VitalSmarts, AORN, & AACN present:

The Silent Treatment

Why Safety Tools and Checklists Aren't Enough to Save Lives

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Imagine you are a nurse who has been given a set of new safety tools that warns you whenever your patients are in danger. That would be powerful, life-saving information, right? But what if nobody listened to you or heeded your warnings? This kind of breakdown is happening in hospitals every day. The quote below is one of 681 collected in the course of this research.

> "I think nearly every day we are faced with the hand-off allergy list. Frequently, the surgeons will order an antibiotic the patient is allergic to according to the safety checklist. When the patient is out of surgery, nurses have to call the surgeon, the anesthesiologist, and sometimes even the pharmacist before someone listens. Sometimes, we go ahead and give the drugs anyway, but when you really listen to the patient's story, sometimes that is not the right thing to do."

Poor communication is deadly, especially in critical care settings[1,2]. When communication breaks down in intensive care units (ICU) and operating rooms, the result is catastrophic harm[3,4,5,6] and even death[7,8]. The study examines an especially dangerous kind of communication breakdown: risks that are known but not discussed, or "undiscussables."

It builds on findings from research conducted in 2005 by the American Association of Critical-Care Nurses (AACN) and VitalSmarts[9] as documented in the research *Silence Kills: The Seven Crucial Conversations for Healthcare*.

Silence Kills was conducted immediately before AACN's national standards for healthy work environments were released[10]. It identified seven concerns that often go undiscussed and contribute to avoidable medical errors. It linked the ability of health professionals to discuss emotionally and politically risky topics in a healthcare setting to key results like patient safety, quality of care, and nursing turnover, among others.

The Silent Treatment shows how nurses' failure to speak up when risks are known undermines the effectiveness of current safety tools. It then focuses on three specific concerns that often result in a decision to not speak up: dangerous shortcuts, incompetence, and disrespect. *The Silent Treatment* tracks the frequency and impact of these communication breakdowns, then uses a blend of quantitative and qualitative data to determine actions that individuals and organizations can take to resolve avoidable breakdowns.

Background

When communication breaks down, it breaks down in two very different ways. Business theorist, Chris Argyris ,groups these breakdowns into two categories: honest mistakes and undisscussables[11]. Each category has a different cause, produces a different range of outcomes, and requires different solutions. Honest mistakes include accidental or unintentional slips and errors—for example: poor handwriting, confusing labels, difficult accents, competing tasks, language barriers, distractions, etc. Somehow, the baton is dropped during handoffs between shifts, departments, specialties, or caregivers. Psychologist, James Reason, describes these honest mistakes as the human equivalent of gravity[12]—they are inevitable. So they must be guarded against.

When healthcare organizations invest in improving communication, they usually focus on reducing these

honest mistakes. They implement handoff protocols, checklists, computerized order entry systems, automated medication dispensing systems, and other similar solutions all aimed at doing away with these unintentional slips and errors. These improvements are absolutely essential but they fail to address the second category of breakdowns, the undiscussables.

When people know of risks and do not speak up, the breakdown feels more intentional. Someone knows, or strongly suspects, that something is wrong, but chooses to ignore or avoid it. He or she may attempt to speak up but quits when faced with resistance. It's not a slip or error; it's a calculated decision to avoid or back down from the conversation. Information-based solutions like protocols, checklists, and systems don't do much to solve the breakdowns in this second category. The literature on organizational silence[13],[14] suggests that solving undiscussables will require deeper changes to cultural practices, social norms, and personal skills.

The Silent Treatment examines these calculated decisions to not speak up. It tracks how risks that are known but not discussed undermine many current safety tools. It documents the frequency and impacts of these discussions, and shows how individuals and organizations can make undiscussables discussable.

Study Design and Sample

Two survey instruments were employed: a Story Collector and a Traditional Survey. The Story Collector generated rich, qualitative data; the Traditional Survey produced purely quantitative data.

Convenience sampling was used for both instruments. Members of the AACN and the Association of periOperative Registered Nurses (AORN) were invited via e-mail to participate in the study. The e-mail invitation included an online link that assigned respondents to one of the two instruments. The Story Collector was completed by 2,383 registered nurses, of whom 169 were managers; The Traditional Survey was completed by 4,235 nurses, of whom 832 were managers.

Story Collector: This survey instrument asked respondents to share actual incidents—stories that described times when they were personally unable to speak up or get others to listen. The data obtained through the Story Collector is similar to what researchers otherwise might gather from interviews, but with several differences. First, the Story Collector methodology can reach more people than interviews allow. Second, Story Collector questions are standardized and presented in writing, so interviewer bias is eliminated. Third, respondents write their own responses, so transcription errors are eliminated. Fourth, people generally do not share more than a couple stories in writing—fewer than what a researcher might generate from an interview, so less data is collected from each respondent.

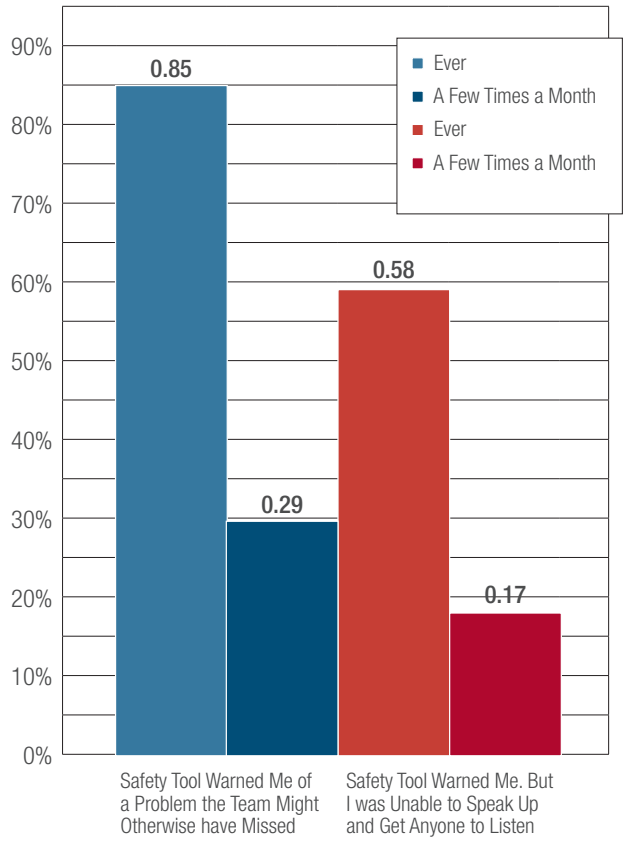
Traditional Survey: This survey instrument was a more traditional Likert-scale questionnaire. It collected quantitative data related to three concerns: dangerous shortcuts, incompetence, and disrespect. Respondents were asked how often they face these concerns within their immediate work group, how they handle these concerns, and how these concerns have impacted patients on their units. In addition, the instrument included questions that explored personal, social, and structural sources that could influence how dangerous shortcuts, incompetence, and disrespect are handled.

Safety Tools and Organizational Silence—Story Collector Findings

The Story Collector listed four survey safety tools that are intended to prevent unintentional slips and errors (Universal protocol checklist[15], WHO checklist[16], SBAR handoff protocol[17], and drug-interaction warning systems). The respondents (nurses) were then asked how often they had been in situations where one of these tools worked—where it warned them of a problem that otherwise might have been missed and harmed a patient.

As noted in the chart below, 85 percent (2,020) of the nurses said they had been in this situation at least once, and 29 percent (693) said they were in this situation at least a few times a month. These results strongly confirm that safety tools work. Operating rooms and ICUs are fast paced, complex, and full of disruptions. Checklists, protocols, and warning systems are an essential guard against unintentional slips and errors.

However, the Story Collector data documented that the effectiveness of these safety tools is being undercut by undiscussables: 58 percent (1,403) of the nurses said they had been in situations where it was either unsafe to speak up or they were unable to get others to listen. And 17 percent (409) said they were in this situation at least a few times a month.



The nurses who indicated they experienced these undiscussables were asked to describe the incident in some detail, and were given the following prompt:

> Please describe a specific incident when a tool warned you about a possible problem, but it was either hard to speak up or hard to get others to listen and act. We want to understand what happened. Please relate this incident as if you were telling us the whole story from beginning to end. What kind of tool/checklist/warning system were you using? What was the possible problem you discovered? Who did you need to convince and collaborate with to solve it? What did you do? How did they react? What made it difficult? What happened in the end? What conclusions did you draw as a result?

Each nurse then rated the incident he or she had described using three dimensions:

- Permanence: Was this experience a one-time event, or is it part of a continuing pattern in how people treat each other in your work environment?
- Pervasiveness: Was this experience isolated to only one part of your work life (for example, experienced with just one physician, one caregiver, one manager, one patient, or one kind of problem) or is it widespread across all areas of your work?
- Lack of Control: When incidents like the one you just described happen, does it feel as if they are out of your control, or do you feel able to solve them or prevent them from happening again in the future?

Using this tool, the study documented 608 incidents, averaging 128 words each. Of these self-described incidents, 8 percent represented patterns that were described by the respondent as permanent, pervasive, and beyond his or her control—what the current study refers to as "triple negatives." Triple negatives represent the kinds of communication breakdowns that systematically prevent safety tools from protecting patients.

All of the triple negatives were high-stakes incidents because they involved a risk to patient safety. Three quarters of the incidents involved confronting physicians, two thirds involved standing up to a group, and half involved disrespect, threats, and anger.

Below are three examples of the triple negative incidents:

- "A special graft was ordered and due to arrive at 10:00. The surgeon insisted the day before he had to have this particular graft. The day of surgery the graft was not yet physically in the building but the surgeon insisted we put the patient to sleep. My stand was that unless you were prepared to use something else we should wait until it arrived. All of our checklists and protocols require that all implants and necessary items are available before the case begins. The surgeon said he would [get the graft] if necessary. I felt we were jeopardizing patient care, setting a poor example to the staff and why do we go through all these things in the first place?"
- "As a cost saving measure, the institution I worked for looked for the lowest priced generic item, so the same medication ordered looked different every time you dispensed it. The bin on the shelf might have four different shaped and colored vials all labeled as the same item. I took one of the administrative safety people through our medication room to show them how easy it was to make an error when no two vials of the same medication looked the same. After that we saw much less substitution and greater consistency."
- "Inserting central line at bedside in ICU. Used checklist but surgeon refused maximal sterile barrier and in fact, ridiculed me and hospital staff for instituting (this precaution) when there is no 'proof' it works. Hospital does not allow RN to stop procedure so it was inserted without maximal sterile barrier."

The incidents above capture the kinds of high-stakes and emotional differences of opinion that occur within operating rooms and ICUs. These differences become dangerous when they become undiscussable.

Three Undisscussables: Traditional Survey Findings

As noted earlier, the 2005 *Silence Kills* study examined seven concerns that often go undiscussed, and linked the ability to discuss these emotional, risky topics to key results such as patient safety, quality of care, and nursing turnover.

The 2010 study examines three of the seven concerns found in the 2005 study, using the same Likert-scale survey items. These three concerns—dangerous shortcuts, incompetence, and disrespect—are not necessarily prompted by any of the safety tools examined with the Story Collector. Instead, they tend to emerge over time, as people observe each other on the job. Findings from non-supervisory nurses who completed the current study's Traditional Survey are summarized below:

1 **Concerns about dangerous shortcuts.**

a. Shortcuts are common.

- 84% work with people who "take shortcuts that could be dangerous for patients (for example, not washing hands long enough, not changing gloves when appropriate, failing to check armbands, forgetting to perform a safety check)."

b. Shortcuts are dangerous.

- 34% say that these dangerous shortcuts have led to near misses.
- 27% say shortcuts have affected patients, but without harm.
- 26% say shortcuts have harmed patients.

c. Shortcuts are often left undiscussed.

- 41% have spoken to their manager about the person whose shortcuts create the most danger to patients.
- 17% have spoken to the person taking the dangerous shortcuts, but haven't shared their full concerns.
- 31% have spoken to the person taking the dangerous shortcuts, and shared their full concerns.

2 **Concerns about incompetence.**

a. Incompetence is common.

- 82% work with people who "are not as skilled as they should be (for example, they aren't up-to-date on a procedure, policy, protocol, medication, or practice or are lacking basic skills)."

b. Incompetence is dangerous.

- 31% say that incompetence has led to near misses.
- 26% say incompetence has affected patients, but without harm.
- 19% say incompetence has harmed patients.

c. Incompetence is often left undiscussed.

- 48% have spoken to their manager about the person whose missing competencies create the greatest danger to patients.
- 11% have spoken to the person, but haven't shared their full concerns.
- 21% have spoken to the person, and have shared their full concerns.

3 **Concerns about disrespect.**

a. Disrespect is common.

- 85% work with people who "demonstrate disrespect (for example, are condescending, insulting, or rude—or yell, shout, swear, or name call)."

b. Disrespect causes problems.

- 46% say that disrespect undercuts respect for their professional opinion.
- 19% say that disrespect makes them unable to get others to listen.
- 20% say that disrespect is making them seriously consider leaving their job or profession.

c. Disrespect is often left undiscussed.

- 49% have spoken to their manager about the person whose disrespect has the greatest negative impact.
- 16% have spoken to the person who is demonstrating disrespect, but haven't shared their full concerns.
- 24% have spoken to the person who is demonstrating disrespect, and shared their full concerns.

Silence Kills: The Seven Crucial Conversations For Healthcare **found that seven categories of conversations are especially difficult and, at the same time, especially essential for people in healthcare to master.** These seven conversations include: broken rules (including dangerous shortcuts), mistakes, lack of support, incompetence, poor teamwork, disrespect, and micromanagement. The study showed that a majority of healthcare workers regularly see colleagues take dangerous shortcuts, make mistakes, fail to offer support, or appear critically incompetent. **Yet the research reveals fewer than one in ten speak up and share their full concerns.**

The data presents a convincing case. Organizational silence leads to communication breakdowns that harm patients.

1. More than four out of five nurses have concerns about dangerous shortcuts, incompetence, or disrespect.
2. More than half say shortcuts have led to near misses or harm.
3. More than a third say incompetence has led to near misses or harm.
4. More than half say disrespect has prevented them from getting others to listen to or respect their professional opinion.
5. Fewer than half have spoken to their managers about the person who concerns them the most.
6. And fewer than a third have spoken up and shared their full concerns with the person who concerns them the most.

The data also shows that nurses are more likely to take their concerns to their managers than they are to speak directly to the person they are concerned about. Since working through the hierarchy is often assumed to be the appropriate way to address a problem, it is important to examine how well this strategy works.

Results from Nurse Managers

The responses from the 832 nurse managers who completed the Traditional Survey were reviewed separately from the non-supervisory nurses. A surprising finding was that managers do not appear to be a reliable path for resolving concerns about dangerous shortcuts, incompetence, or disrespect.

Only 41 percent of the nurse managers reported that they had spoken up to the person whose dangerous shortcuts create the most danger for patients. Equally troubling is that only 28 percent had spoken up to the person whose missing competencies create the most danger for patients, and only 35 percent had spoken up to the person whose disrespect has the greatest negative impact.

The data above comes from the nurse managers, themselves. They admit their failure to address these important patient safety issues. The Story Collector data provides dramatic confirmation from the subordinate's perspective.

- "During the surgical safety checklist, we realized the permit and the scheduled surgery did not match (wrong side). We tried to stop the doctor (plastic surgeon) and he said the permit was wrong. The patient was already asleep and he proceeded to do the wrong side against what the patient had verified, which had matched the permit. We could not get any support from the supervisor or anesthesiologist. The surgeon completed the case. Nothing was ever done. "We felt awful because there was no support from management to stop this doctor. What is the point of having a checklist when it is not consistently followed? We felt absolutely powerless to being an advocate for the patient."
- "A cardiovascular surgeon was putting in an arterial line at the bedside. We have a checklist that must be completed for line placement that includes full barrier, washing hands, etc. The M.D. refused the sterile gown, mask, hat, and drape, and used only sterile gloves. The nurse offered the full barrier again telling him that all lines were put in with full barrier in our unit. He continued with the procedure. The bedside nurse did not feel empowered to stop the procedure. She later took the problem to the unit manager. No action was taken."

This study shows that taking problems to a manager, and assuming he or she will handle them, doesn't produce the kind of immediate and reliable results needed in healthcare.

Differences Between 2005 and 2010 Studies

In general, the results from *The Silent Treatment* 2010 study are in line with the *Silence Kills* 2005 data. But there are a few differences that need to be explained. More of the nurses in the 2010 study have concerns about dangerous shortcuts, incompetence, and disrespect; more have seen patients harmed; and more speak up about their concerns. The authors of the 2010 study believe these differences likely stem primarily from the differences in the two samples.

The nurses in the 2010 study were more likely to come from settings where the job demands and patient acuity are higher: 87 percent work in an operating room, recovery room, ICU, cardiology unit, emergency department, or progressive care unit. The nurses in the 2005 study were randomly selected from 13 participating hospitals, and were more likely to work in medical-surgical units.

When the nurses in the 2010 study were compared to the 2005 nurses who worked in critical care and surgical settings, their levels of concern and patient harm were similar. But there is a hopeful difference in one area.

A much higher proportion of critical care and perioperative nurses speak up in 2010. In 2005, only 10 to 12 percent of nurses spoke up. In 2010, these percentages have improved to between 21 and 31 percent. While these percentages are still unacceptably low, the authors of the 2010 study believe these increases represent real progress and may be due to the increased focus that healthcare organizations have placed on creating cultures of safety.

Resolving Undiscussables—Learning from Exceptional Nurses

Silence Kills found that caregivers who are able to speak up and resolve undiscussables report better patient outcomes, are more satisfied with their workplace, exhibit more discretionary effort, and are more committed to staying in their unit and their hospital.

The findings reported in *The Silent Treatment* show that only a small minority of non-supervisory nurses spoke up when they had a concern related to dangerous shortcuts, incompetence, or disrespect. Only 9 percent spoke up in all three of these situations, and only 14 percent spoke up in two of the three. Given the benefits that come from speaking up, the authors of the current study turned back to the Story Collector data to learn more about how nurses can successfully approach undiscussables.

The literature on positive deviance[18],[19],[20] provides helpful insight into this group of nurses. Positive deviants are similar to their peers in most ways: they have similar backgrounds, work in the same environment, and have access to the same resources. Yet they have found a way to succeed in the very circumstances where most of their peers are failing.

The nurses who spoke up—the positive deviants or exceptional nurses—were asked to share a second story, this time a positive one. They were given the following instructions.

> Please share one other story with us. Think of a time when you made a positive difference by speaking up. This could be a time when others would have let the situation slide, not recognized its importance, or felt unable to speak up—but you did, and it was important that you did. Describe this incident so we can understand the skills you used. Please relate this incident as if you were telling us the whole story from beginning to end. What was the possible problem you discovered? Who did you need to convince or collaborate with? What did you do? What was it that made you effective? What happened in the end? What conclusions did you draw as a result?

Each exceptional nurse then rated the incident he or she had described using the same three dimensions as before: permanence, pervasiveness, and control.

Using this methodology, the exceptional nurses described 284 incidents in detail, averaging 123 words per incident. Twenty-eight percent of the incidents represented patterns that were described by the respondent as permanent, pervasive, and empowering—what the current study refers to as triple positives. These triple positives are the kinds of communication skills that make undiscussables discussable and protect patients from harm.

Like the triple negatives, these conversations were high stakes differences of opinion where emotions ran high. As the exceptional nurses described how they handled these conversations, several patterns emerged. Below are some of the skills and actions exceptional nurses cited as leading to their success:

1 When the issue wasn't urgent, they collected facts, ran pilot tests, and worked behind the scenes.

- "I took the hospital protocol, came up with a worksheet…and included little cheat sheet notes. I had one other nurse use it to start, then I saw what else could improve the worksheet… The form was presented to the staff, and I had many other nurses thanking me."

2 They assumed the best, and spoke up. Sometimes it just takes one person to pave the way.

- "They were opening sterile supplies in one room, covering them, and moving them across the hall to another room. The OR manager knew this was wrong, and stopped the practice after I complained."
- "Staff ratio not safe for acuity of patients. Spoke with charge nurse. She was receptive to talking to administrator. Changes were made to assignment. It

is worth the risk to speak up when patient and nurse safety [are] at risk."

3 They explained their positive intent—how they wanted to help the caregiver as well as the patient.

- "I asked the surgeon if he had made the patient aware that he was in critical condition and that he would struggle to survive the surgery. He said he had not. I then asked if I could make the patient aware for him. The surgeon agreed by saying, 'If you think you can, then go ahead.'"
- "A nurse was teaching a patient about a medication, misread the name of the medication and had not noted the past medical history thoroughly. She was teaching about a condition the patient did not have, and describing a sound-alike medication the patient was not taking. I called [the nurse] to come out of the room and helped her see the error. She returned to the patient and cleared up the mistaken information. By acting quickly and discreetly, I was able to help her and her patient."

4 They took special efforts to make it safe for the caregiver—to avoid creating defensiveness.

- "The surgeon was marking the wrong foot, while talking to the patient about something social . . . I opened the chart to the permit and lightly reminded him we were doing the other foot today . . . Presenting the issue to the surgeon in a nonthreatening manner saved face in front of the patient and made him grateful that I spoke up when I did."
- "[I] described [to a colleague] the potential interaction between an antihypertensive drug and an over-the-counter drug the patient was taking. The colleague had not taken a full history of drug exposures, and was grateful for the reminder, agreed the interaction was important to note, and warned the patient not to take this class of over-the-counter medication."

5 They used facts and data as much as possible, often taking the other person into the actual situation.

- "I brought up the labs on the computer, and had them available to show the doctors . . . I was effective because I had the facts at hand."
- "I asked the surgeon if this contrast medium would be a problem. He brushed it off. I approached the rep who brought in some of the kypho materials needed for the procedure. He thought there may be a problem. The surgeon was approached again. There was no literature available. The surgeon called the radiologist . . . Anesthesia was also consulted. The pharmacy was called. The result was that the contrast was not the same, but that Benadryl was given as a precaution."

6 They avoided telling negative stories or making accusations.

- "A mistake does not mean a bad practitioner . . . not correcting a mistake does."

7 They diffused or deflected the person's anger and emotion.

- "He looked at me and said, 'You've been drinking the corporate Kool-Aid . . . and lost your common sense.' I tried very hard to avoid taking his statement personally, and laughed it off . . . I saw the surgeon in the hallway about an hour later and expanded the joke to include more than Kool-Aid…We both had a laugh."

Two behaviors were notable by their absence in the Story Collector data: none of the exceptional nurses tried to use threats to influence the physicians and other caregivers, and none showed their frustration or anger. These nurses kept their feelings and emotions in check.

The stories the exceptional nurses tell make it clear that skills alone are not enough. Many of the stories show the extraordinary courage it takes to step up to these conversations. When caregivers fail to voice their concerns, it's easy to accuse them of bystander apathy. But apathy is the wrong word. It's more like bystander agony. These exceptional nurses were desperate to speak up, but often believed that voicing their concerns would violate norms, accepted practices, and even rules.

Below are themes that reveal elements that helped these exceptional nurses overcome their concerns about speaking up:

1 They had spoken up sometime in the past, and a patient had been protected.

- "[During] pre-op screening before taking a patient to surgery, I have discovered discrepancies between the consent form and what the patient says. The surgeons never want to go back after their initial visit. I feel very good advocating for the patient. All they have is me and I will not let them down. There is nothing more important than the patient being safe and confident that they understand their procedure."
- "The surgeon . . . was at a dinner party and was very vocal about how much trouble I would be in if he had to come back for no reason. He came back and took the patient into surgery. The leg had occluded. I was never so nervous about the outcome, and was so relieved to have been correct."

2 A patient had already been harmed, and the incident was being reviewed.

- "The patient died five days later. We did an RCA (Root Cause Analysis) on this case, and it revealed that the

multiple surgeons attending this patient had not had any direct communication with one another—just paper consults . . . The VP of Medical Staff . . . was very helpful . . . I also received support from the Chief of Surgery. I felt very supported by the Chief Nurse Executive in helping me go up the chain of the medical staff."

- "Both surgeons and anesthesiologists give Toradol intra-op or post-op . . . but don't always communicate . . . This has resulted in patients receiving double doses. I took this concern to the OR Management meeting, Dept of Surgery meeting, and Dept of Anesthesiology meeting. A new protocol was developed and increased communication in hand off."

3 They had a strong trusting relationship with the person they needed to confront.

- "I was a nurse the surgeon worked with most of the time. Even though he wasn't happy, he trusted my judgment. He is aware that I know the AORN standards as well as the evidence behind practice issues."
- "I think what made me effective was my relationship with the surgeon. I trusted my clinical judgment and experience, and refused to be intimidated by the residents and hierarchy."
- "I have made efforts to introduce myself to staff I do not know. My getting to know others has helped . . . us work as a team."

4 One or more physicians had made it clear that they appreciate it when nurses speak up.

- "I spoke up and stated, 'This patient is fully anticoagulated right now. Do you think it is wise to start a central line when we are okay with PIV [peripheral intravenous] for now?' All the surgeons turned to me and stated, 'Wow, we forgot. Thanks for making a good point.'"
- "[I] asked M.D. to wash his hands before central line insertion. He did it and thanked me in front of the patient for reminding him."
- "I looked closely at the specimen, and informed the surgeon that I did not see an appendix. He came over, looked at the specimen, and confirmed what I saw. He told everyone in the room that's why anyone in this room can speak at any time. Then went back in and took the appendix."

If the goal is to eliminate the communication breakdowns that are fueled by organizational silence, then caregivers need the skills and motivation exhibited by these exceptional nurses. However, individual skills and personal motivation won't be enough unless speaking up is also supported by the social and structural elements within the healthcare organization. The current lack of speaking up is not just a matter of individual initiative; it reflects social norms, organizational policies and practices, and sometimes even formal evaluation and reward systems.

The next section of *The Silent Treatment* study focuses on what organizations can do to create a culture that encourages and enables people to speak up.

Resolving Undiscussables—What Organizations Can Do

Undiscussables represent an entrenched organizational problem. As such, they will require a multifaceted solution[21],[22]. A helpful way to think about this multifaceted solution is to use six sources of behavioral influence[23] as summarized below:

Source 1—Personal Motivation. If it were up to them, would the nurses want to speak up? Does it feel like a moral obligation or an unpleasant annoyance to them?

Source 2—Personal Ability. Do the nurses have the knowledge and skills they need to handle the toughest challenges of speaking up?

Source 3—Social Motivation. Are the people around them (physicians, managers, and co-workers) encouraging them to speak up when they have concerns? Are the people they respect modeling speaking up?

Source 4—Social Ability. Do others step in to help them when they try to speak up? Do others support them afterward so the risk doesn't turn against them? Do those around them offer coaching and advice for handling the conversation in an effective way?

Source 5—Structural Motivation. Does the organization reward people who speak up or does it punish them? Is speaking up included in performance reviews? Are managers held accountable for influencing these behaviors?

Source 6—Structural Ability. Does the organization establish times, places, and tools that make it easy to speak up—for example, surgical pauses, SBAR handoffs, etc.? Are there times and places when caregivers are encouraged to speak up? Does the organization measure the frequency with which people are holding or not holding these conversations—and use these measures to keep management focused on this aspect of patient safety?

Organizations must overwhelm the problem of organizational silence. This requires deploying multiple sources of influence—all aimed at motivating and enabling people to speak up. Research shows that combining four or more of sources of influence can increase success by as much as ten times[24].

The Traditional Survey that was used for *The Silent Treatment* study included a series of questions that measured how many of these six

sources were combined to make undiscussables discussable. For example, the following questions were used to measure Personal Ability:

- People here have the skills they need to intervene without being disrespectful.
- When people here have a concern, they know how to politely get others to stop what they are doing and listen.

The number of sources of influence an organization used predicted the concerns nurses had, the harm they saw, and their intent to leave the organization or profession. The negative correlations in table 1 below are all highly significant. They show that when hospitals employed more sources of influence nurses saw fewer dangerous shortcuts, less incompetence, and less disrespect. These nurses also saw less harm being done to patients and were less likely to consider leaving their organization or profession.

The Magnet Recognition programs[25] and the AACN Beacon Award for Excellence[26] are two national programs that encourage a multifaceted approach to improving patient care.

Although neither program specifically targets all six sources of influence, each requires that a broad range of strategies be employed in combination. The positive correlations in the table below show that hospitals that achieve Magnet Recognition or AACN's Beacon Award use significantly greater numbers of the six sources of influence. See table 2 below.

table 2 Correlations	Magnet Recognition	Beacon Award
Number of Sources of Influence	r = .21 p < .01	r = .20 p < .01

The negative correlations in table 3 below show that these multifaceted approaches are associated with fewer concerns, less patient harm, and lower intent to leave the organization or profession. While many of the correlations are significant, the associations aren't as consistent or as strong as those found with the number of sources of influence. See table 3 below.

The Magnet Recognition Program®, a program of the American Nurses Credentialing Center, recognizes healthcare organizations that provide nursing excellence. It is based on more than a dozen quality indicators and standards of nursing practice as defined in the 3rd edition of the ANA Nursing Administration: Scope & Standards of Practice (2009).

The Beacon Award for Excellence™, a program of the American Association of Critical-Care Nurses, recognizes excellence at the unit level where patients receive their principal nursing care after hospital admission. It is based on criteria in six categories: leadership structures and systems; appropriate staffing and staff engagement; effective communication; knowledge management and best practices; evidence-based practices and processes; and patient outcomes.

table 1 Correlations	Concerns about Shortcuts	Harm from Shortcuts	Concerns about Incompetency	Harm from Incompetency	Concerns about Disrespect	Harm from Disrespect	Intent to Leave Job or Profession
Number of Sources of Influence	r = -.24 p < .001	r = -.11 p < .001	r = -.36 p < .001	r = -.14 p < .001	r = -.35 p < .001	r = -.33 p < .001	r = -.27 p < .001

table 3 Correlations	Concerns about Shortcuts	Harm from Shortcuts	Concerns about Incompetency	Harm from Incompetency	Concerns about Disrespect	Harm from Disrespect	Intent to Leave Job or Profession
Magnet Status	r = -.07 p < .05	r = -.00 not signif.	r = -.16 p < .05	r = -.03 not signif.	r = -.06 not signif.	r = -.04 not signif.	r = -.06 p < .05
Beacon Award	r = -.07 p < .001	r = -.02 not signif.	r = -.12 p < .05	r = -.05 not signif.	r = -.10 p < .05	r = -.08 p < .05	r = -.08 p < .05

Recommendations

The results presented in *The Silent Treatment* point the way toward positive change. When healthcare organizations tackle the silence using a combination of sources of influence, they achieve substantial improvements. Below are recommendations for how healthcare organizations can use this multifaceted approach to create a safety culture where people speak up effectively when they have concerns.

1 Establish a Design Team. Enlist a small team that includes senior leaders, managers in the targeted areas, and opinion leaders among physicians, nurses, and other caregivers. This design team works with all caregivers to identify crucial moments, vital behaviors, and strategies within each of the six sources of influence described below. The design team then provides a few initial strategies within each of the six sources and helps teams in patient care areas select, modify, and create additional strategies.

2 Identify Crucial Moments. There is a handful of perfect-storm moments when circumstances, people, and activities combine to put safety protocols at risk. The design team needs to identify and spotlight these crucial moments so that people will recognize when they are in them. An example of one of these crucial moments is when the surgery schedule is pushed into the evening, and people are in a rush.

3 Define Vital Behaviors. People need to know what to say and do when they find themselves in these crucial moments. These are the vital behaviors that keep patients safe. Examples of vital behaviors used at Spectrum Health include:

- 200 percent Accountability. Each staff member is 100 percent accountable for following safe practices and 100 percent accountable for making sure others follow safe practices.
- Thank You. Staff members make it safe for others to hold them accountable. When they are reminded of a safety practice, they thank the other person and redouble their efforts to keep the patient safe.

4 Develop a Playbook. Safety requires that the vital behaviors be acted on in a highly reliable way—especially during the crucial moments when they are the toughest. The most powerful way to make sure these behaviors are consistently followed is to create a multifaceted influence plan that uses all six sources of influence. This plan is captured in a playbook that can be disseminated throughout the organization.

Departments and individaul patient care areas can use this playbook as the starting point. They may adopt some of the strategies wholesale, modify others, and invent new strategies on their own. But they need to make sure they have a few strategies within each of the six sources of influence.

Below are examples of strategies that fit within each of the six sources.

Source 1—Personal Motivation. The goal is to connect to people's existing values to stimulate their passion for keeping patients safe. The most effective way to make this connection is through sharing personal experiences. The least effective way is to resort to verbal persuasion: data dumps, lectures, sermons, and rants. Examples of sharing personal experiences include:

- Physicians, nurses, and other caregivers tell stories of near misses—times when patients would have been harmed if the safety practices hadn't been followed.
- Physicians, nurses, and other caregivers share examples of times when speaking up saved a patient from harm.
- Physicians, nurses, and other caregivers tell stories of injuries—times when a shortcut might have been taken and no one spoke up, and a patient was harmed.
- Physicians, nurses, and other caregivers meet with patients who have been injured when receiving healthcare to learn about the harm and how it affected the patients.

Source 2—Personal Ability. The goal is to make sure everyone has the skills they need to be 200 percent accountable for safe practices. Design teams make the mistake of assuming people can "just do it." Effective organizations use training, have patient care areas develop their own scripts, and use role-plays that include physicians, nurses, and other caregivers. Examples include:

- Supervisors, managers, and team champions participate in formal training in how to handle high-stakes, emotional differences of opinion[27].
- Patient care areas develop their own scripts. For example, "Doctor, I have a safety concern."
- Patient care areas practice these scripts with the physicians, nurses, and other caregivers they will be holding accountable.

Sources 3 and 4—Social Motivation & Social Ability. The goal is make sure people have the support they need to be 200 percent accountable for safe practices. The mistake made here is to assume that verbal support from management is enough. Effective organizations use both managers and physician champions for each patient care area. Examples include:

- Patient care areas identify the physicians who would make the best champions, and then invite them to join in. Rarely are these invitations rejected.
- Patient care areas discuss and define the champion role. They identify the forms of participation and support a patient care area requires from its champions.
- Champions meet with individuals who challenge the initiative and win them over. For example, they work with people who object to safety practices, to being held accountable, or to holding others accountable, and gain their support.

Source 5—Structural Motivation. The goal is to make sure incentives support safe practices and reward people for 200

percent accountability. The mistake organizations make is to forget that rewards and punishments matter. Effective organizations build incentives into performance reviews, promotions, pay, and perks—and they don't shy away from using punishments when necessary. Examples include:

- Organizations create gift certificates, badges, and other small tokens to recognize and reward people for consistently following safe practices and for demonstrating 200 percent accountability.
- Organizations build safe practices into physician contracts and performance reviews.
- Organizations create a quarterly measure of the frequency with which people practice the vital behaviors area by area. They build a specific improvement goal for this measure into the accountability system of all directors and above.

Source 6—Structural Ability. The goal is to make sure there are places, times, and systems that support safe practices and 200 percent accountability. Effective safety cultures use the principles of organizational improvement to make safe practices and accountability easy and convenient. Examples include:

- Physicians, nurses, and other caregivers review safe practices to make them less cumbersome and more effective.
- Compliance is measured and tracked. These measures include quality as well as consistency, so that safe practices never degrade into box-checking exercises.
- Design teams and patient care areas create cues, reminders, and protocols to make 200 percent accountability safe and simple.
- The organization publishes quarterly data by department to keep attention focused on the vital behaviors.

The recommendations above are a starting point. The goal is to create a playbook that includes crucial moments, vital behaviors, and strategies within each of the six sources of influence. Organizations and teams can then use the ideas within the playbook to create a multifaceted plan that is tailored to their individual situation.

Conclusions

The Silent Treatment details the success and limitations of current safety tools. Most of these tools work by warning caregivers of potential problems. But warnings only create safety when the caregiver who is warned is able to speak up and get others to act. The data in this study reveals that caregivers, including nurse managers, are often unable to accomplish this level of candor. As a result, they either clam up or blow up. They fail to have an influence; and patients are harmed.

This inability to influence extends beyond safety tools. Caregivers are often unable to speak up and resolve their concerns about dangerous shortcuts, incompetence, and disrespect. More than four out of five nurses in this study have these concerns, more than one in four have seen either shortcuts or incompetence lead to patient harm, and more than half say disrespect from others has undermined their ability to take action. Yet less than a third of these nurses spoke up in an effective way about their concerns.

The stories nurses tell about trying to speak up reveal the variety of challenges they face. Three quarters involved confronting physicians, two thirds involved standing up to a group, and half involved disrespect, threats, and anger.

Focusing on the exceptional nurses who do speak up highlights some key skills they employ. They begin by explaining their positive intent; use facts and data as much as possible; make it safe for the other person; avoid negative stories and accusations; and deflect anger and emotion. If every caregiver has these skills, it will go a long way toward resolving the problem of organizational silence.

There is cause for optimism at the organization level. Nurses today are voicing their concerns nearly three times more often than they did just five years ago. This improvement suggests that speaking up is becoming easier and more accepted within healthcare organizations.

Key programs such as the Magnet Recognition Program and AACN's Beacon Award for Excellence have contributed to this progress, most likely because they demand that organizations take a multifaceted approach to improving care. AORN also provides powerful tools—one focused on Just Cultures and another on Human Factors—that can help organizations create a culture of safety. This research shows that explicitly multifaceted approaches, such as the six sources of influence, are the most predictive of success.

There were strong negative correlations between how many of the six sources of influence were employed and the incidence and harm of the three concerns. This means that combining multiple sources of influence all aimed at improving people's ability to speak up is associated with fewer dangerous shortcuts, incompetence, and disrespect, as well as with lower levels of the harm they produce.

Healthcare organizations need to learn from both successful individuals and successful organizations. The communication skills that exceptional nurses already have should become the norm among all caregivers. Healthcare organizations should establish a design team, identify crucial moments, define vital behaviors, and develop a playbook that combines change strategies within each of the six sources of influence.

Together, these approaches will create a safety culture where people who know of or strongly suspect risks do speak up, even when they encounter resistance. Patients can no longer afford to have issues related to their health and safety remain undiscussable.

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The **Association of periOperative Registered Nurses**, representing the interests of more than 160,000 perioperative nurses, provides nursing education, standards, and services that enable optimal outcomes for patients undergoing operative and other invasive procedures. AORN's 40,000 registered nurse members facilitate the management, teaching, and practice of perioperative nursing, are enrolled in nursing education or engaged in perioperative research. **www.aorn.org**

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