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NURSES OF DIVERSE CULTURES' ATTITUDES REGARDING MISTAKE AND NEAR MISTAKE IN THE HEALTH SYSTEM

Gilat Yeganeh COHEN[1], Stefan COJOCARU[2]

Abstract

This article deals with the issue of whether near mistake is a mistake, and what are the feelings of nurses from different cultures about reporting near mistake incidents. Research literature shows that there is knowledge on the subject, but not on the issue that distinguishes between mistake and near mistake. Studies indicate that there is no need to report events that are almost unintentional, so that no harm is done to the patient. Hence, near mistakes are not reported and therefore are not investigated (Reason, 2000). This article shows that the mistake is perceived by the nursing staff as a negative value in view of the negative response from the environment, the fear of punishment and guilt (Gutman, 2001). Additionally, mistakes in the health system are not always caused by a human factor, they are usually influenced by the environment and the conditions under which the nurses work, such as long hours, fatigue, stress and more (Koren, 2003). This article is based on a qualitative study that was written as part of a doctoral thesis on perceptions and feelings of nurses from different cultures about near mistake reporting. In this article I will discuss the difference between mistake and near mistake and the importance of reporting incidents of near mistake.

Keywords: mistake, near mistake, reporting near mistake, organizational change

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Introduction

According to estimates, about 2000 patients die every year in Israel as a result of human error (Rosenblum, 2004). In the United States, about 200,000 patients die every year. Imagine that in Israel every month a plane would explode, while in the US every day a plane would explode. How would you feel? And what would we do about it?

One of the major problems in risk management in the medical world is that not all mistakes and near mistakes are reported. As a result, they are not investigated. There might be many reasons for not reporting, including fear of punishment, uncertainty that the reporting would be beneficial, and lack of tools to cope with the mistake. Examining the cause of mistakes by combining systemic vision will reduce the probability of recurrence of mistakes and increase the desire of medical teams to report mistakes (Greenberg, 2000). In the study of Crigger and Meek (2007), a mistake was defined as an act that caused actual medical harm to the patient, whereas the nurses almost defined it as an act or event that did not cause actual harm. In the study of Uribe et al. (2002), which dealt with the main barriers that motivate nurses to report near mistakes, respondents in this study replied that the barriers to non-reporting are fear of punishment, lack of anonymity, and no harm caused to the patient which indicated that there was no need to report.

Similarly, Wu and others (2008) examined processes of reporting medical mistakes, evaluating reports for near mistakes (defined in the study as hypothetical errors), and reporting near mistakes. The results of the study showed that nurses had a clear tendency to report mistakes that led to patient damage rather than reporting near mistakes. The study also found that in every nursing staff there is a small percentage of nurses who never report near mistakes, despite the potential harm of this lack of reporting. As described in Lois et al. (2013), a supportive organizational culture motivates nurses to a large extent to report, and thus creating a safer work environment. The principle of the program described in the study was to present errors as points for improving processes within the organization, conducting surveys and feedback within the teams, making long-term feedback to hospital administrators, and so on. According to Conerley (2007), these improvements made it possible to neutralize the existing barriers in the process of reporting medical mistakes and near mistakes.

This article is based on part of a qualitative study written as part of a doctoral thesis on the attitudes, perceptions and feelings of nurses from different cultures about reporting near mistake incidents in the health system. The objectives of the study were to examine the perceptions and feelings of nurses from different cultures about reporting near mistakes, to raise awareness of reporting near mistakes among nursing staff, and to build a reporting model for near mistake incidents.

Methods

The study population consisted of 20 nurses from different cultures (Jewish, Arab and Russian culture) and from various departments in a hospital in northern Israel. Semi-structured interviews were conducted. The interviews were recorded transcribed verbatim. Then, the respondents received a "near mistake" workshop that was built by the researcher. Two weeks after the workshop, the respondents were interviewed again using semi-structured interviews in order to ascertain their views about reporting near mistakes. Two focus group discussions were conducted, one consisting of nurses from Jewish culture, while the other group consisted of nurses from different cultures, Jewish, Arab and Russian. Content analysis was conducted in order to make sense of the data collected through the semi-structured interviews and the focus group discussions. It is worth noting that the research has been a nurse for 29 years, and five years prior to the workshop had gone through a near mistake workshop.

Findings

Table 1. The categories that emerged from the content analysis

Category 1: Definition of "near-mistake":	Category 2: Definition of "mistake":	Category 3: Cases of "near-mistake":
"A near-mistake is an incorrect action that is carried out and we manage to detect it and stop it mid-way and no harm comes to the patient."	*"By mistake - there might be harm or not, but the action has been done already."*	*"The doctor gave an order to give Optalgin to a patient who is sensitive to Optalgin."*

The definition of the concept of "mistake" in all nurses of all cultures depends on the final product, that is, whether the process or act is fully completed and whether the patient is harmed. The common denominator of all cultures is that the act is done, the process is not stopped, and in most cases the patient is harmed. Additionally, the definition of the concept "near mistake" is perceived as a process dependent on culture but the common denominator is that near mistake is a mistake in the process which was avoided and did not cause harm to the patient. Most cases of near mistake raised by the interviewees from all cultures are drug events and patient identification. These events are not culture-dependent but dependent on exposure to cases, the exposure can be personal or in other staff members, nurses and doctors.

The main factors that recruit the reporting process

One of the main findings of the study presented lies in a different response of nurses following a near mistake discovery, which seems to have been largely influenced by ethno-cultural affinity. It can be seen that in the Jewish and Arab ethno-cultural groups the interviewees spoke of fear. Fear of punishment, fear of harming self-image and professionalism as a nurse, and the associated shame were revealed as berries to reporting near mistake incidents. At the same time, in the ethno-cultural Russian group the respondents spoke more about bureaucratic issues and the lack of time required to write long reports. Fewer feelings were cited as factors that prevent reporting. Anger and helplessness were mentioned as a reversal of joy when the mistake was denied.

In any case, the above responses reflect a strong desire of nurses for a positive solution of mistake or near mistake problems, reflected by descriptions of the time and effort they spend in identifying the cause of failure in performance and trying to do so correctly. These findings added to the literature on the nurses' response to errors and proved an unknown stage in the management of nursing errors. Previous studies also claimed that without feedback on mistakes and near mistakes made at the nurses' level, organizational learning cannot be achieved from mistakes and near mistakes.

The significance of reporting

One of the most interesting findings obtained during the proposed study matches the differences in interpretation of near mistake reporting. Thus, representatives of the Jewish ethno-cultural group believed in the growing need to report a near mistake, while the representatives of the ethnic-cultural group in Russia saw a great difference between reporting near mistake and reporting a mistake. This difference clearly indicates the different interpretation of the near mistake events with uncertainty about its location within the clinical routine or within the implementation failures. Moreover, all respondents without exception believed in the importance of reporting on near mistake events, as these events can provide significant value for learning and minimizing future treatment failures. This is the most obvious experience of learning from mistakes and is generally consistent with the literature on clinical learning and clinical judgment. The proposed study participants agreed that sharing the mistakes discovered is fruitful and promotes further learning in the organization and thus represents some importance for them. Despite this fact, such sharing of information about the mistake is not done.

Discussion

A near mistake is perceived as a failure to implement, a cultural issue within the framework of the social and cultural affiliation of members of the organization. Identifying and recognizing the mistake is a key element in shaping the professional identity of the nurses. The intention of reporting a near mistake is influenced by the culture of the members of the organization and their positions regarding the values of the profession and the implications of reporting on the professional future of the nurse. Reporting a near mistake is perceived as dependent on the level of risk that the patient may be exposed to the near mistake. Reporting a near mistake is an opportunity for personal and collective learning within the organization. The main factor predicting the implementation of both medical error reports and near mistakes involves the aspect of organizational learning that leads to organizational change and the non-recurrence and prevention of other errors. Reporting near mistakes was perceived as an opportunity to improve treatment and safety of the treatment.

The reasons for not reporting near mistake events are influenced by and accompanied by feelings that are largely influenced by the ethno-cultural affiliation of the reporter. The feelings accompanying the reporting of the mistake are affected by the desire to provide quality treatment and the desire to assess the source of the mistake. Psychological barriers such as fear and anxiety affect the organization's reporting culture. The management's support in carrying out investigations on a near mistake is a tool for developing an organizational safety culture. Investigation of near mistake events leads to changes in organizational work processes. Information sharing is essential for organizational learning as indicated by Benn et al. (2009).

However, organizations control the nature of the shared information (Benn et al., 2009) on significant differences between the feedbacks mechanisms employed in the different reporting systems. The reporting systems vary in both the preliminary responses to the reporting errors and the speed of the intervention following error reporting. The persistence of the excellent psychological barriers and their impact on reporting indicate the difficulty of trying to change the reporting culture in the organization. Lawton and Parker (2002) attempted to provide an empirical evidence of how the accusatory culture that developed within the health system could actually determine the anxiety expressed by doctors and nurses about being accused or punished in the context of an error. These authors found that all respondents showed equally fear of punishment for mistakes and continued to think that fear of guilt was related to the culture of the workplace, which ultimately led to a lack of reporting the error. Interestingly, these results cover only some of the findings found in the proposed study.

As noted, the fear of punishment was unique only to the Jewish and Arabic ethno-cultural groups, while the representatives of the ethno-cultural group of Russia experienced anger and disappointment. The implications of this finding are that the culture around error reporting may be well mediated by the reported ethnographic component.

Conclusion

Fear of low self-esteem, fear of punishment, and a long reporting process are the main causes of mistake and near mistake reporting. Collective dynamics have a significant influence and connection with the consolidation of nurses' professional identity. It appears that the nurses' professional performance is closely linked to processes, such as developing collective standing and promoting organizational learning, and as such provides a place for the consolidation of the professional identity of nursing. This relationship is particularly evident in the presence of a strong emotional background, influenced by the ethnographic components of the social identities of the nurses, which inevitably affect the behavior of the nurses, as part of a collective. Learning from near-mistakes rarely occurs at the corporate level. Therefore, the organization management's support for reporting near mistakes and mistakes, lack of punishment and blame, providing feedback on reports, a short reporting mechanism, and workshops on all employees in the organization will lead to increased reporting and organizational learning.

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