The ethics and practical importance of defining, distinguishing and disclosing nursing errors: A discussion paper

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Abstract

Nurses globally are required and expected to report nursing errors. As is clearly demonstrated in the international literature, fulfilling this requirement is not, however, without risks. In this discussion paper, the notion of ‘nursing error’, the practical and moral importance of defining, distinguishing and disclosing nursing errors and how a distinct definition of ‘nursing error’ fits with the new ‘system approach’ to human-error management in health care are critiqued. Drawing on international literature and two key case exemplars from the USA and Australia, arguments are advanced to support the view that although it is ‘right’ for nurses to report nursing errors, it will be very difficult for them to do so unless a non-punitive approach to nursing-error management is adopted.

Keywords: Nursing errors; Patient safety; Ethics; Incident reporting; Clinical risk management

What this paper adds to the literature

What is already known about the topic?

- Nursing errors (e.g. medication errors) are an acknowledged and ever-present problem in health care domains.
- Nursing errors, like other errors, tend to be under-reported—even by nurses who are acknowledged as the ‘majority reporters’ of incidents.
- Non-punitive, anonymous incident reporting is now universally recognised as an important strategy in improving incident reporting rates and helping to reduce the risk and incidence of ‘honest errors’ in nursing and health care domains (‘We can’t fix what we don’t know about’).

What do we now know as a result of this study?

- Individual nurses who make honest mistakes continue to be treated in a punitive way and are often ‘named, blamed and shamed’ for their mistakes, despite calls being made internationally for a non-punitive approach to human-error management in health care domains.
- The notion of ‘nursing error’ as such is poorly defined in the nursing literature making its meaningful discussion problematic; this paper addresses this oversight by offering a carefully considered operational definition of ‘nursing error’.
- There are important practical and moral reasons, not previously discussed in the nursing and related literature, for defining, distinguishing and disclosing nursing errors even though this might seem at odds with the new ‘system approach’ to human-error management that is being advocated worldwide.
As disciplinary and legal cases in a range of jurisdictions continue to demonstrate, reporting nursing errors is not without significant risk to the nurses involved.

Nursing errors will continue to be under-reported and a ‘system approach’ to managing human error in nursing care domains continually undermined unless nurses are given complete immunity from disciplinary action and legal prosecution when making and disclosing their ‘honest errors’.

1. Introduction

Since the early 1990s, research studies conducted, respectively, in the USA, UK and Australia have found that between 4% and 16.6% of patients suffer from some kind of harm (including permanent disability and death) as a result of adverse events while in hospital (Brennan et al., 1991; Department of Health, 2000; Kohn et al., 2000; Leape et al., 1991; Vincent, 2001; Wilson et al., 1995). These studies have also found that a significant percentage (around 50%) of the reported harms that occurred could have been prevented—that is, were ‘preventable adverse events’ (Kohn et al., 2000, p. 28; Leape, 1994). Concerned by these figures and their possible implications on health services outside the jurisdictions in which the research studies were originally conducted, governments, health care services and health professional groups around the world have turned to giving unprecedented attention to the development and implementation of processes aimed at reducing the incidence and impact of preventable adverse events in health care and to improving generally the safety and quality of their health care services (Committee on Quality of Health Care in America, 2001; Kohn et al., 2000; WHO, 2001; World Health Professions Alliance, 2002).

It is widely accepted that a critical first step in adverse-event prevention in health care domains is to identify the problem. This is because, as Bagian et al. (2001) have famously argued, ‘You can’t fix what you don’t know about’. The process most commonly used in hospital practice to identify problems is incident reporting. Reporting incidents, however, is not without risks—particularly where the incidents reported involve adverse events resulting from preventable practice errors and mistakes (Johnstone and Kanitsaki, 2005; Johnstone, 2004a; Dickens, 2003; Hall, 2003; Anderson and Webster, 2001; Bovbjerg et al., 2001; Liang, 2001; May and Aulisio, 2001; Pinkus, 2001; Smetzer, 1998; Cohen, 1997). Nurses who make honest errors (to be distinguished from nurses who are reckless, incompetent, impaired, uncaring, or who have malicious and/or criminal intent) are particularly vulnerable in this regard. As case studies to be presented later in this paper will show, errant nurses can sometimes find themselves the subjects of severe disciplinary action and even criminal prosecution for their honest mistakes and, related to these outcomes, burdened with what May and Aulisio (2001, p. 142) describe as ‘the stigma of implied “failure to care”’.

In this paper, attention is given to examining discourses surrounding nursing errors and the professional and ethical requirement of nurses to report nursing errors. In advancing this discussion, brief attention is first given to clarifying what constitutes a ‘nursing error’, the incidence and impact of nursing errors and the problem of nursing errors being under-reported. Attention is then given to advancing a philosophic critique of why it is important to define and distinguish nursing errors (i.e., as distinct from other kinds of errors) in patient safety discourses, processes contributing to the problem of nurses under-reporting their errors (including the inherent risks to the nurses themselves of making disclosures) and the apparent contradiction in terms of distinguishing nursing errors in the context of the ‘system approach’ to human-error management that is being widely advocated in the international patient safety literature and management practices. Finally, consideration is given to the implications for nurse education, research and global practice of taking a non-punitive approach to nursing-error management. It is the ultimate conclusion of this paper that if the new ‘system approach’ to human-error management and patient safety that is being advocated globally is to succeed, nurses must be given complete immunity from disciplinary action and legal prosecution when disclosing their honest mistakes.

2. What is a ‘nursing error’?

The word error originates from the Old French errer, meaning to wander or to stray (from the from Latin errāre) and is defined by the New Oxford Dictionary of English (2001) as simply ‘a mistake’ and as ‘the state or condition of being wrong in conduct or judgement’. For the purposes of patient safety research, practice and management, however, the following more sophisticated definition (devised by Reason, 1990) has been adopted:

Error will be taken as a generic term to encompass all those occasions in which a planned sequence of mental or physical activities fails to achieve its intended outcome, and when these failures cannot be attributed to the intervention of some chance agency (Reason, 1990, p. 9).

According to Reason (with reference to the work of Rasmussen and Jensen, 1974), errors maybe classified into three types: skill-based slips and lapses, rule-based
mistakes and knowledge-based mistakes. *Skill-based slips and lapses* are those ‘in which actions deviate from current intention due to execution failures and/or storage failures’ (Reason, 1990, p. 53). Such errors commonly occur during the performance of ‘some routine task, usually in familiar surroundings’ (Cho, 2001, p. 79) or when ‘skilled people perform many tasks at once’ (Runciman and Moller, 2001, p. 14). An example of a skill-based error is wrong drug administration.

**Rule-based and knowledge-based mistakes**, in turn, concern those in which ‘the actions may run according to plan, but where the plan is inadequate to achieve the desired outcome’ (Reason, 1990, p. 53). Rule-based errors may arise in at least three forms: ‘the misapplication of a good rule (usually because of a failure to spot the contraindication), the application of a bad rule, or the non-application of a good rule’ (Reason, 2001, p. 13). Reason (2001) explains that rule-based errors ‘relate to problems for which the person possesses some pre-packaged solution, acquired as the result of training, experience, or the availability of appropriate procedures’ (p. 12). An example of a rule-based error is a ‘routinely inadequate checking process)—a process that can (and does) lead to many incidents and accidents, such as wrong patient/site surgery.

**Knowledge-based mistakes**, in contrast, ‘occur in novel situations where the solution to a problem has to be worked out on the spot without the help of pre-programmed solutions’ (Reason, 2001, p. 13). A knowledge-based error may occur, for example, when ‘trying to diagnose what has gone wrong with a malfunctioning system’ (Reason, 2001, p. 13). Reason explains that in a situation such as this, we are at risk of making mistakes because of a tendency to:

“pattern match” a possible cause to the available signs and symptoms and then seek out only that evidence that supports this particular hunch, ignoring or rationalising away contradictory facts (Reason 2001, p. 13).

What then is a *nursing error*? For the purpose of this discussion, a *nursing error* (as distinct from a medical error, for example) is defined as a discipline-specific term that encompasses an unintended ‘mishap’ (e.g. involving slips, lapses, misjudgements, etc.) made by a nurse and where a nurse (as opposed to some other health care professional) is the one who is situated at the ‘sharp end’ of an event that adversely affected—or could have adversely affected—a patient’s safety and quality care. In short, a nursing error is that in which a nurse (as opposed to a doctor or a pharmacist or someone else) stands as being the last causally and critically linked person to an unintended ‘effect’ (consequence or outcome). It is important to clarify at this point that it is not inconsistent for more than one nurse, or for a nurse and another health professional (e.g. a doctor), to *both be situated concurrently at the ‘sharp end’ and both being causally and critically linked* (like two handles on a vase) to an unintended effect (consequence) to a patient. Indeed, an error might consistently involve *both a nursing-identified and other-identified* (e.g., medical) error.

Significantly, it is only recently that attempts have been made to define and formally classify nursing errors. For instance, in a study examining 21 case studies of nursing errors from nine State Boards of Nursing filed in the USA, Benner et al. (2002) identified eight categories of nursing errors representing what is described as a ‘broad range of possible errors and contributive or causative factors’. Listed in Benner et al.’s taxonomy of nursing errors are the following:

- **Lack of attentiveness** (e.g., missed predictable complications, such as a postoperative haemorrhage)
- **Lack of agency/fiduciary concern** (e.g. failure to advocate for the patient’s best interests/ failure to question a doctor’s inappropriate directives)
- **Inappropriate judgement** (e.g., failure to recognise the implications of a patient’s signs and symptoms)
- **Medication error** (e.g. wrong drug, wrong route, wrong amount, etc.)
- **Lack of intervention on the patient’s behalf** (e.g., failure to follow up on signs of hypovolemic shock)
- **Lack of prevention** (e.g., failure to prevent threats to patient safety such as via breaches of infection control precautions)
- **Missed or mistaken doctor/health care provider’s orders** (e.g., carrying out inappropriate orders/ mistaking orders, resulting in an erroneous intervention)
- **Documentation errors** (e.g., charting procedures or medications before they were completed/ failure to chart observations) (adapted from Benner et al., 2002).

Unfortunately, it is beyond the scope of this present paper to provide a critique of Benner et al.’s and other’s (e.g., Berry, 2000) taxonomies of nursing errors. Nonetheless, it is evident that the taxonomies that have been developed stand as an important starting point for what is shaping up to be a rich and fertile area for future international research and professional debate.

### 3. Incidence and impact of nursing errors

All nurses who have practised nursing have made a mistake at some time during their career. Even so, there are no precise figures on the incidence and impact of
nursing errors in health care. Compounding the difficulties associated with trying to estimate the incidence and impact of nursing errors is the reality that:

- not all practice errors result in adverse events and, conversely, not all adverse events are the result of practice errors (Leape, 1994); and
- errors (and their ‘near misses’) tend to be under-reported—even by nurses, who are widely acknowledged as a group that reports incidents more significantly than do other health professionals, including doctors (Kingston et al., 2004).

In regard to the latter, estimates vary on the degree to which incidents (including errors and mishaps) are under-reported, with some commentators suggesting that under-reporting rates could be as high as 94% in some areas (e.g., the reporting of adverse drug events), with average reporting rates being between 15% and 48%—depending on the perceived seriousness of the incident (Secker-Walker and Taylor-Adams, 2002, p. 424; King, 2001; Antonow et al., 2000). Incidents perceived as being ‘serious’, intentional and/or that have had a bad outcome tend to be reported more frequently than incidents that are perceived to be ‘not serious’, unintentional and that have not had adverse outcomes (Lawton and Parker, 2002; King, 2001; King and Hermodson, 2000). Given the enormous variables that exist in the field (Clark, 2004) and the acknowledged underdevelopment of the epidemiology of ‘medical mishaps’ (Mulcahy and Rosenthal, 1999, p. 14), it is unlikely that a reliable estimation of the incidence and impact of nursing errors in health care domains will be obtained in the near future.

It is acknowledged that there exists some controversy surrounding the reliability of the statistics of preventable adverse events in hospitals and that caution should be exercised when interpreting and applying them in patient safety discourse (e.g. Clark, 2004; Hayward and Hofer, 2001; Lilford, 2002). Nonetheless, there is an emerging consensus that the figures reported are a ‘very modest estimate of the magnitude of the problem’ (Kohn et al., 2000, p. 2) and are more likely to be a ‘gross underestimation’ of the actual incidence of preventable adverse events (Clark, 2004, p. 7). Whatever the figures, as Kuhn and Youngberg (2002, p. 159) correctly point out, ‘the actual number is less important than the fact that anyone dies (or is harmed) needlessly from preventable medical (and nursing) error’.

4. Human-error management

Human error in health care (as in all lines of work) is inevitable. While it is impossible to eradicate human error, it is nevertheless possible to design and put in place systems (processes) that will help:

- reduce the likelihood of error; and
- reduce the negative impact of error when it does occur (Faugier et al., 1997; Kohn et al., 2000; Reason, 2000; Vincent, 2001).

Kohn et al. (2000, p. ix) explain that ‘errors can be prevented by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing’. For instance, just as cars are designed ‘so that drivers cannot start them while in reverse’ (i.e. to prevent drivers from accidentally backing over people or into things when starting their cars), so too can health care systems be designed to ensure that ‘patients are safe from accidental injury’ (Kohn et al., 2000, p. ix).

There is an emerging international consensus that most human errors are largely the products or consequences of a series of events or ‘upstream’ system processes, rather than of individuals ‘at the sharp end’ (the practice edge) doing the wrong things (Reason, 2000). Nevertheless, as Reason (2000) points out, there has been a longstanding and widespread tradition (that is still dominant in health care and elsewhere) of naming, blaming and shaming individual people who have been involved in unsafe acts. While blaming errant persons (what Reason calls the ‘person approach’) might be more satisfying than targeting institutions (‘If something goes wrong, it seems obvious that an individual (or group of individuals) must have been responsible’), such an approach stands to thwart the development of safer health care institutions (Reason, 2000, p. 768). This is because the ‘person approach’ overlooks two key features:

Firstly, it is often the best people who make the worst mistakes—error is not the monopoly of an unfortunate few. Secondly, far from being random, mishaps tend to fall into recurrent patterns. The same set of circumstances can provide similar errors, regardless of the people involved (Reason, 2000, p. 769).

In contrast, a ‘system approach’ (which takes as its basic premise that ‘humans are fallible and errors are to be expected, even in the best organisations’) does not seek to name, blame and shame. Rather it seeks to ‘discern and learn’ and to treat ‘every defect as a treasure’ because each one presents us with an opportunity to improve’ (Walshe, 1999, p. 59). Reason’s position on this point is unequivocal: ‘when an adverse event occurs, the important issue is not who blundered, but how and why the [system] defences failed’ (emphasis added) (Reason, 2000, p. 768).
5. Nursing-error management

The International Council of Nurses (ICN) holds that ‘patient safety is fundamental to quality health and nursing care’ and that all nurses have a fundamental responsibility to ‘address patient safety in all aspects of care’, including (but not limited to) ‘informing patients and others about risk and risk reduction’, ‘advocating for patient safety’ and ‘reporting adverse events to an appropriate authority promptly’ (ICN, 2002, p. 1). In keeping with the principles of a ‘system approach’ to human-error management, the ICN explains:

Early identification of risk is key to preventing patient injuries, and depends on maintaining a culture of trust, honesty, integrity, and open communication among patients and providers in the health care system. ICN strongly supports a system-wide approach, based on a philosophy of transparency and reporting—not on blaming and shaming the individual care provider—and incorporating measures that address human and system factors in adverse events (ICN, 2002, p. 1)

The nursing profession has long been at the forefront of the development and implementation of processes aimed at preventing practice errors, injuries and threats to patient safety. Indeed, although not widely recognised, Florence Nightingale was among the first of the modern health professionals to advocate a system approach to human-error management in hospitals. In her classic book Notes on Nursing (first published in 1859 and still in print today), Nightingale laments the ‘fatal accidents’ she had observed directly or known of and which, in her opinion, would not have happened had there been in existence an ‘organised system of attendance’ notably of qualified nurses. She writes:

If you look into the reports of trials or accidents, and especially of suicides, or into the medical history of fatal cases, it is almost incredible how often the whole things turns upon something which has happened because ‘he’, or still oftener ‘she’, ‘was not there’ [...]. The person in charge was quite right not to be ‘there’. he was called away for quite sufficient reason, or he was away for a daily recurring and unavoidable cause: yet no provision was made to supply his absence. The fault was not in his ‘being away’, but in there being no management to supplement his ‘being away’ (Nightingale, 1980 edn., pp. 28–29)

She goes on to state:

Upon my own experience I stand, and I solemnly declare that I have seen or known of fatal accidents, such as suicides in delirium tremens, bleeding to death, dying patients being dragged out of bed by drunken Medical Staff Corps men, and many other things less patent and striking which would not have happened in London civil hospitals nursed by women. The medical officers should be absolved from all blame in these accidents. How can a medical officer mount guard all day and all night over a patient (say) in delirium tremens? The fault lies in there being no organised system of attendance. [...] Were a trustworthy woman in charge of the ward, or set of wards, the thing would not, in all certainty, have happened (Nightingale, 1980 edn., p. 29).

Notwithstanding Florence Nightingale’s insights and innovations and the long history of the nursing profession’s advocacy of patient safety, it has never been easy for nurses to fulfill their many responsibilities associated with preventing practice errors, injuries and threats, to patient safety. As the nursing literature (too numerous to list here) and the examples to be given later in this paper amply demonstrate, fulfilling the responsibilities associated with upholding patient safety has not been without significant moral and legal risk to nurses, raising important questions concerning the ethics of committing, communicating and correcting nursing errors in practice domains.

6. The ethics and practical importance of reporting nursing errors

When a mistake is made, admitting and promptly reporting the error to an appropriate authority is the ‘right thing to do’. This is because hiding errors can have serious adverse consequences at both a moral and a practical level. At the moral level, hiding errors (especially those that are clinically significant) may result in:

- otherwise avoidable harm to patients, i.e., on account of:
  - depriving the relevant parties (doctors, nurses, patients and their loved ones) of information that is otherwise necessary to correct the error that has been made, including the provision of effective post-error care and treatment;
  - depriving the patient (and his/her surrogates) of their entitlement to make informed choices and to provide informed consent to ongoing post-error remedial cares and treatments;
  - imposing on patients and their loved ones an unjust burden of suffering on account of a hidden error not being remedied;
- the nurse–patient fiduciary/trust relationship being seriously undermined and, ipso facto, the good standing and reputation of the nursing profession as a whole (notably on account of the agreed ethical and professional practice standards of the profession
concerning patient safety reporting requirements) being violated.

On a practical level, if errors are left unreported, hospital incident data collected may be unreliable and hence misleading, resulting in lost opportunities for valuable ‘lessons to be learned’ from the mistakes that were made. Without complete data sets, it will not be possible to get a picture of the true nature and frequency of a problem which, if left unchecked, may result in future otherwise avoidable harmful errors occurring (Secker-Walker and Taylor-Adams, 2002, p. 423; see also Amoore and Ingram, 2002; Hart and Hazelgrove, 2001). As noted earlier (with reference to Reason, 2000), if the same set of circumstances continues to exist, then even if different people are involved, the same error will occur.

7. The problem of under-reporting nursing errors

Earlier in this paper, it was acknowledged that nursing and related errors tend to be under-reported. A key reason for this concerns the ‘name, blame and shame’ approach that continues to be predominant in health care domains when dealing with incidents (Webster and Anderson, 2002; Anderson and Webster, 2001; Mission, 2001; Cohen, 2000). Despite the substantial change in thinking that is occurring with regard to practising error management in health care, those who are the subject of a report are still likely to find themselves ‘vulnerable to increased surveillance, complaints, negligence claims, disciplinary action and a loss of respect among colleagues’ (Mulcahy and Rosenthal 1999, p. 12). In cases where a practice error has resulted in a patient’s death, practitioners may also find themselves the subjects of criminal prosecution for their mistake (Cohen, 1997; Smetzer, 1998; Johnstone, 1994).

Those who report the errors of others might likewise find themselves vulnerable to increased surveillance, complaints and a loss of respect among colleagues (Bolstin, 2003; Johnstone, 2004a, b). Employer organisations, meanwhile, may find themselves being brought into disrepute and their services shunned (even by people needing emergency life-saving treatment) as a result of adverse media publicity surrounding practice-error cases (Johnstone, 2004a).

Nurses, like others, are often reluctant to report practice errors because of their ‘fear of reprimand from those in authority’ and a related ‘unwillingness to accept responsibility for errors in which they may merely have been a final player in a complex series of events’ (Walker and Lowe, 1998, p. 97). The nurses’ fear in this instance is not without basis. Indeed, the nursing profession has a long and confronting history of its members being named, blamed and shamed for practice errors, including those made by others, such as medical practitioners and pharmacists. Reliable and convincing evidence of this can be found in the various law reports on nursing negligence cases that have occurred over the past 150 years in a range of common law jurisdictions, including those found in the UK, USA, Canada, Australia and New Zealand (see, in particular, Johnstone, 1994, pp. 188–194).

A poignant example of nurses being unjustly named, blamed and shamed for a practice error can be found in a 1996 US case in what has become known colloquially as the ‘Colorado Nurses’ Trial’. This case involved three Colorado nurses who were indicted for a criminally negligent homicide after mistakenly giving a 10 fold (and lethal) overdose dose of the intramuscular medication penicillin G benzathine intravenously to a neonate (Smetzer, 1998). Following their indictment, two of the nurses pleaded guilty in response to a plea bargain; the third nurse, who refused the plea bargain, was acquitted (Smetzer, 1998). Significantly, the indictment of all three nurses was met with widespread criticism of the Colorado criminal justice system, with some accusing it of taking ‘a giant step backward’ and undermining new initiatives aimed at encouraging the active reporting of errors and, ipso facto, improving the system (Cohen, 1997). Of particular interest to commentators, however, was information that was provided for use at the trial that enabled the relevant parties to identify ‘over 50 different failures in the system that allowed this error to develop, remain undetected and ultimately, reach the infant’ (emphasis added) (Smetzer, 1998, p. 49).

Commenting on the case, Smetzer (1998), a Fellow at the Institute for Safe Medication Practice, reflects:

Had even one [of the major system failures] not occurred, the chain of mistakes would have been broken and the infant wouldn’t have been harmed (p. 49).

Nurses in Australia have likewise experienced being named, blamed and shamed for practice errors that, as in the case of the Colorado nurses, were largely due to major system failures, not their own. This is most evident in what might be broadly referred to as the ‘fatal intravenous KCl cases’ involving the mistaken administration of a fatal dose of concentrated potassium chloride (KCl) intravenously to patients. Nurses involved in such cases have been severely disciplined for failing to prevent the error from occurring. An informative example of this can be found in a 1996 Australian case in which three nurses were reported to the Nurses Board of Victoria for their involvement in the administration of an incorrect intravenous dose of potassium chloride that resulted in a patient’s death. During the disciplinary hearing that followed, all three
Nurses were said to be experienced nurses ‘with very good records who had never previously done anything to warrant any disciplinary action’ and ‘had all been seriously affected by the patient’s death, suffering distress and loss of confidence’ (Nexus, 1996, p. 6). The disciplinary panel hearing the case accepted that, on the basis of evidence presented to it, the drug order was confusing. The panel found, however, that the nurses had nevertheless ‘failed to read the concentration and dosage details on the label of the medication bottle’ and that if they had found the order confusing ‘they should have sought clarification’ from the prescribing doctor. Accordingly, the panel found that all three nurses had engaged in unprofessional conduct of a serious nature and determined that each nurse have her/his registration suspended (Nexus, 1996, p. 7).

Almost 8 years after this determination, in recognition of the systematic processes that contribute to intravenous KCl errors in hospitals, the Australian Council for Safety and Quality in Health Care (2003) posted its ‘Medication alert 1- potassium chloride, intravenous’. This alert, outlining a systematic approach to preventing the incidence and impact of intravenous KCl drug errors, has been widely adopted by Australian healthcare services. Nonetheless, nurses at the ‘sharp end’ of KCl drug errors still face the prospect of severe disciplinary action for their mistakes.

8. The importance of distinguishing ‘nursing errors’

Earlier in this paper, the notion of what constitutes a ‘nursing error’ was explored and its working definition provided. In light of the discussion so far and the emphasis that has been given to taking a ‘system approach’ rather than a ‘person approach’ to human-error management, it might seem that the notion of ‘nursing error’ is in itself a contradiction in terms. Some clarification is thus required here of why it is important to define and distinguish nursing errors and why making such a distinction is neither inconsistent nor incompatible with a system approach to human-error management in healthcare. First, a system approach is concerned not so much with de-identifying persons who make mistakes, but to defusing the naming, blaming and shaming that might otherwise be directed at such persons when at the ‘sharp end’ of an error event. A system approach makes it possible to identify a person or category of persons (e.g., nurses) as being located at the end of a causal chain of events without necessarily blaming them and holding them individually responsible for the effect (consequence). Second, distinguishing nursing errors from other kinds of errors stands as a necessary precondition to taking a system approach and to tracking and correcting the system processes ‘upstream’ (e.g., inadequate nursing staffing levels or poor working environment of nurses (Page, 2004)) that may have contributed to the event (e.g., a drug administration error). Thus, paradoxically, failures in the system often cannot be tracked, tagged and corrected unless (and until) they become manifested at the ‘sharp end’, viz. as an individual mishap. Third, identifying nursing errors is critical to the development of the profession and practice of nursing. If, for instance, nursing activities are found to be disproportionately represented in preventable adverse-events statistics (i.e., relative to other activities), then serious questions can be raised about the processes that may have contributed to this situation and how the profession and practice of nursing as a whole (rather than a few errant individuals) can be developed to respond effectively to this disproportionate representation and, more specifically, the system processes that may have contributed to it. Finally, identifying and taking a system approach to correcting errors that are distinctively ‘nursing’ enables the profession to demonstrate its accountability and commitment to the public and to demonstrating its commitment to assuring the quality of its services.

9. Implications for nurse education, research and practice

Nursing, like medicine, is a stressful and intrinsically ‘risk-laden practice’ (Mulcahy and Rosenthal, 1999, p. 14; Rosenthal, 1999, p. 143). Clinical nursing work is carried out in situations that are largely unpredictable and it relies heavily on qualitative assessments and judgements about the clinical conditions of patients and the environments in which they are being cared for. Thus, from the moment a nurse engages in providing nursing care, she/he runs the risk of ‘doing something wrong’. This is because, as Rosenthal explains in another context:

Clinical judgment is ‘acting as if’ but without complete certainty. Most clinicians are technically competent and knowledgeable, but this is always circumscribed by uncertainty and emerging, sometimes unpredictable, events (Rosenthal, 1999, p. 143).

In short, nurses, like others, are ‘susceptible to error and vulnerable to its fallout’ (Wu, 2000, p. 727). However, in the light of new initiatives that are being progressed for human-error management in healthcare, it is important for the nursing profession to accept that genuine mistakes made by nurses are largely the product of ‘system flaws, not character flaws’ (Leape, 1994) and that practitioners who make mistakes are not necessarily ‘bad’, a threat to the public interest or guilty of unprofessional conduct (i.e., acting contrary to the agreed and accepted standards of the profession).
(Johnstone and Kanitsaki, 2005). This, in turn, requires the nursing profession not just to think about new things, but also to engage in a new way of thinking about nursing-error management. There are a number of areas that require attention at an educational, research and practice level.

First, there needs to be a whole new approach to the way patient safety and quality care is taught to and practised by nurses. If nurses are to improve their capacity to reduce the incidence and impact of practice errors, they need first to understand the broad principles of human-error management. For this to happen, however, it is evident that sustained attention needs to be given to systematically exploring via research and other forums the following questions:

- How do we deal with and teach students of nursing about the uncertainties of the clinical nursing practice?
- How do we convey the realities of these uncertainties to patients and allied health workers without undermining their trust and hope in nurses and the nursing care services that nurses provide?
- How do we improve data sets and collection of data on the nature, incidence and cause of nursing errors?
- How should we use the data and other information collected on nursing errors?
- How do we deal with nursing errors and what is the best way to manage them?
- How should we deal with non-reporters (e.g., should nurses who fail to report errors or their ‘near miss’ be sanctioned?)
- How are the victims of nursing errors best served (acknowledging here that when serious mistakes are made, it is not only the patient who is the victim, but also the nurse who is often left the ‘second victim’ (see also Wu, 2000))?
- How might we improve the strategies and incentives for a cultural change in this area?
- What kind of information is required to inform the development of processes aimed at improving patient safety and quality care in nursing domains? (adapted from Mulcahy and Rosenthal, 1999, p. 5).

Second, there needs to be a change in the culture of expectation that nurses (and students of nursing) ‘must know everything’—often reflected in teaching methods that treat students of nursing (both undergraduate and postgraduate) as ‘empty vessels’ that need to be filled with knowledge (Greenwood, 2000). Instead, we need to foster a culture of inquiry and recognition that we do not know—and indeed it is not possible to know—everything. Third, there needs to be a major shift in the way error reporting and complaints are viewed and handled. Rather than seeing error reports and complaints as a reason to name, blame and shame individuals, they need to be viewed as ‘learning treasures’—that is, as valuable opportunities to learn and to improve (Walshe, 1999). Finally, we need to foster inquiry into and improve our understanding of error reporting processes in nursing, how nurses tend to respond to such processes, how nurses account for their practice errors, the emotional impact of being the subject of a practice error report and what actions they may take following a report or complaint being made about them (adapted from Mulcahy and Rosenthal, 1999, p. 5; see also Pugh, in progress).

For the above approaches to succeed, however, there also needs to be a major law reform and a significant shift away from the punitive approach (e.g., disciplinary action, criminal prosecution) that has been taken traditionally in response to nursing practice errors. As an increasing number of scholars are pointing out, not only is punitive litigation directed at errant practitioners an inefficient mechanism for deterring future error and even for providing compensation for victims, it is also unacceptably setting back the patient safety agenda (May and Aulisio, 2001; see also Bovbjerg et al., 2001; Dickens, 2003; Liang, 2001; Sharpe, 2003). There is also an emerging consensus that unless the law is substantially reformed apropos, giving practitioners who make and report honest errors complete immunity from disciplinary action and prosecution, the new approach to improving patient safety that is being advocated globally will fail (Andrus et al., 2003).

10. Conclusion

Human error in health care domains carries a high burden of cost and suffering for all involved. Neither the nursing profession nor others in the field can afford to turn their backs on the opportunities that are now available to learn from practice errors and to use the lessons learned to help prevent future errors from occurring. To turn our backs away from this learning opportunity would be akin to what one commentator describes as ‘19th-century practitioners turning away from the new scientific discoveries available to improve 19th-century medicine’ (Pinkus, 2001, p. 130).

The open admission of mistakes is not only the ‘right thing to do’ morally, but is also of practical importance for the development of the profession. However, so long as legal and organisational processes conspire against nurses making open disclosures of their practice errors, the ethical aspirations made explicit in various professional position statements and nursing codes of ethics concerning patient safety will be very difficult to uphold, thereby enabling the status quo to endure.
References


