Dealing with Errors on the Job

A young woman, I met someone at a social event who commented on my career choice by acknowledging that nursing was a very demanding but admirable profession. At the time, I thought that he was referring to aspects such as shift work and the physical tasks as demanding. However, over time, in addition to those aspects, I discovered some unanticipated challenges along with the many rewards. One challenge I encountered—and that I believe confronts every nurse—is dealing with personal errors or mistakes on the job.

The present-day trend toward quality assurance and looking at mistakes as systems issues, more so than individual transgressions, has helped. However, as individuals who elect to work in a profession that sees caring and concern for patients’ well-being as its central mandate, making an error can be a traumatic personal experience. First, there can be legal and professional implications, but even if there are not, making an error can be an intensely emotional experience. Many years ago, I made an error for which there were fortunately no negative effects on the patient. I reported it through the proper channels and, at the same time, shared it with some of my colleagues. I found an unexpected well of support from many colleagues who also shared their stories, some of which sounded much worse than mine and others that I thought sounded very minor in comparison. However, we all shared a feeling that we were inadequate, had made a hasty decision, had not exactly followed procedures, or were under pressure to perform in an expected manner. I reviewed the scenario in my mind several times, along with some of the possible outcomes that thankfully did not occur. I also reflected on what I had done wrong and set up a personal rule to guide my future practice. I was lucky not only because nothing adverse happened but also because I had support.

Of course, this was not my only mistake; various times I have questioned my decision making. This led me to wonder how others deal with the situation of making errors and how many people leave nursing or change areas of nursing because of feelings of guilt, lack of support, or lack of discussion about how to manage the emotions that arise from such situations.

An abundance of research addresses preventing mistakes and how organizations can develop a culture of patient safety. However, there is much less emphasis how individual nurses resolve their personal conflicts associated with their mistakes so they can continue to view themselves as proficient and caring professionals. When errors occur, Crigger (2004) recommends a process of disclosure, apology, and if possible, making amends. Following this approach is thought to be most beneficial in terms of protecting the patient, resolving any long-term emotional issues for the nurse, and lessening chances of litigation.

Disclosure can be difficult for nurses because of the many risks involved. There are several reasons mistakes are not reported. However, research indicates that one of the major reasons errors are not reported is that nurses fear reprisals from administration and repercussions from their peers.
(Mayo & Duncan, 2004; Osborne, Blais, & Hayes, 1999). Other reasons include organizational factors such as inefficient reporting mechanisms (Uribe, Scheweikhart, Pathak, Dow, & Marsh, 2002), loss of professional self-esteem, fear of lawsuits (Uribe et al., 2002), degree of risk to patient and nurse, and loss of patients’ and families’ trust (Cook, Hoas, Guttmannova, & Joyner, 2004; Crigger & Meek, 2007; Shannon, Foglia, Hardy, & Gallagher, 2009; Uribe et al., 2002). All of these reasons can make the individual nurse feel like he or she is in a very precarious and vulnerable position.

An additional factor that compounds these feelings of vulnerability is the dominant societal view that health professionals are expected to be perfect practitioners (Leape, 1994). This view is apparent in nursing, as nurses are not supposed to make errors (Crigger, 2004). Not only do nurses place high expectations on themselves to be faultless practitioners but assume a major responsibility for patient safety. Cook et al. (2004) found that nurses are viewed by nurses, physicians, and administrators as the professional group that is most responsible for patient safety. Crigger and Meek (2007) indicated that while this pattern of perfectionist thinking persists, reporting and managing feelings associated with errors cannot be addressed in a healthy manner.

The predominant emphasis related to improving patient safety is on reporting medication errors and developing safer systems for medication delivery (Cook et al., 2004; Uribe et al., 2002). While this is important, Cook et al. also noted that this focus limits a more encompassing view of mistakes that need to be addressed at a systems level. Although health care stresses the importance of nonpunitive approaches to reporting mistakes, Crigger and Meek (2007) found that “a culture of denial, blame, shame and secrecy” (p. 180) is apparent in nursing. This indicates that a culture change is badly needed within the profession to enable nurses to be more open about mistakes. Acknowledging that mistakes are unlikely to be completely eradicated and that errors of clinical judgment will always occur is likely to be more beneficial for safer nursing practice in the long term.

As a profession, nursing needs to have well-established mechanisms for supporting individuals when mistakes occur. This information should be introduced early in nurses’ careers in a manner that does not overwhelm and frighten them. Because peer approval in the workplace is important and because peers are a primary source of support, we will need to move the focus from the individual to finding solutions that are far reaching in an atmosphere where we are often very critical of others as well as ourselves. Further, we need to provide advice to our students and introduce them to approaches that will assist them.

In addition to identifying ways to support the individual nurse, it is also crucial that mistakes be seen as a collective problem in which all members of the health care team play a role in problem solving (Cook et al., 2004). Cook et al. further indicated that emphasizing organizational commitment to include interdisciplinary approaches would be helpful to nurses, as it would encourage more collective and creative ways to address problems of patient safety. Nurses need support to work through their mistakes, but they should not assume the entire burden of responsibility, as this keeps the emphasis on the individual instead of on the collective.

So we must acknowledge within the profession that these situations happen and continue to move toward making this an open and frank issue for discussion. Further studies are also needed about how nurses can be supported by administration and by peers when such inevitable events occur.

REFERENCES

Anne L. Dewar, PhD, RN
Associate Professor
School of Nursing
University of British Columbia
Vancouver, British Columbia, Canada

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