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Nurses' Perception of Their Role in Patient Safety

Janeane L. Walker, PhD

Problem

There is a growing concern that, despite the fervent increase in focus on preventing medical errors in the last few decades, **small achievements have been made in patient safety efforts**.

This study fills the gap in gaining an understanding on why medical errors are still occurring from the nurses perspective.

Purpose

The purpose of this study was to examine the nurses' perception of their role in patient safety and to determine the nurses' perception regarding why errors are still occurring despite the implementation of evidence-based safety strategies.

Significance

Limited improvements in quality and safety demonstrates how deeply complex the healthcare system is, and that there is not a "one size fits all" solution.

This study makes a unique contribution to patient safety initiatives in the healthcare field because there have not been prior studies exploring nurses perceptions on why errors are still occurring despite the use of safety strategies.

Social Change Implications

Addressing the reasons why safety measures are by-passed can affect positive social change by improving the quality and safety of patient care outcomes. The primary social change implications from this study was to serve as a catalyst to improve the quality and safety of patient care outcomes.

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Conceptual Framework

The **Systems Engineering Initiative for Patient Safety** (SEIPS) model was the conceptual framework used to guide this patient safety study.

Relevant Scholarship

Based on the literature, healthcare is complex and the approach to patient safety is multifactorial. A singular approach to patient safety will not help make a significant reduction in medical errors. Researchers have approached patient safety from various angles inclusive of examining nursing roles, promoting organizational safety culture, leadership training, patient involvement, to evidenced based safety strategies (Kowalski and Anthony 2017; Ulrich, 2015; Weaver, Lubomski, Wilson, Pfoh, Martinez & Sydney, 2013).

Preventable adverse events are associated with systems failures and human error (Zegers, et al., 2009). Although many quantitative and qualitative approaches have been researched in patient safety, there are still barriers that exist impeding improvements in patient safety (Landefeld, Sivaraman, & Arora, 2015). Strengths of previous and current research have demonstrated that patient safety is a problem that requires all health care providers to identify how their role contributes to patient safety efforts.

Human factors, communication, and health information technology have been identified by the Joint Commission as contributing factors most frequently associated with medical errors (Joint Commission, 2015).

Research Questions

1. **What are the perceptions of nurses regarding their role in patient safety in a hospital setting?**
2. **What factors are contributing to patient harm despite the use of evidence-based safety strategies in the hospital setting from the nurses' perspective?**
3. **Why are preventable medical error events still occurring from the nurses' perspective?**

Participants

A purposeful, convenience sampling strategy was employed for participant recruitment.

Registered nurses (N = 11), who worked in a Magnet designated hospital, were selected as the participants because they are primarily at the bedside and interact with patients daily.

Procedures

Design

- Qualitative constructivist grounded theory methods were used.

Data Collection

- Data were collected via focus group interviews for a one week period. A standardized interview protocol was designed by the researcher that was used for each interview conducted to facilitate the discussion with the research participants. Open ended questions were used during the interview.

Analysis

The analysis plan strategy for this study involved memoing, coding, theoretical sampling, reflexivity, and constant comparative analysis.

Findings

The nurses clearly defined their role in patient safety as being patient advocates. Three main themes were identified highlighting contributing factors to why medical errors are still occurring. The categories were technology, busy work environments, and human factors.

These categories are in alignment with components of the SEIPS model that was the framework used to organize the literature section and the study findings. The participants stressed how technology was the primary cause of medical errors followed by having a busy work environment throughout the interviews.

Interpretation

An emphasis on how technology is adding to the nurses' workload compounded with a busy work environment was noted as a contributing factor for bypassing safety mechanisms in place.

As a result, the **by-pass model theory** was derived from the interviews conducted describing the conditions that nurse's work under that result in by-passing safety systems.

Limitations

This study was conducted at a single site pediatric hospital.

Recommendations

Future Research

- Examine the nurses' perception at other Magnet pediatric facilities and compare similarities or differences in the nurses' responses.
- Study the difference in viewpoints between adult and pediatric nurses since they serve different patient populations with differing needs.

Recommendations for Practice

- Nurses will need to be educated on upgrades and changes to technology as they are being made. Nurses should be included in how the functionality of technology changes impact workflow.
- Therefore, further research needs to go beyond engaging nurses with the implementation of health IT system, but examine its long-term impact on workflow as changes are being made.
- Including more frontline staff nurses into the design and upgrades of electronic systems used to care for patients would benefit how the end-user both uses and perceives the benefits of technology in their daily workflow so that it will not be viewed as a hindrance to patient safety.