



Increasing Nursing Staff Voice: A Key Ingredient in Improving Patient Health and Safety¹



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Opinion

In 2011 I edited a book on occupational health and safety [1] followed later by a book on voice in organizations [2]. I have also undertaken nursing research along the way. I am currently developing a book proposal on increasing occupational health and safety. The strong association between nursing voice in health care settings and the quality of patient care needs to be given much more attention. Perlow (2003) makes a strong case why not speaking up can have negative effects for workplaces. And most organizations have too little voice or “speaking up”.

There is research indicating that nursing staff can be physically and psychologically abused by patients and family and friends of patients [3] and efforts have been made to address such concerns [4]. Nursing staff in better psychological and physical health can more effectively respond to needs of their patients. Healthier nursing staff can also improve the health and safety of their patients if they engage in voice behavior. In the healthcare setting, engaging in voice is referred to as “speaking up”.

Edmondson (2003), using both quantitative and qualitative data in a study of 16 operating room teams learning to use new cardiac surgery technology, found that ease of speaking up was associated with more successful technology implementation. Nembar and Edmondson (2006), in a study of 23 neonatal intensive care units undertaking quality improvements, found that both leader inclusiveness and having high professional status were associated with feelings of psychological safety and important element in speaking up and learning behaviors. Ajelgbe et al. [5] examined the effects of nurse-physician teamwork in emergency departments on job satisfaction among both groups of respondents, in departments having high levels of teamwork and departments with low levels of teamwork. Status differences were lower in departments indicating more teamwork and levels of teamwork were positively associated with levels of job satisfaction of both nurses and physicians. Belyansky et al. [6] found in a study of 38 surgical residents/trainees and 23 surgeons who were asked to recall an incident

when a trainee spoke up to prevent an adverse effects, that more than 70% of trainees indicated that speaking up prevented an adverse event. But fewer trainees than surgeons indicated doing so. In general the hierarchical nature of their circumstances reduced such speaking up. Monk et al. [7] found that few health care providers disclosed and apologized for medical errors that they made. Rainer [8] based on a literature review, concluded that speaking up is still a rare occurrence among nurses; one factor influencing this is the organizational character of their units.

Martinez et al. [9] undertook a study in six US academic medical centers involving 1800 medical and surgical interns and residents. Data were collected on their views about barriers, facilitators, and their own experiences in speaking up, their likelihood of speaking up and the potential harm to patients in two vignettes were also examined. Finally, established scales included the Safety Attitude questionnaire on teamwork and safety, Speaking up Climate for Patient Safety scale, and the Speaking up for Climate for professionals scale.

Interns and residents observed higher levels of unprofessional behavior than more traditional safety threats but indicated speaking up less often about unprofessional behavior. Fear of conflict was a major barrier to speaking up in both cases, higher when unprofessional behavior was observed. Speaking up to physicians over cases of unprofessionalism was less likely even when a high potential for patient harm existed. A more favorable team and safety attitude climate was associated with higher levels of speaking up in the safety vignette while only the Speaking up Climate for Professionalism was associated with speaking up in the professionalism vignette. Okuyama et al. [10] reviewed the literature on “speaking up” for patient safety by hospital-based health care professionals, 26 studies meeting their criteria.

Conclusion

- a. Motivation to speak up was related to perceived risk for patients, clarity of the situation, quality of teamwork and

hospital administration support higher levels of individual job satisfaction, feelings of responsibility for patients and as professionals, level of confidence based on one's experience, communication skills and educational background. In addition, perceived safety of speaking up, low levels of fear and low levels of potential conflict as well as concerns about being seen as incompetent affected speaking up.

b. Individuals were strategic in speaking up in that they collected facts, tried to appear positive, and gave care in selecting who to speak up to.

c. Thus both individual factors and hospital-level characteristic influenced levels of speaking up.

d. Training programs increased levels of speaking up behaviors.

Let us now consider potential benefits of nursing training to increase speaking up. Sayre et al. [11,12] two interventions to increase speaking up by nurses. Both involved training sessions to encourage speaking up. In their [11] study, the training began with a discussion of speaking up and why it was important, the viewing of 5 realistic patient situations where speaking up would have increased safety and effectiveness, support from senior leadership for speaking up, and the development of a personal action plan to increase their speaking up. A control group of nursing staff did not receive the training. Follow-up data indicated increases in levels of speaking up by the trained group with no increases in the control group. Their [12] research essentially used the same basic training program and the same training group and control group design. Their findings replicated their [11] results. Thus it is possible to increase levels of voice and speaking up in nursing and health care environments.

It is also important to locate speaking up in the larger workplace culture. Hignett et al. [13] studied barriers to effective, high quality and safe patient care in the United Kingdom. A sample of 330 National Health Service staff indicated 760 issues or challenges preventing high quality and safe health care. Further analysis aggregated these into eight categories. These categories, from largest to smallest, were organizational culture, staff number and competency, pressure at work, risk management culture, communication, resources, finance and budget and patient complexity. In organizational culture the key elements were leadership support for innovation and change, low self protection of one's own interests, the system culture including old ways of doing things lack of integration across silos, difficulty accessing information, and unclear reporting

relationships, and administration bureaucracy-duplication of jobs and paperwork, stifling and increasing bureaucracy.

Patients experience about adverse effects-harm-in their hospital experiences. The healthcare system spends considerable monies dealing with patients experiencing these adverse events. The quality of care and patient safety are now important worldwide concerns. It is possible to reduce these safety concerns through simple staff training to increase their speaking up behaviors and more teamwork in their units.

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