Submitted by

Association of Registered Nurses
of Newfoundland and Labrador

ARNNL Brief to Task force on Adverse Health Events

The Association of Registered Nurses of Newfoundland and Labrador (ARNNL) is the regulatory body and professional organization representing all Registered Nurses and Nurse Practitioners in the province. In pursuit of its vision, "Excellence in Nursing", ARNNL exists so there will be public protection, quality health care, and healthy public policy.

The Association of Registered Nurses of Newfoundland and Labrador (ARNNL) welcomes this opportunity to comment on the management of adverse events as there is a lot of work to be done to move our health care system from the traditional culture of blame to a new client safety culture. We recognize and support the need to thoroughly analyze how government, regulatory bodies, health care authorities, and the professions can collaborate to create solutions that will establish the new culture of client safety required to prevent and effectively manage adverse events in the public interest.

As the regulatory body for Registered Nurses, ARNNL's primary responsibility is public protection through promoting excellence in nursing and quality health care. This responsibility is accomplished in part, through the setting of standards for licensure, education and practice, and a code of ethics. Patient safety is fundamental to nursing care and, as such, ARNNL clearly articulates that RNs have a professional and ethical obligation to identify potential and actual issues of patient safety and to respond appropriately. The significance of client safety is specifically articulated in the following ARNNL goals or Ends statements, which serve to direct our ongoing activities:

- RNs understand and act upon their responsibility as client advocates.
- Client safety is enhanced through a culture of discovery including a focus on root cause analysis, education, prevention, and remediation

(See Appendix A for more examples of ARNNL standards, indicators and responsibility statements related to client safety.)

Client safety is a pressing concern for Registered Nurses in our province. On an annual basis ARNNL receives over 200 consultation requests from nurses related to maximizing client safety. This demonstrates the inherent value nurses place in the prevention and mitigation of unsafe acts in their workplaces. Consequently, any means of improving the processes to enhance the prevention, early identification as well as managing of potential and actual adverse events is welcome.

Improving patient safety involves a wide range of actions at the individual, interprofessional, health authority and government levels. The focus of this response will be limited to the nursing profession's views on how to improve the management of adverse events as one aspect in the development of a culture of safety. ARNNL is making suggestions regarding the need to:

1. Create and sustain a safety culture,
2. Standardize policies and processes,
3. Enhance professional development and RNs' role,
4. Improve professional practice supports,
5. Enact legislation that supports the culture of safety, and
6. Support knowledge transfer.

1. **Creating and Sustaining a Safety Culture**
Continued attention and interventions are required to create and sustain a culture
of safety in our health care system.

Anecdotal evidence indicates that despite the fact that an increasing amount of attention and resources are being dedicated towards client safety, we have not yet created a culture whereby healthcare professionals inherently feel safe to openly and thoroughly discuss and participate in measures to prevent and manage actual adverse events. Further interventions are required. In particular, ARNNL is suggesting four areas for consideration.

- Address the current and future leadership challenges.
- Include front line nurses in all relevant discussions on client specific incidences for which they were involved.
- Provide timely feedback to nurses on client safety initiatives that relate to their role and area of practice.
- Explore measures to capitalize on the value of clients as true partners in health care.

Address Leadership Challenges
Strong leadership at all levels is needed to create the required environmental attitude where staff believe in and endorse practices which support a culture of safety. In particular, attention is required to support the role of front line managers in implementing changes in practice and culture. Data from the ARNNL Survey of *Nurses in Management Positions* (2007b, 2008d) identify unreasonable spans of control; almost 75% reported having > 30 staff and, 80% has staff from more then one unit and/or geographical location. This impacts managers ability to nurture and support front line staff and others in making the required paradigm shift to achieve a culture of safety.

Experience and research tell us that the future generations of health care professionals will likely have a different perspective from those of today. Sustaining a culture of safety into the future will require that the potential implications of generational differences are explored. For example, future approaches in the management of adverse events must consider the value these professionals place on technology as the means for acting, communicating and learning. Their perspective must be incorporated into the planning of today to ensure that our future care providers remain positively engaged.

Include Frontline Nurses
There is still an element of role delineation between disciplines and even within the profession of nursing when it comes to managing adverse events. Historically, direct care nurses' primary role has been to identify and report concerns. The management or follow-up on reported events is frequently assigned to physicians or agency quality teams. Reporting refers to communication of information about an adverse event or near misses through appropriate channels in the organization for the purposes of reducing the risk of re-occurrence (Canadian Patient Safety Institute [CPSI], 2008). Although an important component of improving patient safety, reporting is a first step. Registered Nurses need to be a part of the entire process. Being respected and accepted into the team of responders can nurture the value of identifying and addressing concerns, build expertise, and enhance professional accountability. To achieve this, there needs to be a coordinated and comprehensive approach to managing adverse events, which incorporates true interdisciplinary

collaboration and team work. If a nurse has been involved in reporting the near miss or adverse event then he/she should play a more significant role in the entire process, including disclosure.

Provide Feedback on Safety Initiatives
RNs report limited knowledge about the outcomes of client safety initiatives that have been implemented in their area of practice. Data extracted from ARNNL and College of Licensed Practical Nurses of NL's Quality Professional Practice Environment (QPPE) sites indicated that 33.3% of the RNs and LPNs (n= 179) stated they did not have access to or did not know (11%), the results of quality improvement initiatives they participated in. Nurses described reporter fatigue, implying 'why bother' to continue to raise concerns or participate in initiatives if nothing is ever done [but it is more likely that nothing was ever reported back]. Reporter fatigue, when coupled with reports of excessive workload, can lead to under-reporting of concerns.

Involve Clients
Clients want and will increasingly desire to be more active participants in their health care. Consequently, exploration on how to maximize client engagement and self accountability in their healthcare needs to be explored. Client engagement supports social justice by encouraging equity in decision making, distributing power, and acknowledging human rights (SRNA, 2008). For example, clients require and often request information about their rights and responsibilities, including their role as a team member and their responsibility to question practices. To fully move away from the paternalistic model, or as stated by Herbert (2008) to move from the therapeutic approach where the client is included in what the provider determines is in their best interest, to the democratic approach, where all clients have a right to be truly involved in their care, will require reflection, planning, and courage. Client engagement in the prevention of adverse events is one of the most effective untapped prevention strategies available.

2. Standardize Policies and Processes
A standardized provincial template for addressing adverse events is required. This template needs to include policy direction and processes that promote the objective collection of data that can be shared and compared.

Critical to the client safety agenda is the need to develop policies and processes that support communication of concerns in a standardized, user-friendly, and effective manner. Furthermore the policies and processes must be utilized by all members of the health care team. Currently not all health care agencies have policies that clearly direct practice in this area. Those that do exist often do not reflect the relevant professional standards published by the regulatory bodies, and thus miss the opportunity to heighten practitioners' awareness of the magnitude of their accountability to participate in patient safety activities. In addition, there are a number of different forms and processes that supposedly serve a similar purpose, often with different titles and different implications based upon the setting, for example, incident, adverse, occurrence and professional practice forms (Burkoski, 2007). The lack of standardized policies and processes may also limit sharing of data between agencies locally, provincially and even nationally, as one cannot determine if apples are being compared to apples.

The CPSI *Guidelines for Disclosure* (2008) provide a template for health care agencies to develop their own policies on communicating with clients when an adverse or potential adverse event occurs. However, the guidelines do not address prevention, internal reporting, managing or informing the public. There is more

work needed to identify best practices in these areas and convert applicable recommendations into polices and processes within all healthcare settings.

3. Enhance Professional Development and RNs' Role
RNs can play a more prominent role in communicating with clients when actual or potential adverse events occur.

Client safety and the expectation to identify and act upon concerns about actual or potential adverse events are a professional and ethical imperative in caring for others. These concepts are embedded in both the undergraduate curriculum, as articulated in the ARNNL document, *Competencies in the Context of Entry-Level Practice in NL 2007-2010 (2006a)* , and the professional *Standards for Nursing Practice* (2007c) and *Code of Ethics* (2008) (see appendix A for specific indicators). However, both front-line and nurse managers report a need for additional education to become proficient in advanced communication techniques to effectively manage adverse events. For example, nurses have requested education on presenting information in a regretful but non- accusatory, objective manner. Nurse managers have specifically identified the need for continuing education to assist them in their role as leaders (ARNNL, 2007a). Appendix B provides a more detailed list of research that illustrates both the need for and value of enhanced communication education for nurses. As the need for education on the appropriate management of adverse events is likely shared by other disciplines, this topic would be an excellent focus for interdisciplinary education in both undergraduate and continuing education forums.

With appropriate education and support RNs can play a greater role in initial communication with clients. Research tells us that clients want to know sooner rather then later when an adverse event has occurred. Traditionally, RNs have not been given the autonomy or authority to initiate communication with clients when an adverse event occurs. This situation potentially conflicts with nurses professional and ethical obligations. The CPSI *Disclosure Guidelines* endorse the precautionary principle, which stresses the value of early communication and action. Nurses are the most frequent health care provider clients interact with, and are trusted by the public. The latest Ispos-Reid public poll that found that 84% of Canadians trust nurses' information compared to 77% for physicians and 60% for information originating from health ministers (ARNNL, 2008a). As nurses are also often the first to identify that a client has or could have experienced an adverse event, educating and supporting nurses to enhance their role in sharing appropriate information with clients can result in a more timely process for open and transparent communication. One supportive strategy is use of an interdisciplinary educational approach which incorporates role modeling and mentoring. Collaborating with professionals who have traditionally assumed this role is an excellent means of supporting nurses to enhance their role in client communication in adverse events.

4. Improve Professional Practice Support
Health care providers require the assistance of experts and mentors to maximize client safety.

In today's complex ever changing health care environment the demands have increased, yet practice supports have diminished. Quality of workload studies indicate that nurses are feeling the impact, which in turn, is impacting the quality of client care (Statistics Canada, 2005). Likewise there is evidence that the introduction of supportive roles such as educators, infection control practitioners, safety officers, and clinical leaders such as clinical nurse specialists, enhance the quality of care (ARNNL, 2006b). However the

implementation of these roles has been very limited in our province. To fully adopt a culture of client safety dedicated experts and mentors at the practice level are required.

The ARNNL and CLPNNL Quality Professional Practice Environment Program (QPPE) has made significant differences within the participating units (ARNNL, 2008b). The QPPE program and other initiatives, which support quality of worklife and quality care, need to be implemented in all health care agencies. This will require dedicated resources, both financial and human. ARNNL believes that the dedication of a person or persons responsible for creating quality professional practice environments is needed in all four regional health authorities. Such a role can effectively increase health care professionals' ability and authority to prevent and address situations that are known to be risky practices.

The value of creating a provincially mandated patient safety role or office should be explored. There appears to be significant improvement and standardization of policies occurring when a provincial position/office has been created to address an important area of concern in the past. There are a variety of models available for consideration, for example, the role of the Primary Health Care Office or the Provincial Blood Coordinating Program. The introduction of an arms length publically supported structure such as a Quality Council, has shown success in other jurisdictions. Provincially mandated organizations who have been involved in client safety and quality of worklife issues, such as the Newfoundland and Labrador Health Boards Association, could be another approach for consideration to lead this initiative.

5. Enact Legislation that Supports the Culture of Safety
The introduction of legislation to support the identification, management, and disclosure of adverse events needs to be fully explored.

Legislation can serve a valuable role in supporting and protecting persons and agencies seeking to maximize their ability to appropriately and effectively address adverse events. There are several areas where legislation can be helpful:
- Protection of Information from Quality Initiatives
- Mandatory Reporting
- Whistleblowing
- Public Information
- Apology Protection

It is important to carefully consider the advantages and disadvantages and expected outcomes before the time and effort is invested in the creation or revision of any legislation. First and foremost, the merit of legislation to support the desired culture of safety must be validated.

Quality Initiatives
ARNNL supports the need to examine and revise as necessary the Evidence Act so that quality assurance / initiatives records and the release of information by individuals involved in quality assurance activities are protected from legal proceedings. We believe that peer review processes/documents are intended to improve client care outcomes and are therefore, a means to enhance care and protect the public. As the introduction of quality control measures within regulatory bodies and health care agencies continues to grow in response to the call to strengthen public accountability and maximize client safety, the type of information that is

considered to be "protected" needs clarification. ARNNL is in the process of developing a continuing competency program for RNs. With such a program nurses are encouraged to identify their strengths and challenges and to engage in learning activities to meet those challenges. If nurses are to participate wholly in this program they will require reassurance that the personal information they disclose will be used only for the intended purposes. Failure to provide that reassurance may limit nurses' willingness to fully disclose. A similar response could likewise be expected for participation in quality control initiatives undertaken in health care professionals' places of employment.

Mandatory Reporting
Legislation to mandate reporting of adverse or sentinel events has been implemented in other jurisdictions e.g. Saskatchewan. Although some provinces have established mandatory reporting to a provincial government structure, there appears to be more merit in mandating that health care agencies and professionals report potential and adverse events to an established arms length national database. National reporting supports the ability to share lessons learned. Entities such as, the Institute for Safe Medication Practices- Canada and Health Canada's Canada Vigilance Adverse Reaction Monitoring Program and Database are already funded and well situated to collect and disseminate data on adverse events and near misses with the goal of preventing reoccurrence in another setting or situation. These national databases are currently underutilized. Mandatory reporting to an appropriate national organization should be explored.

Whistleblowing
Whistleblowing is defined as the exposure of negligence, abuses, or dangers, such as professional misconduct or incompetence, which exist in the organization where the whistleblower works (CNA, 1999). There are two interpretations on what constitutes whistleblowing; internal and/or external reporting (Wikipedia, 2008). As there are no jurisdictions in Canada that have enacted such legislation, the Canadian interpretation of this term remains undefined. ARNNL, as the regulatory body for RN practice, supports the value of protecting a nurse who appropriately followed professional processes for addressing client safety concerns as outlined in the ARNNL document, *Registered Nurses Professional Duty to Address Unsafe and Unethical Situations* (ARNNL, 2008c), but who are unable to achieve effective results. (A brief description of this process is described in Appendix C). However, most references to whistleblowing refer to externally reporting or warning the public about a particular concern without first going through all the appropriate internal channels.   ARNNL is concerned that whistleblowing legislation may be perceived as approval to bypass the expected internal reporting and thus used inappropriately. Inappropriate external or public whistleblowing often serves the opposite effect, causing undue public fear, jeopardizing client privacy, creating suspicion that can affect organizational functioning, and affecting the individual whistleblower's employment and/or professional status (ARNNL Disclosure Teleconference, February, 2007).

Public Information
The act of informing is normally the responsibility of an institution (not an individual function). The public sharing of information about a concern and the measures implemented to address a concern, is an important part of managing adverse events as it helps maintain the public's trust in the health care system (Espin, 2008). The CPSI *Disclosure Guidelines* (2008) identifies this level of accountability to senior administration. ARNNL supports the need for the CPSI or some other entity to develop guidelines which address the appropriate process for informing the public. These guidelines need to then be incorporated into health care policy.

Apology Laws

Saskatchewan, British Columbia and Manitoba have enacted apology laws which supports the merit and responsibility of an agency and/or individual to apologize while protecting the apologizer from the risk that this endeavor can be used as an admission of guilt (Robertson, 2008). This type of legislation supports early, open, and transparent communication with clients who experienced an adverse event. ARNNL supports the value of apology legislation.

6. Support Knowledge Transfer

Data are needed on what works and what does not work. Funds are needed to support what works in the management of adverse events and client safety.

The Canadian client safety agenda has been active for almost six years. Since then there have been a number of initiatives implemented both as research and pilot projects. There is an urgent need to formally share what projects worked and what did not, to articulate best practice evidence in this area, and to fund/support/promote programs that make a difference. ARNNL supports the value of creating or supporting a network for disseminating information that enhances client safety. Three areas are highlighted as examples. The work of the national organization, Quality Worklife: Quality HealthCare Collaborative, deserves consideration. There are a number of viable and practical solutions articulated in the document, *Within Our Grasp*- A Healthy Workplace Action Strategy for Success and Sustainability in Canada's Healthcare System (2007). The Registered Nurses Association of Ontario has developed over 29 best practice clinical guidelines and six guidelines to create healthy workplaces. To date there has been only limited uptake on these guidelines with our province. Finally, the 30 healthcare practices that have been proven to be effective in clinical settings to reduce the risk of client harm put together by the US National Quality Forum, could be reviewed for merit in the Canadian health care system.

Conclusion

ARNNL is pleased to see Government leadership on the management of adverse events in our health care system. The Association believes in the old adage, "leadership must come from the top" when a system is being asked to make the fundamental reforms needed to move from a culture of blame to one of discovery. Registered nurses are keen to work with all stakeholders to improve the management of adverse events and to create the quality of practice environments which are needed to address client safety. ARNNL's six suggestions for improving the management of adverse events are a good starting point for action.

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Appendix A

Enhancing, preventing and supporting a patient safety philosophy is a professional expectation for all registered nurses practicing in Newfoundland and Labrador. These expectations are clearly identified in several ARNNL key documents as described below.

Registered Nursing Act (2008)

20. (1) A registered nurse who has knowledge, from direct observation or objective evidence, of conduct deserving of sanction of another registered nurse shall report the known facts to the Director of Professional Conduct Review.

Association of Registered Nursing of Newfoundland and Labrador (ARNNL) Standards for Nursing Practice (2007)

Self Regulation and Professional Accountability.
1.5 Is accountable and responsible for own actions and decisions at all times.
1.8 Participates in the identification and resolution of professional practice issues, conflicts, and ethical dilemmas.
1.9 Responds to, and reports situations that may be adverse for clients and/or health care providers.
1.11 Documents adherence to responsibilities and accountabilities appropriately.

Specialized Body Knowledge
2.3 Uses reflective thought and feedback from others in assessing own practice, and provides feedback to others to support their professional development.

Competent Application of Knowledge
3.9 Recognizes any limitations to safe, competent, and ethical care and reports concerns, and consults and/or initiates appropriate changes as necessary.

Professional Interactions and Advocacy
4.1 Demonstrates honesty, integrity and respect for others.
4.11 Acts as an advocate to protect clients from harm due to unsafe situations and/or incompetent or unethical care

Professional Leadership
5.5 Questions practices and contributes to improvements to support client and nurse safety.
5.6 Advocates for and/or contributes to the development of organizational policies, quality improvement initiatives, and programs based on evidence/best practice standards.

Canadian Nurses Association (CNA) Code of Ethics (2008) select indicators:

Providing Safe, Compassionate, Competent and Ethical Care

3. 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.

4. Nurses question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care to those to whom they are providing care, and they support those who do the same.

5. Nurses admit mistakes and take all necessary actions to prevent or minimize harm arising from an **adverse** event. They work with others to reduce the potential for future risks and preventable harms.

6. When resources are not available to provide ideal care, nurses collaborate with others to adjust priorities and minimize harm. Nurses keep persons receiving care, families and their employers informed about potential and actual changes to delivery of care. They inform employers about potential threats to safety

Preserving Dignity

4. Nurses intervene, and report when necessary, when others fail to respect the dignity of a person receiving care, recognizing that to be silent and passive is to condone the behavior.

Maintaining Privacy and Confidentiality
4. When nurses' are required to disclose information for a particular purpose, they disclose only the amount of information necessary for that purpose and inform only those necessary. They attempt to do so in ways that minimize any potential harm to the individual, family or community.

Ethical Endeavours
xii. Advocating for the discussion of ethical issues among health-care team members, persons in their care, families and students. Nurses encourage ethical reflections, and they work to develop their own and others heightened awareness of ethics in practice.

ARNNL Competencies in the Context of Entry-Level RN Practice in NL (2007-2010)

Professional Responsibility and Accountability

2.   Recognizes limitations of practice and seeks assistance as necessary.

8.   Exercises professional judgment when using agency policies and procedures, or when practising in the absence of agency policies and procedures.

12.   Demonstrates an understanding of the concept of duty to report unsafe practice in the context of professional self-regulation.

13.   Protects clients through recognizing and reporting unsafe practices when client or staff safety and well-being are potentially or actually compromised.

14.   Questions are prepared to challenge, and take action as necessary, on questionable orders, decisions or actions made by other health team members.

15.	Questions, recognizes and reports errors (own and others) and takes action to minimize harm arising from adverse events.

16.	Identifies, reports, and takes action on actual and potential safety risks to clients, themselves or others.

18.	Integrates quality improvement principles and activities into nursing practice.

Knowledge-Based Practice

24.	Knows how and where to find evidence to support the provision of safe, competent, ethical nursing care.

30.	Knows how and where to find evidence to ensure personal safety and safety of colleagues in the workplace.

52.	Anticipates potential staff safety concerns and initiates appropriate action.

59.	Incorporates evidence from research, clinical practice, client preference, staff safety and other available resources to make decisions about client care.

62.	Recognizes, seeks immediate assistance, and helps others in a rapidly changing condition of clients that could affect client health or safety, (e.g., in situations of myocardial infarction, surgical complications, acute neurological event, shock, anaphylactic shock, acute respiratory event, cardiopulmonary arrest, perinatal crisis, premature birth, diabetes crisis, mental health crisis, and trauma).

72.	Consistently applies safety principles evidence-informed practices and appropriate protective devices when providing nursing care to prevent injury to clients, self,, and other colleagues in the work place.

73.	Implements preventive strategies related to the safe and appropriate use of medication.

74.	Implements other preventive and therapeutic interventions safely (e.g., positioning, managing intravenous therapies, drainage tubes, skin and wound care).

Ethical Practice

84.	Identifies effect of own values, beliefs and experiences concerning relationships with clients, and uses this self-awareness to support culturally safe client care.

87.	Promotes a safe environment for clients, themselves, and other health care workers that addresses the unique needs of clients within the context of care and uses a culturally safe approach to nursing care.

Service to the Public

104.	Uses established communication protocols within and across health care agencies, and with other

service sectors.

105. Uses safety measures to protect self and colleagues from injury or potentially abusive situations (e.g., aggressive clients, appropriate disposal of sharps, lifting devices, low staffing levels, increasing work-load and acuity of care).

107. Uses health care resources appropriately to ensure a culture of safety (e.g. patient lifting devices, safer sharps).

Appendix B

Communication Education for Nurses

- "Nurse's communication skills have been criticized for years, as have the theoretically weak approaches to communication skills training in nurse education."

    Quoted from: Bowles, N., Mackintosh, C., & Torn, A. (2001). Nurses' communication skills: an evaluation of the impact of solution-focused communication training. *Journal of Advanced Nursing, 36(3): 347-354*.

- Study of nurses' attitudes towards truthful communication found that most respondents reported that they did not feel sufficiently trained in communicating difficult news to patients.

    Georgaki ,S., Kaladipopulou, O., Liarmakopoulos, I., & Mystakidou, K. (2002). Nurses' attitudes towards truthful communication with patients with cancer. *Cancer Nursing, 25: 436-41*.

- "Oncology nurses may find communicating bad news difficult for several reasons. First, nurses may fear that sharing unfavorable medical information can cause harm such as hopelessness, depression or a sense of failure. Second, delivering bad news can be uncomfortable because of nurses' lack of practice or skill."

    Quoted from Radziewicz, R., Baile, W., Lockhart, L.S., & Oberleitner, M. (2001). Communication Skills: Breaking bad news in the clinical setting. *Oncology Nursing Forum, 28(6): 951-3*.

    Note: section on opportunities for RNs to deliver bad news in the article – discusses how RNs are in a position to deliver bad news because of role in care delivery (educator, supporter, advocate).

- "There is little evidence that practical advice and guidance exist for nurses in general and for emergency nurses in particular regarding the issue of medical error recognition, reporting, and resolution…There is a need for a practiced, standardized approach to medical error reporting that includes improved teamwork, conflict resolution, and appropriate reporting methodology education that should be paired with mandatory reporting laws."

    Quoted from: Hohenhaus, S.(2008). Emergency nursing and medical error – a survey of two states. *JEN: Journal of Emergency Nursing, 34(1): 20-25*.

- "Efforts to decrease errors in health care are directed at prevention rather than at managing a situation when a mistake has occurred. Consequently, nurses and other health care providers may not know how to respond properly and may lack sufficient support to make a healthy recovery from the mental anguish and emotional suffering that often accompany making mistakes."

    Quoted from: Crigger NJ, (2004). Always having to say you're sorry: an ethical response to making mistakes in professional practice. *Nursing Ethics, 11 (6):568-76*

- Study of ER physicians, RNs and EMTs using ten case vignettes involving medical errors found that 59% of RNs would disclose the error to patients (compared to 71% of physicians) and that RNs were more likely to indicate they would report the error to administrator/committee than physicians (68% vs. 54%).

  Hobgood C, Weiner B, Tamayo-Sarver JH, (2006). Medical error identification, disclosure, and reporting: do emergency medicine provider groups differ? *Academic Emergency Medicine, 13 (4): 443-51*

- A study investigating the effects of medical error disclosure training in a simulated setting for pediatric oncology nurses (n=16) found statistically significant increases in nurses' communication self-efficacy to carry out medical disclosure after training.

  Wayman KI, Yaeger KA, Sharek PJ, Trotter S, Wise L, Flora JA, Halamek LP. (2007). Simulation-based medical error disclosure training for pediatric healthcare professionals. *Journal for Healthcare Quality 29 (4):12-19*.

Appendix C

ARNNL Process: Supporting RNs to Identify and Address Client Safety Concerns.

RNs have a professional and ethical obligation to identify potential and actual issues of patient safety and to respond appropriately. These responsibilities are articulated in the document *Professional Duty to address unsafe and unethical situations* (ARNNL, 2007).

The primary responsibility of all RNs is to maximize client safety but to do so in a professional and efficient manner. The nurse is therefore directed to internally report any identified actual or potential issues of client safety up the line of authority within his/her organization. If the response is not reasonably efficient or the issue is of dire consequence, the nurse is further instructed on how to proceed. The nurse has the option to involve any and all applicable health professional regulatory bodies. ARNNL will confidentially advise any RN needing assistance with this process up to and including reporting to senior management. If necessary ARNNL will also support the nurse to bring his/her concern to an external body.

There may be a moral obligation to whistleblow if the following obligations are met:
- One reported up through the hierarchy as described.
- The harm or potential harm must be very serious: the more serious the harm the more serious the obligation.
- The employee must have a good reason to believe that the act of whistleblowing will significantly increase the probability of the desired change (CNA, 1999).