

## PATIENT SAFETY

### CNA POSITION

Patient safety is the “reduction and mitigation of unsafe acts within the health-care system as well as through the use of best practices shown to lead to optimal patient outcomes.”<sup>1</sup> However, for nursing it must mean more than that. It means being under the care of a professional health-care provider who, with the person’s informed consent, assists the patient to achieve an optimal level of health while ensuring that all necessary actions are taken to prevent or minimize harm. Patient safety is fundamental to nursing care and to health care more generally, across all settings and sectors. It is not merely a mandate; it is a moral and ethical imperative in caring for others.

Ensuring the provision of safe, compassionate, competent and ethical care to patients within the health-care system is a responsibility shared by all health-care professionals, health-care organizations and governments and requires the involvement of the public.

The Canadian Nurses Association (CNA) believes that providing for patient safety involves a wide range of actions at the level of the individual nurse,<sup>2</sup> the profession, the interprofessional team, the health-care organization and the health-care system.<sup>3</sup> These actions must include adequate clinical support for nurses by nurse managers. It is also critical that nursing care data are collected and interpreted at the national level to support research on best nursing practices.<sup>4</sup>

CNA believes that the nursing shortage, inappropriate staffing practices and the understaffing and underskilling<sup>5</sup> of health-care services pose a significant threat to patient safety and contribute to incidents of failure to rescue.<sup>6</sup> At times nurses have such heavy workloads that they are unable to develop therapeutic relationships,<sup>7</sup> make the comprehensive assessments needed or seek nursing or other expertise as required. Such workloads also prevent experienced nurses from being available to guide less experienced nurses. The casualization of the nursing workforce over the last 15 years, in the interest of cost reductions, has also contributed to decreasing the availability of nurses to mentor other nurses and at the same time has reduced the continuity of care, a consequence that is a threat to patient safety in and of itself.

Human health resources issues affecting patient safety, such as those indicated above, must be addressed on a system level and in an evidence-based manner. An appropriate balance must be sought between full-time nursing personnel and part-time, casual and temporary personnel. An evidence-based approach must be central to decisions about the nursing competencies (and therefore on the level and mix of nursing staff) required for a particular patient population in a particular setting.<sup>8</sup> Even with the right number of nurses and the right mix of nursing competencies, nurses in

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<sup>1</sup> (Royal College of Physicians and Surgeons of Canada, 2007)

<sup>2</sup> In this document, the term *nurse* refers to registered nurses.

<sup>3</sup> (International Council of Nurses [ICN], 2002)

<sup>4</sup> (CNA, 2001)

<sup>5</sup> *Underskilling* in this context refers to situations in which the competencies of the health-care provider do not match the needs of the patient. (CNA, 2005)

<sup>6</sup> (Clarke & Aiken, 2003; Aiken et al., 2003; Ellis et al., 2006)

<sup>7</sup> “Nurses build trustworthy relationships as the foundation of meaningful communication, recognizing that building these relationships involves a conscious effort. Such relationships are critical to understanding people’s needs and concerns” (CNA, 2008, p. 8).

<sup>8</sup> (CNA, 2003)

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clinical leadership and unit management roles must have a span of control that reasonably permits them to provide sufficient supervision and support for nurses to ensure patient safety.

Patient safety cannot be achieved without system accountability and system competence. Sustainable solutions directed at the system level are necessary. Efforts to analyze and reduce adverse events<sup>9</sup> are most effective when such events are viewed as system failures. This perception represents a paradigm shift from a culture of individual blame to a culture of safety in which disclosure of adverse events is required and promoted.<sup>10</sup> Although individual competency may be a contributing factor, and individuals remain accountable for their own actions, it is increasingly evident that system competency plays a major role in patient safety. Only when adverse events and near misses are disclosed can they be analyzed in a collaborative manner by the health-care team and other stakeholders to identify and address problems in the system.<sup>11</sup>

Patients have the right to know when an adverse event has occurred in their care and to have appropriate treatment to address the effects of this event as far as possible. When such an event results in injury or even death, there must be open and honest communication with the patient or the family as soon as possible. Clear policies on the reporting of adverse events and near misses and on the disclosure of adverse events to the patient and family must be implemented to support good clinical practice and to improve patient safety overall in the system.

Nurses must advocate for an environment in which nurses and other health-care workers are treated with respect and support when they raise questions or intervene to address unsafe or incompetent practice.<sup>12</sup> Whistle-blowing legislation should be enacted in all jurisdictions so that a nurse who has unsuccessfully tried all avenues to address the problem and who subsequently speaks out publicly in good faith can be protected from reprisals.<sup>13</sup> Apology legislation should also be enacted in all jurisdictions so that apology as part of disclosure does not imply blame or an admission of legal responsibility. Nurses should be aware of disclosure procedures and of appropriate documentation.<sup>14</sup>

The practice environment supports or hinders nurses and other health-care professionals in their ability to provide safe care. Developing and supporting quality professional practice environments is a responsibility shared by practitioners, employers, governments, regulatory bodies, professional associations, educational institutions, unions and the public.<sup>15</sup>

Strong leadership across the nursing profession is essential to moving forward the cultural reform required to ensure the delivery of safe, quality care in professional environments. The number of first-line managers should be sufficient to allow them to have reasonable levels of contact with the nurses in their practice environments. In settings where the majority of staff are nurses, the first-line manager should be an experienced nurse with strong leadership abilities.

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<sup>9</sup> An *adverse event* is an event that results in unintended harm to the patient and is related to the care and/or services provided to the patient rather than to the patient's underlying condition. (Disclosure Working Group, 2008)

<sup>10</sup> (Disclosure Working Group, 2008, p. 12; Affonso, Jeffs, Doran & Ferguson-Paré, 2003, p. 78)

<sup>11</sup> (Disclosure Working Group, 2008, p. 10)

<sup>12</sup> (CNA, 2008, p. 9)

<sup>13</sup> (CNA, 1999)

<sup>14</sup> (Canadian Nurses Protective Society [CNPS], 2008; Disclosure Working Group, 2008, p. 23). "Several provinces have enacted legislation to prevent an apology from being used as evidence of negligence. Statutory patient safety measures, such as apology legislation, vary across Canada, so nurses should ensure they are in possession of current applicable information when involved in an adverse event. Risk management and quality assurance departments are good resources for nurses." (CNPS, 2008)

<sup>15</sup> (Quality Worklife-Quality Healthcare Collaborative, 2007, p. 1)



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Nurses have a significant contribution to make in protecting and improving patient safety. As the principal health-care providers for patients, who oversee, coordinate and provide care 24 hours a day, seven days a week, nurses are well positioned to strengthen the safety net for patient care. The nursing perspective on disclosing adverse events and improving systems must be part of a collaborative approach involving the public, other professions, employers and governments. Adequate resources must be made available to undertake this work at all levels of the health-care system.

## BACKGROUND

Studies in the United States, the United Kingdom, Australia and New Zealand have shown that adverse events may occur in anywhere from 3.7 per cent to 16.6 per cent of all hospital admissions and that a significant portion of these may be preventable.<sup>16</sup> The 2004 Canadian Adverse Events Study found an incidence rate of adverse events of 7.5 per cent among patients in acute care hospitals.<sup>17</sup>

Problems with patient safety are seen as being driven by systemic factors such as rapid changes in the health-care system, increased use of technology, the quickening pace of work and restricted resources, including shortages of qualified professionals.

Canadian nurses have increasingly expressed concern about the ability to deliver safe care in today's health-care system. Given the commitment of nurses expressed in the *Code of Ethics for Registered Nurses* to provide safe, compassionate, competent and ethical care,<sup>18</sup> nurses are experiencing increasing moral distress as they continue to work in environments that are not able to support quality professional practice. Much work has been done by nurses to address concerns for patient safety, as evidenced by the growing body of research on best practices and by the promotion by CNA and the Canadian Federation of Nurses Unions of quality practice environments and appropriate human resources planning in the health-care system; however, much remains to be done.<sup>19</sup>

Nursing has always given the highest priority to patient safety. CNA and provincial and territorial nursing associations have centred their work around patient safety and excellence in nursing practice in the interest of the public. CNA, over many decades, has led the development of standards of nursing practice, education and administration; it also regularly updates the *Code of Ethics for Registered Nurses*.

Provincial and territorial nursing associations and colleges regulate the practice of nurses. They continually develop and maintain standards of practice within their jurisdictions through many programs, including licensure, disciplinary procedures and requirements for quality assurance, often with the involvement of other health-care professionals and public representatives. CNA develops and maintains the Canadian Registered Nurse Examination.

This combination of setting and promoting standards for the profession at the provincial, territorial and national levels has worked well in guiding individual practice to ensure patient safety. However, in recent years it has been recognized that although the systems aimed at promoting and ensuring individual competence and accountability are necessary, they are not sufficient. Patient safety cannot be achieved without system accountability and system competence.

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<sup>16</sup> (Doran, 2003, p. 212)

<sup>17</sup> (Baker et al., 2004)

<sup>18</sup> (CNA, 2008, p. 8)

<sup>19</sup> (CNA & Canadian Federation of Nurses Unions, 2006)



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Patient safety concerns need to be evaluated and addressed as system-wide problems. The various movements for continuous quality improvement have tried to bring appropriate attention to system issues, but there continues to be a strong reliance on flawless performance by individuals. Flawless performance is often expected without regard to circumstances. We are still working in a culture of blame, in which the investigation of adverse events is focused on assigning responsibility to individuals.

The work of CNA in promoting quality, professional practice environments is one of its most important initiatives for patient safety. CNA is a member of the Canadian Patient Safety Institute and supports various efforts by other groups in relation to research on quality work-life indicators, dissemination of drug safety information, medication reconciliation and other initiatives related to patient safety.

Central to CNA's work on patient safety is the recently revised *Code of Ethics for Registered Nurses*. The code provides an up-to-date framework of values and professional obligations to guide nurses' actions in promoting and advocating for patient safety. It speaks to the many responsibilities for individual practice, such as obtaining informed consent, advocating for the patient's right to self-determination and disclosing adverse events. In addition, it highlights the importance of the practice environment and nurses' duty to advocate for a quality practice environment and for the human and material resources necessary to ensure safe, competent and ethical care.

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**Replaces:**

*Patient Safety* (2003)

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