

A Culture Of Patient Safety Requires A Culture Of Staff Security

By Larry Johnson

“All the procedural and systemic improvements in the world will not work if people are afraid to report what they see and contribute to changing what’s wrong.”

CJ, my wife of 37 years, was involved in a serious bicycle accident that left her paralyzed on one side of her body and unable to speak. She spent two years in a skilled nursing facility before I could finally bring her home. During that time, there were several encounters with medical error: Wrong diet given at meals, forcing her to drink thickened liquid when she can swallow, allowing her to dehydrate, which caused a UTI which then lead to sepsis. The list goes on and on. One event stands out in my mind, however, not so much for its seriousness as for its reflection of the cultural status that underlies so many organizational errors.

Part of her injury occurred in the brain stem, which controls wakefulness. Consequently, she suffered from narcoleptic-like symptoms, where she was groggy all day and then unable to sleep all night. To counteract her chronic sleepiness, her doctor had prescribed Ritalin and Provigil twice per day. None-the-less, the symptoms continued.

After several months of this regimine, a medication nurse, who was filling in from the registry one evening asked me, “Why is your wife getting a dose of speed just before bedtime?”

“Good question,” I responded. When I asked the doctor the same question the next day, she said, “Well, you have a point there. I

guess I should have specified when the medication was to be given.” She changed the order to 8:00AM and 12 Noon – and the sleepless nights and groggy mornings went away.

The most important question to ask here is, “Why did it take a nurse from the registry to question the timing of the dosage? For months, the regular nursing staff had been giving CJ the stimulating medication at 8:00PM without ever saying a word. And I, a layman, hadn’t given it a thought. So I asked the charge nurse, “How come?”

Her response was, “We don’t question doctors’ orders. Twice a day means 8:00AM and 8:00PM unless otherwise specified.”

Fact: A study of 26 nursing homes in Iowa found that one in five nurses and CNAs feel punished when they question a process or report a mistake.

Fact: The same study found that 40% of nurses and CNAs feel that when they do report a mistake, it is received by management as if it were a personal attack.

Fact: 40% of nurses feel that making changes in their facilities to improve patient safety is next to impossible.

Reality: If mistakes aren’t reported, they don’t get fixed.

Reality: If medical employees are afraid to contribute suggestions for improvement, well-meaning, management-driven improvements may miss the mark.

Reality: If the culture dictates that you don’t question mistakes that you see occurring, it is unlikely that you will raise your voice in protest.

I'm reminded of a similar attitude that resulted in much worse consequences:

On February 9, 2001, while conducting a special tour for a group of civilians off the coast of Hawaii, the nuclear submarine USS Greenville launched an "emergency blow," rapidly rising from the ocean depths and breaking through the surface like a whale playing in the waves. The crew wanted to show the visiting civilians what the submarine could do and, according to testimony, "give them a bit of a thrill." Unfortunately, the rapidly emerging submarine collided with the Ehime Maru, a Japanese fishing vessel, sinking the small boat and leaving nine of the thirty-five people on board dead.

A subsequent U.S. naval inquiry uncovered many mistakes made by the Greenville's captain, Commander Scott Waddle, and his crew that contributed to the deadly accident. Not the least was the failure of the fire control technician (FCT) to warn Commander Waddle that the sonar display had identified a ship in the area. During the inquiry, Rear Admiral Charles Griffiths, Jr., who conducted the pre-hearing investigation, testified, "The fire control technician should have heard Waddle's assessment of the situation and questioned it...he should clearly have forcibly told the captain and the officer of the deck."

In a subsequent interview, Navy Captain Conrad Donahue, who has commanded two nuclear submarines during his twenty-seven-year career, stated that, "On this particular ship, and on a lot of ships in the Navy, the crew has so much trust in the skipper's abilities that they don't question him when they should. The FCT had a ship on the display but he saw the captain looking through the periscope. He probably assumed that if the skipper didn't see it...it wasn't there."

This looks like a case of "The Emperor's New Clothes." How often

does it happen that a doctor prescribes the wrong medication, or a nurse delivers the wrong dose, or a respiratory therapist gives a medication to someone who's allergic to it – and no one says a word because “It's on the doctor's order so I assume the doctor knows what she's doing.” or “The nurse is in charge, so better not question him.” or “I don't want to get in trouble, so I'll just look the other way?”

Doctors and healthcare managers don't need to be as vain and stupid as the naked emperor to make bad decisions. Sometimes, the brightest and best simply have limited perspectives. Whether they're out of touch with current trends, sensitive about not having all the answers, or simply misinformed, all persons of authority rely on honest feedback from their employees to make wise choices. Otherwise, they, like the naked emperor, are destined to make and support poor decisions. But for managers to trust the feedback they receive, and to get the information they need, it helps if the corporate culture supports open communication and healthy debate.

That's why Bob Phillips and I wrote the book, ***Absolute Honesty: Building A Corporate Culture That Values Straight Talk And Rewards Integrity.*** It addresses the problem of working in a culture where honest communication is inhibited or prevented by fear of retribution or simple inertia. It shows you how to change the culture so that people will be willing to come forward, to speak up, and to express their concerns. It's a perfect fit for the world of Patient Safety. All the procedural and systemic improvements in the world will not work if people are afraid to report what they see and contribute to changing what's wrong.

If you're interested, you can order *Absolute Honesty* by clicking on the “Products” section of this website.

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