Operational managers experiences of a culture of blame following nurse related adverse events in a regional hospital in Gauteng

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OVERVIEW

• Purpose

• Background

• Problem statement

• Research design and method

• Measures to ensure Trustworthiness, Ethics

• Discussion of findings – operational managers experiences of a culture of abuse

• Conclusion
PURPOSE OF STUDY

• To explore describe the experiences of operational managers (OMs) regarding the management of nurse related adverse events in a specific hospital in Gauteng.

• To develop nursing leadership strategies for the constructive management of nurse related adverse events.
PURPOSE OF THIS PAPER

• To explore and describe operational managers experiences of a culture of blame following nurse related adverse events in a regional hospital in Gauteng.
NURSE RELATED ADVERSE EVENTS

“When error occurs, the customary focus on blaming the individual care-giver overlooks the conditions in which the error occurred.”

(WHO ,2008:19)
NURSE RELATED ADVERSE EVENTS OCCUR:

HOSPITALS MAY BE HAZARDOUS TO YOUR HEALTH

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Not because nurses intentionally hurt patients
but rather that the health care environment is so complex that outcomes for each patient are affected by a range of factors and NOT JUST THE COMPETENCE OF AN INDIVIDUAL NURSE. (Hughes, 2008:6)
THIS REPORT SAYS MEDICAL ERRORS SUCH AS INDECIPIERABLE PRESCRIPTIONS CAUSE THE DEATHS OF 98 PATIENTS A YEAR, OR IS THAT 98,000? IT'S HARD TO READ THIS. IN ANY CASE, WE'RE SUPPOSED TO REPORT THEM, OR IS THAT REPEAT THEM?

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Hughes (2008:6) reported some hospitals as having:

“vulnerable system syndrome”

- More liable to unsafe practices with repeated nurse related adverse events.

- Characterised by:
• Culture of individual blame,

• Denial,

• Punishment of staff involved in adverse events,

• Covering up of errors,

• Common failures being considered as isolated.
Nurses who have experienced adverse events:

- Feel demoralised, demotivated
- Suffer loss of confidence, loss of self-esteem
- Feeling personally responsible for the unexpected patient outcomes,
SECOND VICTIM EFFECTS

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PROBLEM STATEMENT

SCENARIO:

• Operational manager (OM) whose professional nurse was involved in a nurse related adverse event
• Reported to line manager – shouting, blaming, threats.
• OM devastated, would rather cover up and not report.
PROBLEM STATEMENT

FOCUS IS ON: HUMAN ERROR

No consideration of the prevailing situational and organizational factors.

Research imperative – no focus on OMs

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RESEARCH DESIGN AND METHOD

A. RESEARCH METHOD

Qualitative, exploratory, descriptive and contextual research design using a phenomenological approach
B. SAMPLE : PURPOSIVE

• Operational managers

• Willing to participate in the study

• Experienced the management of adverse events.
E. MEASURES TO ENSURE TRUSTWORTHINESS & ETHICS

- Credibility, Dependability, Confirmability, Transferability & Authenticity, Lincoln and Guba (1985)

ETHICAL PRINCIPLES: Dhai and Mcquoid-mason (2011)
C. DATA COLLECTION

CONSENT FROM:

• UJ REC and HDC (Ethical Clearance no. aec 51-01-2013).
• GDOH
• Participants
• and context
C. DATA COLLECTION

• In-depth individual phenomenological interviews – lived experiences of OMs
“What are your experiences regarding the management of nurse related adverse events in this hospital?”
D. DATA ANALYSIS

- THEMATIC ANALYSIS: Tesch’s in Creswell (2013) eight steps of the descriptive method of data analysis

Theoretical Foundation

- Watsons Theory of caring (1999)
- (UJ)THPN (2010)
Operational managers experiences of a culture of blame following nurse related adverse events.
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<th>THEME :</th>
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<td>CULTURE OF BLAME</td>
<td>Blaming for work environment and organisational factors</td>
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CLARIFYING CONCEPTS

• **Blame** - finding fault with (for something) and to place responsibility for an error or fault on someone or something (Webster’s New World College Dictionary, 2010: n.p.)
A CULTURE OF BLAME

• A set of attitudes within a particular business or organisation that is characterised by an unwillingness to take risks or to accept responsibility for mistakes due to fear of criticism or prosecution.

(http://www.businessdictionary.com/definition/blame-culture.html).

• Looking for one person or organisation that can be held responsible (Henry, 2014: 1)
A historical perspective to the culture of blame in organisations
• 2100 BC, the Code of Hammurabi

A blame culture in hospitals made to flourish by:

• compliance-driven, bureaucratic management styles that demand personal accountability for systemic problems.

• The traditional process for conducting root-cause analyses (RCA)
Participants found it difficult and emotional to express their lived experiences……
• All 12 participants articulated that they experienced being blamed as a given response to the management of all adverse events by their line managers.
Blaming:

• For organisational factors and not human errors related to their omissions.

• Even when not at the vicinity of the occurrence at the particular time and

• Even when they were not on duty.
This is congruent with the work of Hughes (2008:1) on patient safety and quality who reported that blame was inherent in organisations even though adverse events were caused by factors other than human error and negligence.
PARTICIPANTS SAID:

• “You get blamed for things that are not your fault, blame is pushed to you.”

• Even if there are weak cot sides and patient falls out of bed, you are asked why you were using that cot side. If things go wrong, due to faulty equipment, malfunctioning equipment, we get blamed.”
PARTICIPANTS SAID:

“if patients want to take their life, no one can stop them. Patient will go to bathroom, close door and take his life. Management blames the nurse.”

“Sometimes a patient may jump out of bed. You are blamed for the incident and yet you cannot be everywhere at the same time.”
PARTICIPANTS SAID:

“if patients want to take their life, no one can stop them. Patient will go to bathroom, close door and take his life. Management blames the nurse.”

“Sometimes a patient may jump out of bed. You are blamed for the incident and yet you cannot be everywhere at the same time.”
“Management and relatives ask, “what did you do to burn the patient, as though patient was burnt on purpose. “The boiler ...... thermostat or something was not working....but we got blamed.”
• “We had patient overflow. No beds. The names of the patients were almost the same but there was only one bed and the files were mixed – I was blamed……..there were no beds for patients and this is not our problem.”

• “Hospital equipment is not up to standard these days. But we get blamed and traumatized.”
• The blame culture is not working for organisations.

• Nursing Leadership may be aware of some of the problems, but staff is aware of every incident that happens – so how likely will staff share information regarding adverse events with managers and administrators if they face retribution (blame and its consequences)? Tocco and Blum (2013:2)
Participants expressed fear of being blamed and the consequences of blame, as a result some participants were reluctant to report adverse events.

- *Adverse events happen unexpectedly, sometimes when you are not there and you get the fear of what will happen...This could lead me to go to jail.***

**Concern – unreported incidents**

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“The treatment is so bad that something says, do not report that” a participant said.

A strategy that moves away from a culture of blame to a blame free, just culture based on caring principles becomes an imperative for nursing leadership to constructively manage these issues in the workplace.
LABELLING AND BEING TREATED

“LIKE A CRIMINAL”

“When you report, the matron shouts, ‘why patient was not in a cot bed’? “you are not looking after patients.”
“I was told that I could not go home until the missing patient is found.”

The participant had to go and look for the patient in a squatter camp (informal settlement).

Participants said:

“I was shouted at as if I had changed files, I was sent to the mortuary ...”
• “They treat you like they were managers who were not nurses before. They forget about nurses.”

• Another participant said:

• “Nurses are very sick. We have chronic diseases because of what we are going through.”
- “management should offer support and show respect when adverse events happen. Not shouting, and blaming rather speak politely to get the facts.”
• The South African Nursing Council DOH (2014) views issues of abuse, harassment of healthcare users and colleagues whilst on duty as acts or omissions in respect of which the Council can take disciplinary steps against a practitioner registered in terms of the Act as outlined in R 767 of the NURSING ACT, 2005 (Act No. 33 of 2005).
Nursing Leadership strategies were developed for the constructive management of nurse related adverse events rather than blame operational managers who may not have been the cause of the adverse events in the first instance.
THE IMPERATIVE FOR CARING
A PARADIGM SHIFT BECOMES IMPERATIVE FROM

BLAME

ABUSE

LACK OF SUPPORT

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NOTABLE QUOTES:

NELSON MANDELA

“As we let our own light shine, we unconsciously give other people permission to do the same”
CONCLUSION

Development of nursing leadership strategies for the constructive management of nurse related adverse events:

• From a blame to a just culture and accountability.
LACK OF CARING
- BLAME
- ABUSE
- LACK OF SUPPORT

CONSCIOUS AUTHENTIC
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CARING
STRATEGIES
THANK YOU
QUESTIONS??

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