play a strategic role in patient safety. In the face of the Tennessee nurse conviction, the deliberate, nurse-centric efforts described here addressed an important issue impacting nurses nationwide. Coordinating these types of just-in-time forums should be considered a key component of patient and nurse safety, as well as nurse well-being.

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1541-4612/2022/$ See front matter
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https://doi.org/10.1016/j.mnl.2022.06.010