Submitted by

College of Licensed Practical Nurses
of Newfoundland and Labrador

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Submission to the Task Force on Adverse Health Events

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Introduction

The College for Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL) welcomes the opportunity to provide input into the Task Force on Adverse Health Events. The following submission provides our perspective regarding the requirements for achieving a blame-free culture that supports the timely reporting of incidents, near misses and adverse events in our Health Services System. Then, we have also commented on the suggested principles to guide adverse health event management and disclosure. Lastly, we have commented on the mandate and structure of the proposed Health Quality Council for the province.

CLPNNL, in accordance with the *Licensed Practical Nurses' Act*, has the legislative responsibility for regulating the practice of Licensed Practical Nurses in Newfoundland and Labrador. The mission of the CLPNNL is to promote safety and protection of the general public through the provision of safe, competent and ethical nursing care.

In fulfilling its role of protecting the public, the CLPNNL assumes the responsibility of determining standards for the education and practice of Licensed Practical Nurses (LPNs) to ensure they have the knowledge, skills, judgements and attitudes required to provide holistic nursing care to a diverse clientele in a variety of settings. The CLPNNL is also responsible for the investigation of all written complaints alleging negligence, incompetence, or professional misconduct by LPNs and any necessary disciplinary measures. As well, the CLPNNL recognizes the need to address mandatory competencies and issues related to maintaining these competencies.

Currently, CLPNNL has 2555 LPNs who work in a variety of acute care, long term care, and community-based settings. LPNs constitute the 2nd largest health professional group in the health care system, both here in the province and throughout the country.

Creating a Blame-Free Culture for Reporting

Despite the best prevention and most rigorous quality management processes, incidents will occur that could potentially place individuals and property at risk. Only through proper and timely reporting of incidents is the opportunity provided for investigation and implementation of actions to prevent further occurrences. This can best be achieved by developing a "blame-free" reporting system which is well understood by both health care professionals and by their patients and clients.

In our view, incidents occur generally as a result of some combination of human error and systems failure. Without consistent and timely reporting of incidents, it is virtually impossible to discover patterns that could point to systems failures that require attention and remedial action. Otherwise, imperfect systems can perpetuate to create the inevitable conditions for

significant adverse health events that cause harm to patients and clients. Near misses, incidents, unsafe acts and conditions are often not reported at all, yet learning from these conditions is really the best opportunity to continuously improve the quality and safety of care.

A significant factor that discourages reporting is the perception that to do so may result in blame for the reporter or a colleague resulting in consequential sanctions. Thus, the difficulty of ensuring complete reporting is, in part at least, a function of culture of an organization, system or society.

If health care providers are to report incidents and near misses they must not feel that they will be personally blamed or disciplined as a result of their reporting. However, we recognize that there will be instances where disciplinary action must be taken against an individual, such as for conscious or deliberate violation of a procedure, and/or in carrying out care that is inconsistent with established professional competencies and standards of practice. However, even in such cases, it is still important to understand why it took place; and whether the procedure was workable; and correct and whether there were extraneous pressures that may have contributed to the individual act. The role of professional regulatory bodies and of health care organizations in these cases is well understood and is working well.

In our view, the requirements for creating a blame-free culture include at least the following:

Unrelenting attention to ongoing education. Education regarding the incident and adverse health event reporting system during orientation is necessary, but not sufficient. Ongoing education is required to ensure there are clear and consistent awareness of what must be reported, the process of reporting, and the expected outcomes of reporting, including how reporting is linked to the organization's quality and risk management system. To facilitate this, it is recommended that one set of policies and procedures be developed and used throughout the province. An additional aim of education programs should be to achieve consistent use of terminology regarding what constitutes an incident, an occurrence, a near miss, and an adverse health event. Educational preparation must also be concrete, including for example how to complete an incident reporting form.

We have also noted that public and patient/client education are also required to raise awareness and confidence in the health system's processes for incident and adverse health event management. We suggest that patients/clients and their family members should also be part of the reporting system and that they too should be equipped to complete incident reports.

In addition to ongoing education, we believe there should be ongoing interdisciplinary, work unit forums that focus on prevention and safety. We believe these forums must be skilfully facilitated to ensure participants are encouraged to challenge the status quo and to overcome attitudinal and professional hierarchical barriers which are still very much prevalent among professional disciplines.

Visible leadership and work unit stability. LPNs are telling us that the visibility and presence of leadership at the work unit level throughout all nursing care settings has significantly diminished over the last decade, and particularly since the establishment of the four regional health authorities. Leadership presence is a vital ingredient to creating work unit environments that are conducive to open and honest communication and trusting relationships. This constitutes a prerequisite for a blame-free culture and for optimal use of reporting systems.

It is well understood that nursing staff within the province's health care system is under constant pressure resulting in high rates of casualization (versus permanent positions) and increased use of float positions. This creates a great deal of staffing instability on work units and significantly diminishes staffs' experience of open, trusting and honest communication. Furthermore a sense of belonging, of being an integral part of a team, and of mutual accountability for safe, quality care is jeopardized. This too is an essential component of a blame-free culture that supports timely and accurate reporting of incidents, near misses and adverse events.

Focus on the cause and not the person. As noted previously, most incidents are the result of a systems failure. Thus, a blame-free culture must focus on discovering the root cause and not on the person(s) who were involved. This also requires effective leadership and communication skill to ensure the focus is on discovery, investigation and action and not on individual blame.

Timely feedback, involvement and action. Unfortunately, staff does not consistently receive timely feedback regarding the incident reports they complete. This breeds skepticism regarding the utility of reporting, and especially so if corrective, systems-oriented action is not taken. It is critically important to ensure this follow-up is in place on a consistent basis.

In formulating corrective action, we believe it is important to directly involve work unit personnel. These personnel should be equipped to meaningfully participate through timely training in root cause analysis and systems problem-solving.

Provider support. Regardless of the care and attention paid to focusing on the cause rather than a person, a staff member who is involved in an incident, near miss or adverse health event will inevitably bear the burden of guilt and self-blame. Thus, provider support is necessary to ensure staff receive the necessary debriefing, counselling and other opportunities to assist them in resolving feelings of self-blame. Here again, training of leaders is necessary to ensure the effective and sensitive communication and resolution of incidents.

Patient and client support. Patients/Clients/Residents are often aware that an incident, near miss or adverse health event has occurred. A system of patient and client support must be available, including policies regarding who should communicate incidents and occurrences to patients and clients.

Changing Health Care Practices

Speciality areas in acute care settings such as critical and emergency care are well understood and supported by specialty education and systems support, including for incident and adverse event reporting. However, other areas of speciality have emerged including in mental health and addictions, elder care and community care. As these systems evolve, professional training has also evolved, for example LPN core education now includes areas such as health assessment, medication administration, intravenous therapy, blood and bloods products, and leadership skills. However, systems and reporting practices have lagged behind, resulting in inconsistencies and potential areas of risk for underreporting of incidents.

For example, in some practice settings, LPNs have full accountability for reporting incidents and near misses, and in settings there is only an expectation that LPNs verbally report these occurrences to a supervisor. Generally LPNs are not part of peer review processes and other review and evaluation processes. This represents a significant change in the management and cultural change that must be addressed if all health care professionals are to fulfill their role in the timely, accurate and complete reporting of incidents, near misses and adverse health events. Indeed, unresolved scope of practice issues and the intimidation that results in some settings is likely to encourage under-reporting as it impedes the ability to engage in open and honest discussion regarding incidents. We suspect this also extends to other professional groups where there are entrenched mindsets regarding scope of practice and hierarchy.

Guiding Principles for Adverse Health Event Management and Disclosure

Based upon the above discussion, CLPNNL offers the following guiding principles for the further development of adverse health event management and disclosure:

1. Focus on safe, quality patient/client care
2. Ongoing education and training of health professionals regarding reporting processes and policies
3. System wide, uniform reporting policies and procedures
4. Blame-free culture that fosters openness and transparency
5. Respect for scope of practice, professional autonomy and accountability
6. Inclusive peer review and other review processes
7. Clear, consistent documented processes that articulate roles and responsibilities
8. Focus on continuous quality improvement and learning; not on placing blame
9. Focus on root causes and systems rather than on individual actions
10. Timely feedback and action
11. Involvement of staff in designing processes and in designing remedies for areas of risk
12. Provider support
13. Patient/client support

14. Timely, direct, and ongoing communication of adverse health events and of measure being taken

Proposed Health Quality Council

We have noted that the Task Force on Adverse Health Events will also propose a mandate, structure, and budget for the establishment of a health quality council in Newfoundland and Labrador. In that regard we are offering the following commentary regarding the mandate and membership of such a quality health council.

Mandate:

Promote quality, accountability and transparency of the province's health system through:

- Monitoring the impact of population health approaches to health services investments and system-wide changes, including delivery models, technology, etc.;
- Developing a system of key performance and quality indicators as a basis for assessment, monitoring and reporting;
- Overseeing the development of strategies to restore public trust in the health system including the publishing of an Annual Public Report Card; and
- Facilitating discussion regarding the future development of the health care system to meet the needs of Newfoundlanders and Labradorians.

Membership:

CLPNNL believes the Health Quality Council should not consist of more than 12-15 members. Members should be selected on the basis of their expertise in areas such as research, quality and risk management, communications, and public administration. We strongly believe that members should be non-partisan and have the ability to take a 'whole system' view rather than a specific organizational view. Finally, we believe that there should be substantial public representation, likely constituting 25-30% of the Council's membership.

Conclusion

Open and transparent adverse health event management and disclosure can only exist when a blame-free culture exists at every level of the health system, especially at the work unit level. This culture can flourish when mutual trust, respect and open communication is the norm, when accountability and respect for professional autonomy and scope of practice exists and when organizational support and investments are made that result in visible and present leadership and staff education and training. Health care professionals must receive active support for reporting incidents. Where adverse health events result in harm, both health

professionals and those patients/clients directly affected must know that there will be open and ongoing communication and support that is immediately available to meet patient/client and family needs. Under these circumstances, the potential for achieving timely and accurate reporting of incidents and for reaping the quality benefits of organizational learning and improved safety are immense.

Thank you for the opportunity to provide input into your Task Force deliberations. The CLPNNL would welcome the opportunity to provide additional input as your work continues and we are ready partners as you commence implementation of recommendations.