When staff speak up on safety, do managers listen—and act?

Checklists, time-outs, and other patient safety tools are supposed to make care safer. But what happens when a safety tool alerts a team to a problem that otherwise would have been missed and could harm a patient? Will team members speak up?

The vast majority—85%—of nurses in a new study say they’ve been in that situation. Yet more than half (58%) admitted they failed to speak up effectively to solve the problem.

The study, titled “The Silent Treatment,” a follow-up to the 2005 report, “Silence Kills,” was conducted by the American Association of Critical Care Nurses, AORN, and VitalSmarts, a corporate training and consulting firm. The study examined the participants’ responses to 3 “undiscussable” issues: dangerous shortcuts, incompetence, and disrespect.

Surprisingly, taking the problem to a manager doesn’t get the kind of immediate and reliable results needed to address patient safety issues, the researchers say.

Only a minority of managers took action when one of these concerns was brought to them:

• 41% of nurse managers reported they had spoken up to the person whose dangerous shortcuts create the most danger for patients.
• 28% had spoken up to the person whose missing competencies create the most danger for patients.
• 35% had spoken up to the person whose disrespect had the greatest negative effect.

Managers do speak up at a higher rate than employees, but “you would hope they’d speak up at a 100% rate,” David Maxfield of VitalSmarts, a member of the research team, told OR Manager in an interview.

Some of the compelling stories nurses and managers submitted for the study are in the sidebar on page 7.

Why managers don’t speak up

The stories lend insight into why managers don’t speak up, Maxfield says.

“I think the most important recognition is that managers are part of the culture,” he says. “They’ve been successful in the culture, and they struggle as much as anyone to make it better and to implement these safety tools.”

Even a manager who is super-motivated and capable will struggle in a social environment and structure that is not supportive, he notes.

Focusing on crucial moments

OR Manager asked Maxfield about common threads he’s seen in organizations where staff, managers, and physicians are willing to bring forth patient safety concerns.

He notes that managers do speak up appropriately most of the time, and people respond.

“That’s why safety tools work as well as they do,” he says. “But that’s not good
enough. We need to focus on those crucial moments when, for whatever reason, the OR manager or professional doesn’t speak up.”

**Build skills, practice**

Two of his suggestions:

- **Build skills and practice.** “It could be as simple as having an OR nurse and physician champion work with the staff to come up with scripts that would work in that moment. Then practice them together,” he says.

- **Don’t assume training will be enough.** “If people are not speaking up because they’re worried about the consequences, they need more skill. They also need support.”

To help organizations build a culture where people feel safe speaking up, Vital-Smarts uses a model called the Six Sources of Influence (illustration, p 8). The model includes 2 key factors—the motivation and ability to address difficult subjects—in 3 domains, personal, social, and structural.

Here’s a look at the model with examples of how it can be applied.

**Personal motivation/ability**

For people to speak up, Maxfield says they first ask themselves 2 questions:

1. Can I do it? (Do I have the ability?)
2. Will it be worth it? (Do I have the motivation?)

When working with OR professionals, he says he often hears stories about patient safety situations they’ve faced but haven’t shared. The key is making it safe for that to happen.

“One of the most powerful helps can be when a surgeon looks at everyone and says, ‘Let me tell you a horrible thing that happened to me once. It didn’t need to happen if someone had spoken up to me. I hope every one of you will speak up when you have that problem.’”

“That gives others permission to speak up and builds personal motivation,” says Maxfield.

Motivation must be coupled with ability. Do nurses and managers have the skills to start a difficult conversation?

One skill-building activity is to have nurses, surgeons, and anesthesiologists agree on a phrase anyone can use to raise a safety issue. Then have them practice using it.

“The phrase can be as simple as, ‘Doctor, I have something important to say,’” Maxfield notes. “Practice the phrase with each other so you’re giving each other permission to use it.”

**Social motivation/ability**

What do the people around you support and reward or punish? Is the social environment conducive to raising concerns?

Enlisting a surgeon and anesthesiologist champion is a way to create that environment. Physician advocates are critical to social support in an OR.

“It needs to be clear that the organization and the management want them to speak up,” he says.

A big question is, “Will the surgeons accept it?”

He responds, “It’s very important to have a surgeon and anesthesiologist champion say, ‘Not only will I support it, but I will back you up. And I will take the message to the other surgeons and anesthesiologists and hold them accountable as well.’”
Nurses’ stories of patient safety threats

Nurses shared stories about managers who did and did not respond when they learned of a patient safety threat in The Silent Treatment study.

“A surgeon refused to mark the patient in the preop holding area. As the manager, I approached the surgeon with the need to assist in our safety efforts for the safety of his patient. He verbally abused me in the hallway, stormed out, and did not mark the patient. The wrong side of the spine ended up being operated upon, the patient had to be reanesthetized, and the correct side had the laminectomy performed.”

“An anesthesia provider wanted to take a patient from the preop holding area and place a block before the doctor had initialed the site (this is contrary to our policy). Two of us protested and would not let her take the patient. We were called into the manager’s office and ‘talked to’ about it. The next day, the anesthesia provider was going around saying, ‘I won, I won,’ and she was permitted to do the block before the doctor was in the building or marked the site. Two weeks to the day, we had our first wrong site surgery. Coincidence? Rules and policies are there for a reason. Administration backed the manager’s decision. People in the trenches see the potential results of these decisions made to appease other people for the purpose of ‘saving a few minutes’ time.”

“As a charge nurse, the staff in the room draped the patient before checking the site marking; they draped the wrong knee and did the wrong side for an arthroscopy. The checklist, if performed, would have stopped this before it happened.”

“During the surgical safety checklist, we realized the permit and the scheduled surgery did not match (wrong side). We tried to stop the doctor (plastic surgeon), and he said the permit was wrong. The patient was already asleep, and he proceeded to do the wrong side against what the patient had verified, which had matched the permit. We could not get any support from the supervisor or anesthesiologist. The surgeon completed the case. Nothing was ever done. We felt awful because there was no support from management to stop this doctor. What is the point of having a checklist when it is not consistently followed? We felt absolutely powerless to being an advocate for the patient.”

Structural motivation/ability

What does your organization support, encourage, and reward? Do structures support patient safety and advocacy? Checklists, time-outs, and briefings are examples, though they’re not sufficient without motivation, ability, and social and structural support.

A structural support Maxfield says some ORs use is a huddle at the beginning of the day. It’s an opportunity for the leadership team to anticipate issues that are likely to arise. Nurses and others can also bring up patterns of problems or behavior they’re concerned about.

Incentives and rewards are another type of structural motivation.

“Some organizations have used stickers or gift certificates to reward people for speaking up during the first month or two, just to give people a pat on the back as they’re getting started,” he says.

What’s getting in the way?

Think about whether any structural incentives are getting in the way of speaking up, he advises.

Does the organization have a history of ignoring or brushing off concerns? Do senior leaders seem to condone disruptive behavior?

“That’s when you really benefit from having a physician champion,” he says, adding that he thinks the situation has improved.
“I think the tipping point has been reached, and professionals understand that disruptive physicians cause unacceptable risks, regardless of the revenue they bring in.”

**Addressing physician frustrations**

Beneath the surface of disruptive behavior another structural issue often lies: Do physicians feel their frustrations are disregarded? Does some of their behavior reflect these frustrations?

These frustrations can stem from issues that require both short- and long-term fixes, Maxfield notes.

For short-term fixes, one strategy is to hold a huddle. “A huddle says to the physicians and staff, ‘What are the key frustrations you ran into yesterday? Let’s see what we can do to make those go away.’”

Long-term issues can be referred to the surgical services executive committee or performance improvement team.

The point, he says, is to give physicians “some confidence that they won’t deal with the same frustration tomorrow they are dealing with today.” An article on creating a culture of mutual respect that also addresses physician frustrations was in the April 2010 *AORN Journal*.

Creating an environment where it is safer to speak up takes a multi-pronged approach, Maxfield says. When he introduces OR teams to the strategies he has outlined, they often say, “We’ve tried that.”

“It’s true, they have;” he continues. “But what they haven’t done is tried them in combination. That’s the secret sauce.”

—Pat Patterson

*For more details and to download the study, visit www.silenttreatmentstudy.com.*

**References**
