The Nurse’s Role in Changing Health Policy Related to Patient Safety

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ABSTRACT

Nurses’ roles in shaping health policy in the United States related to patient safety have not been fully expanded. This article explores various patient safety issues and how nurses can become involved to shape health policy in this area.

Patient safety and quality improvement initiatives have been taking place slowly over the last decade. Since nurses have direct and continuous contact with patients, they can play a vital role in this process if they are knowledgeable, innovative, and active decision makers. Nurses should use information and research to be influential in the health policy arena and to effect change in the current demanding healthcare work environment.

Fostering a culture of safety requires more than introducing new policies and procedures and punishing those who violate policies or are involved in incidents. Developing a culture of safety requires recognition that organizational factors matter, organizational failures occur, and organizational accidents happen. Critical thinking, problem solving, and risk management programs are important ways to reduce medical errors. A confidential reporting system can play an essential role in early identification of problems. Finally, patient interests are an important focus for nurses as they develop strategies to implement patient safety programs.

Nurses have been involved in US health policy at a national level for many years. They are focused on assessing, planning, intervening, and evaluating care processes that are designed to improve care for patients and their families. Despite this, there has not been a significant use of nursing research in policymaking. The purpose of this article is to analyze the nurse’s role in health policy related to patient safety and to present...
some recommendations that will help prevent medical errors and enhance patient safety initiatives.

Background

Major changes have taken place lately in the healthcare system. They have influenced nurses’ practices and work lives. These changes include closing beds, the nursing shortage, shortened lengths of stay, increasing emphasis on cost-effectiveness, downsizing, the presence of new and inexperienced nurses, increased patient acuity and disease chronicity, and nursing as a job becoming more technical and more difficult.1

Most health policies are generalized to cover the vast majority of practice areas. Patient safety is one of the major issues in today’s healthcare environment and in federal legislation. It was estimated in 1999 that 44,000 to 98,000 people per year in the United States die because of medical errors. The estimated cost of medical errors was about $37.6 billion each year, with $17 billion of those costs being related to preventable errors.4 Nurses could have a major role in shaping health policy to enhance patient safety in healthcare settings. A meta-analysis of public policies showed that nurses have started to address many health problems that can be modified or prevented.6 This study focused on the importance of identifying interest groups. In the policy arena, nurses should identify the interest groups that can be influential in the decision-making process. In the patient safety area, one interest group would be patients. Identifying patients as an interest group will lead to development of patient safety programs that take into consideration patients’ preferences, which can be identified through direct communication with those targeted patients. This would also permit nurses to increase patients’ education and awareness regarding nurses’ roles in care provision. As a result of the identification of patients as an interest group, nurses’ efforts would be focused toward targeted goals and result in cost-effective intervention programs in which scarce resources are wisely allocated.7 Decision makers should be mindful that in order to be successful and relevant, patient safety initiatives should be established in the context of patients’ cultural, ethnic, gender, economic, and racial factors.

Medical Errors and Patient Safety

A common misperception exists that medical errors are related only to drugs. However, other types of errors were documented in the Agency for Healthcare Research and Quality’s (AHRQ) 2000 report. These included: (1) blood transfusion errors such as transfusing patients with the incorrect type of blood; (2) diagnostic errors that included misdiagnosis or misinterpretation of results, which resulted in inaccurate treatment; (3) equipment failure such as malfunctioning intravenous pumps that resulted in extra doses of medication; and (4) infections including nosocomial and postsurgical wound infections.5

Patient safety issues related to medical errors can be controversial and range from keeping patients educated and informed about medical errors to disclosing these errors as mandated by the American Hospital Association (AHA). Medical errors are varied in nature, but are mostly related to inappropriate staffing levels in health facilities.4

Between 1995 and 2000 there were 9584 patients killed by accidents in 1720 hospitals.7 Inappropriate and inadequate staffing levels were frequently contributing factors.

General Patient Safety Issues

Patient safety issues are not new. They have persisted with little attention in the past,6 but now present to the public as a major health issue. Safety was defined as “freedom from accidental injury,” while errors were defined as “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.”4(p3)

There are three aspects of patient safety issues that are relevant to public policy debates: public fear, systems’ problems, and the link between errors and staffing cutbacks. The first patient safety issue that should be taken into consideration, as emphasized by AHRQ, is the public’s fear. The public is increasingly aware of medical errors as a public health issue. For example, 32% of people who were affected by a medical error have a resultant permanent negative effect on their health. Although it was reported, through the National Patient Safety Foundation Survey, that the typical respondent thought the US healthcare system was moderately safe, fear arises whenever an unfortunate incident occurs and is publicized.6

The second issue is errors as a system problem. Errors are a part of human conduct, but when the same errors are repeated, close attention should be given to immediate systems interventions. Errors need to be reviewed as secondary to the systems being used and then systems’ solutions need to be sought. For example, one Veteran Affairs hospital used hand-held, wireless computer technology to help to reduce medication errors by 70%.6

The third issue is the link between errors and staff cutbacks. This is also a systems issue, but consists mainly of understaffing and new nurses who are inadequately trained. One aspect of this issue is the calculation of staffing levels based on hours per patient per day regardless of patient severity and staffing mix. It has been stated that the general guideline for staffing should take into consideration that each registered nurse should not be assigned to more than nine patients at a time to provide general nursing care.8

14 JONA’S Healthcare Law, Ethics, and Regulation / Volume 5, Number 1 / March 2003
Nurse staffing in hospitals is linked to patient outcomes. The number and mix of nurses in a hospital makes a difference in the quality of patient care. Further, “a higher number of registered nurses was associated with a 3 to 12 percent reduction in the rates of adverse outcomes, while higher staffing levels for all types of nurses was associated with a decrease in adverse outcomes from between 2 to 25 percent.” The American Nurses Association (ANA) noted that in the 1990s most healthcare institutions reduced the number of registered nurse (RN) staff and replaced them with lesser trained, lower paid unlicensed assistive personnel (UAPs). Such cost cutting and related inappropriate staffing decisions led to excessive overload and overtime work for nurses, which increased the chance of making errors because of diminished time for critical thinking that resulted in inappropriate decision making.

An important aspect of understaffing is that nurses do not have sufficient time to build a trusting relationship with their patients, which can adversely affect both patient and nurse satisfaction. The nurse-patient relationship forms the basis for practice and helps nurses to observe the small changes that may occur in the patient’s condition. A strong nurse-patient relationship is also the basis for augmenting patient education about the importance of compliance with treatment regimens and encouraging patients to report health changes as soon they occur. Early reporting by patients could produce significant reductions in medical errors.

Consequences of understaffing can be severe, both for the patient and the facility. In a hospital in Chicago, the death of a patient resulted in a court settlement of $2.7 million. This patient, who was febrile, ended up in respiratory failure because the patient was neglected as a result of understaffing which led to inadequate patient monitoring. Another staffing issue is the inadequate training of some staff nurses, including for some routine procedures. In a hospital setting in Chicago, a new staff nurse found herself dealing with a life-threatening situation in the case of 2-year-old boy who had fallen at home, resulting in head trauma including a marked bruise on his forehead. The child was not closely monitored in the emergency room and ended up in cardiorespiratory arrest as a complication of brain injury. The case resulted in a court settlement of $3 million.

Patient safety legislation “gives consumers access to information they need to make informed decisions; and protects nurses who speak out on behalf of safe patient care.” On the other hand, the AHA has opposed publishing information regarding nurse staffing and patient outcomes. Professional organizations disagree about the best strategies to address patient safety issues. However, the prevention of medical errors requires redesigning the healthcare system at all levels to make it safer. Addressing systems’ improvement can prevent some of those errors. System improvement is also a strategy that enhances safety and improves quality.

Underlying Causes of Patient Safety Problems

There was growing attention given to patient safety in the late 1990s, especially in 1998 when there was a great focus on quality improvement. The reasons for inadequate quality of care, which could also be considered factors causing problems with patient safety, include:

- growing complexity of science and technology which requires more knowledge and information;
- increasing chronicity of diseases, combined with technological advancements and the collaborative effort of health team members prolonging lives of chronically ill patients;
- a poorly organized healthcare system characterized by decentralization and fragmentation; and
- constraints on exploiting the revolution in information technology due to limited access to Internet-based information.

With a population that is increasingly growing elderly with chronic conditions, it is imperative to increase organization and collaboration among parts of the US healthcare system. Well-established guidelines to treat chronic diseases and the use of informatics systems could positively empower patients’ knowledge. What healthcare professionals need is evidence-based and prospectively planned care with systematic and continuous attention to patients’ individual needs. There is also a growing need to utilize the clinical expertise of all healthcare providers and to develop and upgrade supportive information systems.

Nurses’ Role in Healthcare Policy

In today’s political arena, nurses should have the necessary skills to influence healthcare policies. Monitoring practice issues and keeping current about health policy agendas can shape these skills. A model was proposed for political influence that consisted of: (1) information about current and updated healthcare policies; (2) commitment, which was defined as having a responsibility to act; (3) initiative, which was described as the power and ability to begin or follow through a plan or task; and (4) involvement by being active in setting and accomplishing a healthcare agenda. The primary concern of nurses’ practice is patients and their safety. Because of this, nurses need to be involved at all levels in resolving healthcare issues such as patient safety.

To understand the implications of changes in healthcare policies on the nursing profession, two
perspectives have been proposed. The first is to encourage the analysis of particular policy effects on the nursing profession. The second is to recognize how nurses can affect particular health policies.13 Being reactive means that a nurse analyzes how specific policies will influence his or her work, while being proactive means having strong involvement in creating and implementing health policies that impact both nurses’ job satisfaction and patients’ satisfaction. Nurses’ long history of political involvement shows that they have, in some areas, moved from the reactivity stage to the proactivity stage in setting and accomplishing health policy agendas and recommendations. However, nurses are not yet fully involved in some nursing and patient-related agendas such as patient safety.

Although nurses have the potential to be influential in shaping and changing health policies, their effectiveness is largely invisible in today’s patient safety policies. Nurses are known as highly committed professionals who have direct contact with patients; therefore, they should be active in protecting the safety of their patients. Foley, the president of the American Nurses Association, said, “nurses are the quality and safety monitors.”7(p1) Lack of nurses’ involvement in patient safety policy agendas may be explained by the absence of a nursing framework for analyzing current health-related issues.

Nurses’ political involvement in healthcare has four stages:

1. Buy-in/ political activism stage in which nurses are reactive with a focus on a nursing issue
2. Self-interest stage, in which nurses are a reactive group using a nursing domain or topic, such as nursing diagnosis and care, which could be enhanced through being members of nursing organizations
3. Political sophistication stage, in which nurses are proactive about nursing and other health-related issues through active nursing and healthcare groups. In this stage, nurses have to be appointed to federal panels and agencies to become visible decision makers in areas of finance, election, and public relation strategies
4. The stage of leading the way, in which nurses become proactive in agenda setting for health and social issues.

Nurses become initiators, innovators, and leaders of the policy agendas because of their knowledge and expertise.14 In today’s health policy arena, nurses are proactively involved in some health-related issues, and they strive to be leaders in setting agendas and taking action since they are empowered by their knowledge and expertise. In regard to patient safety policies, nurses are not yet fully involved. Nurses need to be action-oriented to pursue their role in decreasing medical errors.

Nurses can be actively involved in the policymaking process if they have an autonomous work environment that is empowered through innovative management. In the past, nurses and nurse managers were concerned about serving physicians’ interests. Historically, there have been few studies exploring the effects of nursing leadership on health policy. Furthermore, health policy often has been formulated without the input of nurses.3 Today’s healthcare arena requires fundamental rather than incremental involvement of nurses because the issues are serious and complex. Such involvement could be achieved through nursing leadership that allows and empowers nurses’ autonomy, creativity, and participative decision making.

Patient Safety Alternatives and Solutions

In order to address the rising number of medical errors, hospitals need to develop policies and procedures regarding patient safety. Insurers need to form partnerships with hospital managers to develop optimal systems for detecting and correcting the systemic causes of patient injury. The incidence of medical errors could be improved if there was a better understanding of both the causes of patient injury and systems that promote patient health and safety.16 Health professionals can take the initiative to develop analyses that demonstrate how the medical liability system affects internal medical error detection and reporting systems of healthcare organizations and thereby contributes to a reduction in errors and the enhancement of the overall patient care environment.

Patient education plays a vital role in reducing medical errors. The following patient teaching aspects should be addressed by all healthcare organizations and, through continuing education departments, presented to all healthcare providers:

- Foster the patient-healthcare givers’ trust relationship as a key element for patient release of health-related data.
- Make sure that patients give a full medication history to their healthcare providers.
- Encourage patients to read medication pamphlets.
- Let patients know that they should report any side effects to the nearest primary caregiver.
- In case of surgery, encourage patients to ask their primary care provider about exactly what will be done and the possible consequences.
- Encourage patients to have a primary caregiver who will be kept informed about the entire health history.
- Inform all patients that more treatment is not always better.17

Nurses could play a vital role in patient safety if they apply the principles of risk management. Risk management includes identifying and containing risk after an event, education of staff and patients, and risk transfer.18 Effort should be made to move toward
“primary” risk management which focuses on preventing adverse events from occurring. This would help to eliminate errors, save costs, and decrease legal liability of healthcare professionals.

Establishing risk management committees which include all members of the healthcare staff is an innovative step in reducing medical errors. Through risk management, multidirectional communication would be done at all institutional and organizational levels, which would serve as an early alert to identify and fix system errors. To improve patient safety, risk managers should be represented on the governing board, executive committee, or at corporate headquarters.18

The National Patient Safety Foundation survey found that 75% of respondents thought that the solution for medical errors was to “keep health professionals with bad track records from providing care.”6(p2) However, 69% of the respondents thought that professional education and better training would be the best technique for solving medical errors. One practical approach to error prevention is for nurses to be actively involved in healthcare agency teams and to address safety at the local work site level.

National initiatives for patient safety are aimed at improving decision making by policymakers, regulators, and healthcare organizations. Decisions should be based on evidence rather than anecdotes. National patient safety efforts include establishing a center for patient safety, research-focused patient safety measures, and the National Practitioner Data Bank (NPDB).

Creating an information system and building a better evidence base for patient safety are critical strategic approaches needed to reduce medical errors and improve patient safety. The Center for Patient Safety was proposed as a way to:

- establish a limited set of high-priority goals for improving patient safety based on expert opinion and review of evidence of errors;
- assess progress toward national goals by gathering information from state and national reporting systems and healthcare organizations;
- develop research agendas to assess the magnitude of errors, assess the role of human factors, and test and evaluate approaches for preventing errors;
- define feasible systems and tools for safety including both clinical and managerial support systems for medication systems, operating rooms and surgery processes, emergency departments, management of diagnostic tests, screening, and information, intensive care units, neonatal intensive care units, care of frail elderly (e.g., falls, decubitus, etc.), and team training and crew resource management applications in healthcare;
- develop protocols and technical support to ensure widespread implementation of the designed patient safety systems and tools;
- conduct periodic evaluations of error reporting systems;
- provide support to healthcare organizations for internal quality improvement to prevent and reduce errors;
- develop tools and methods for educating consumers about patient safety; and
- issue an annual report on progress made to improve patient safety and recommend changes for continuously improving patient safety to appropriate parties.14

The Healthcare Quality Improvement Act of 1986 required all malpractice insurers and self-insurers to report claims paid on behalf of named practitioners to the NPDB, which is maintained by the Health Resources and Services Administration (HRSA).19 The Healthcare Quality Improvement Act 1986 allows only authorized users to obtain information from the data bank. The NPDB may not give information on any practitioner to any malpractice insurer or member of the general public, although plaintiffs’ attorneys may query the bank under very limited circumstances.

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**Nursing Actions to Improve Patient Safety**

Nursing research can play an important role in patient safety improvement. There are initial areas of research that need immediate attention. These include research-focused patient safety measures designed to:

- enhance understanding of the impact of various management practices such as adequate staffing on decreasing and preventing medical errors;
- apply safety methods and technologies from other industries to healthcare, especially human factors and engineering principles;
- increase understanding of errors in different settings and for vulnerable populations such as children and the elderly;
- establish baseline rates of specific types of errors and monitor trends;
- monitor error rates that accompany the introduction of new technologies; and
- increase understanding of the use of information technology to improve patient safety.4

Patient safety initiatives vary according to the organization and institution. However, all of these initiatives aim to decrease medical errors and enhance patient safety. Nurses can take various steps to become proactive in influencing patient safety policy and practice.

Nurses should keep updated about the current political agenda and have a strong commitment to produce a change in patient care, which could be done in cooperation with other healthcare professionals and organizations.30 Nurses can use Institute of Medicine (IOM) and ANA guidelines for patient safety, general activities for nurses and other healthcare providers which include the following:
• Improve healthcare systems to be safe, effective, patient centered, timely, and equitable.
• Maintain adequate staffing levels, which will protect nurses against stress and burnout that frequently contribute to the occurrence of errors.
• Create open and updated reporting systems, which will guarantee honest reporting of errors and protect human rights.
• Keep open communication with other healthcare professionals and patients.
• Avoid blaming individuals for errors, but rather encourage learning from the past and acting collectively to solve problems. Ensure health team knowledge of confidentiality and constructive use of reporting errors. Focus on errors as a part of human conduct and as a part of system problems that should be identified and eliminated.
• Develop and maintain evidence-based decision making.
• Establish knowledge and research-based protocols in cooperation with other organizations and professional groups. Submit proposals for funding agencies that focus on patient safety issues.
• Identify patients as an interest group to help in cost-effective and efficient use of resources. Eliminate public fear through research-based assurance and develop plans of action to decrease and eliminate medical errors.

Nurses should be involved in nursing organizations, be proactive about nursing and other health-related issues, and become visible decision makers by seeking appointment to federal panels and agencies. Nurses have the potential to be innovators and leaders because of their knowledge and expertise.20

REFERENCES