

UNSAFE NURSING PRACTICES

& WHAT YOU CAN DO ABOUT THEM

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A study conducted a couple of years ago in over 100 California hospitals showed that certain unsafe nursing practices were common. They may, in fact, have caused many nurses to become disillusioned and leave the profession.

The employment scene has changed in the state since then, but the need to watch for such practices is still as great. Wherever you practice, you can benefit from this eye-opening research...and help improve the quality of care.

IS PATIENT CARE—and patient safety—deteriorating? Three years ago, several California nurses who'd left their hospital jobs told us they'd left because patients were endangered by unsafe nursing practices.

We wondered how accurate their criticisms were. Was nursing care as bad as they described?

To find out, we decided to study actual nursing practices.

Designing the study

Based on the nurses' complaints, we made a list of 27 unsafe nursing and management practices that fit into four general categories:

1. Medication management
2. Nurse-patient relationships
3. Unit leadership
4. Management policies.

We deliberately limited our study to:

- nursing practices we felt any nurse would recognize and stop
- management practices we were sure no hospital would routinely permit.

Choosing our research team

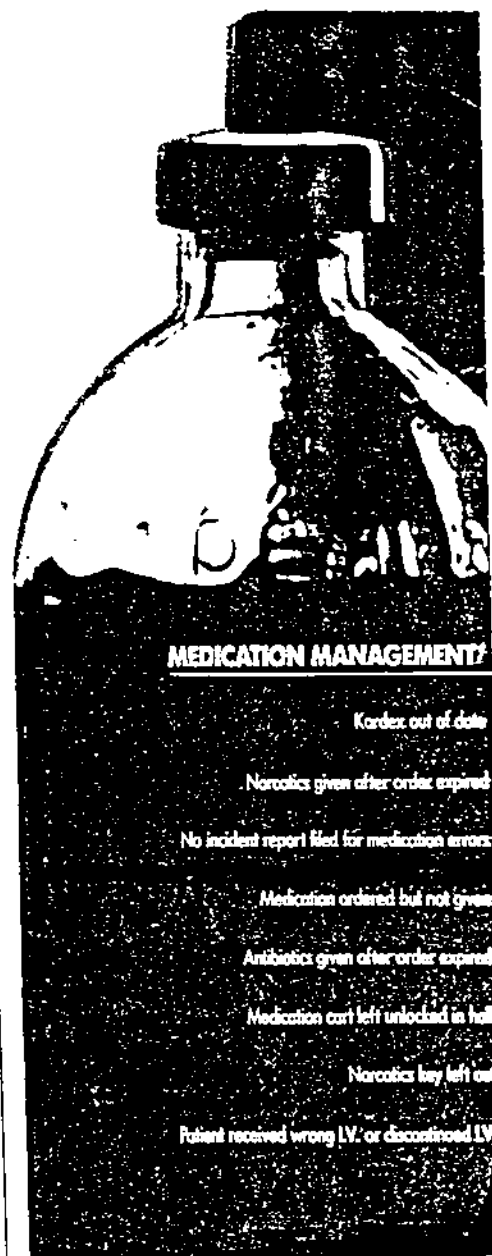
Twenty-five skilled, concerned nurses did the field work on our study, collecting data for nearly a year. Nineteen of them worked for registries, which gave us access to a great many hospitals.

For 50 weeks in 1980 and 1981, they observed nursing practices in 110 California hospitals and collected data on 1,150 shifts.

In every hospital, nursing managers supported our doing the study. As a professional courtesy, we told supervisors and directors of nursing about the study before we collected data at their hospital. All of them

were pleased to be part of the study and said they hoped our results would help their administration identify problems. They agreed not to bias the study by telling staff nurses about it.

For the same reason, our observers didn't mention the study unless staff members questioned them. When that happened, our observers explained exactly what they were doing and reassured them that we wouldn't show our specific observations to the administration or nursing service. Thus reassured, staff members also supported the study. Like their supervisors, these nurses said they were glad we were taking a look at dangerous nursing practices.



MEDICATION MANAGEMENT?

Order out of date

Narcotics given after order expired

No incident report filed for medication errors

Medication ordered but not given

Antibiotics given after order expired

Medication cart left unlocked in hall

Narcotics key left out

Patient received wrong IV or discontinued IV

We kept our promise to protect everyone's confidentiality. We identified each observer and hospital by code number. We didn't tell our observers the names of other observers or the names of other hospitals being studied.

Results showed widespread problems

As the accompanying graphs show, we found that many of the 27 unsafe practices were common.

Many occurred on more than half of the shifts we observed. Some occurred on all the shifts.

Actual occurrences were probably more common than our study showed. For one thing, our research

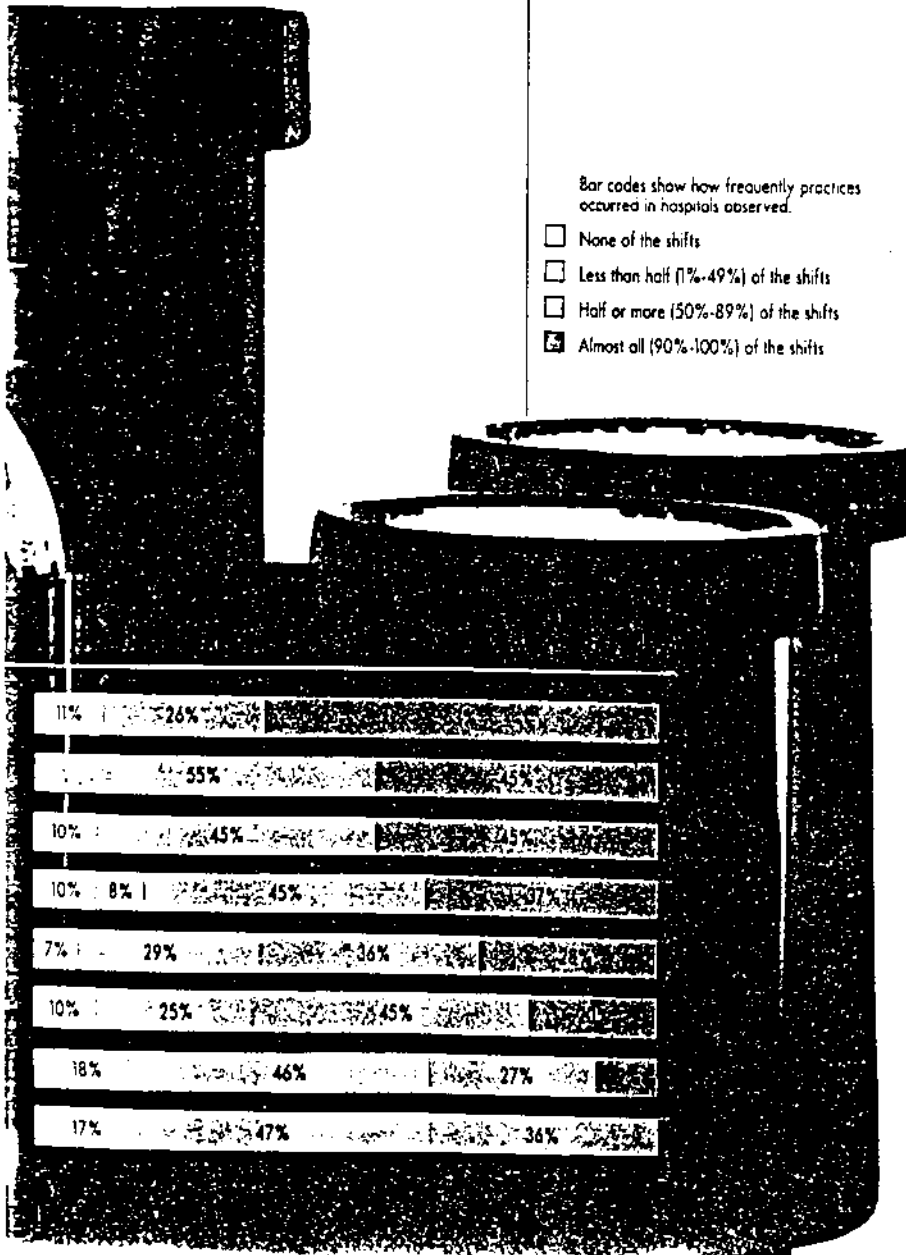
nurses were too busy with their own duties to observe all the time. For another thing, we recorded each behavior simply as occurring—or not occurring—on each shift. Even if a behavior occurred several times on a shift, it showed up in our results as a single occurrence.

Dangerous medication practices were common

In 63 percent of the hospitals, Kardexes weren't kept up to date on almost all shifts. (For brevity, we'll use the term "almost all shifts" to mean 90 to 100 percent.) This tardiness certainly provided the potential for medication errors. And we found a startling number of examples.

Bar codes show how frequently practices occurred in hospitals observed.

- None of the shifts
- Less than half (1%-49%) of the shifts
- Half or more (50%-89%) of the shifts
- Almost all (90%-100%) of the shifts



Narcotics were improperly given on many shifts. For example, narcotics were given after the narcotic order expired on at least half the shifts in every hospital we observed. Some patients received narcotics for many days after the order expired. (Our statistics don't include any cases in which nurses—out of concern for a patient in pain—knowingly gave a narcotic after the order expired.) The observers suspected that nurses habitually gave medications without checking expiration dates on the orders. In other cases, they thought nurses didn't know when narcotic orders had to be renewed.

These and other medication errors should have been reported as incidents. But they rarely were. Such errors were consistently reported in only 10 percent of the hospitals. In 45 percent, incident reports weren't prepared for reportable errors that occurred on almost all shifts. In some cases, charts were falsified to cover up the mistakes.

In 37 percent of the hospitals, our observers found failures in giving prescribed medications on time on almost all shifts. Most of these hospitals had the unit-dose system. And the pharmacy usually caused the delay.

The delay sometimes had far-reaching effects: The nurse usually had to spend time repeatedly contacting the pharmacy, trying to get the medication. During this time, she got behind in her own duties. Later, she had to hurry through them, increasing the likelihood that she'd make mistakes.

In 28 percent of the hospitals, antibiotics were given after the order expired on almost all shifts. In another 36 percent of the hospitals, they were given after it expired on at least half of the shifts.

In 20 percent of the hospitals, the medication cart was left unlocked and unattended in a hallway on almost all shifts.

In 9 percent of the hospitals, the key to the narcotics drawer or cabinet was accessible to everyone on almost all shifts. In another 27 percent of the hospitals, it was left out on half or more of the shifts.

In 36 percent of the hospitals, patients received the wrong intravenous (I.V.) fluids or continued to receive I.V. fluids that weren't ordered on over half of the shifts observed.

Inappropriate nurse-patient relationships were common

Observers noted inappropriate (sarcastic or silly) behavior on almost all shifts in 65 percent of the hospitals. Our observers jotted down comments like these:

- When a patient asked for juice: "What do you think this is, a hotel?"
- When a patient asked for something for a headache: "How about a hammer?"

Such remarks weren't common, but in none of the hospitals were all nurses consistently polite and caring toward patients.

Observers saw nurses who simply put off answering the call lights. They saw many patients who were clearly intimidated by their nurses and who felt guilty asking for care.

In 36 percent of the hospitals, on almost all shifts, at least one *newly admitted* patient had to wait for staff attention for over 30 minutes. (This was a problem particularly at change of shift.) In these cases, no one checked vital signs, gave any care, or brought water or a food tray.

The reason for these practices?

These practices probably weren't deliberate, of course. We interviewed nurses who left their jobs because of such practices: They say nurses get frustrated, then take the frustration out on their patients.

They say some of the practices occur because constant stress makes nurses feel they've lost control over the situation. Feeling out of control, they become mechanistic in their work—operating out of habit, not analyzing their choices and the consequences of them.

Examples of poor unit leadership

Poor leadership was the rule rather than the exception in the units we observed. Many head nurses and team leaders seemed unaware of the importance of assessing their staff's strengths and weaknesses, getting an overview of the unit's problems, then making careful assignments to correct them. Some examples of the problems we saw:

- *No walking rounds.* Initial walking rounds were always done in only 11 percent of the hospitals we observed. In the rest of the hospitals, nurses got to their assigned patients as soon as they could.

- *Delayed report.* We considered a report delayed if it started more than 30 minutes after the shift started or if it lasted more than 30 minutes. Both conditions might increase the likelihood that medications and other treatments would be delayed.

In 17 percent of the hospitals, report ended late on almost all shifts.

- *Unclear responsibility.* On every shift, in every hospital, our observers noted the charge nurse's failure to review the team nurse's or primary

nurse's responsibilities—or to define terms used on the unit—to float and registry nurses. As a result, role confusion was common.

- *Unclear assignments.* In 36 percent of the hospitals, nurses left report on almost all shifts uncertain of their patient assignments.

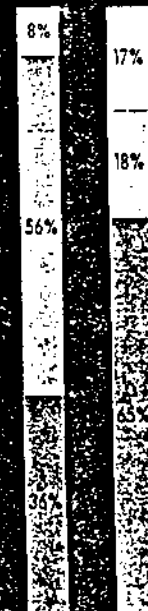
- *Incomplete report.* Observers also evaluated the completeness of the report given on

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NURSE-PATIENT RELATIONSHIPS

Patients left inappropriate waiting orders, response to patients, admissions



each patient. Did it include all the vital information the oncoming nurses needed—such as new orders, laboratory results that affected treatment plans, changes in condition, and special treatments for the day?

In all hospitals, reports were considered inadequate on half or more of the shifts. In 72 percent of the hospitals, they were inadequate on almost all shifts.

- *No assessment of float or registry nurses' skills.* Charge nurses and team leaders rarely asked pool nurses, float nurses, or registry nurses even the most basic questions about their skills. Such skill assessments were routinely done in only 10 percent of the hospitals.

- *Ill-considered assignments.* Patient assignments were often made randomly, with no effort to match patients' needs with nurses' skills.

In 27 percent of the hospitals, head nurses failed to assign the most difficult patient to the most skilled nurse on almost all shifts, according to observers' judgments.

Sometimes patients requiring a great deal of care were assigned to the nurses least likely to complain—registry nurses who'd be on the unit for 1 day only, for example. "Easier" patients were assigned to nurses who did complain.

In some hospitals, charge nurses posted assignments instead of giving them verbally. Our observers suspected that some of them chose this practice to avoid being confronted by staff nurses unhappy with their assignments.

- *Changed assignments.* Changes in assignments after the shift starts obviously increase the risk of confusion, frustration, and interruptions or delays in patient care. Despite these negative results, 47 percent of the hospitals changed assignments on almost all shifts observed.

Examples of poor management policies

Nursing administration policies apparently contributed to unit leaders' difficulties:

- *Unqualified nurses temporarily assigned to the unit.* In 82 percent of the hospitals, almost all shifts contained at least one unqualified nurse. These nurses were pulled from other units or called in from registries despite their lack of experience in caring for patients on the unit.

- *Unfamiliar charge nurses.* Some 38 percent of the hospitals regularly used registry nurses as charge nurses, even though these nurses couldn't know the individual skills and experience of the nurses they took charge of.

- *Majority of staff from a registry.* To make the charge nurse's task even more difficult, a third of the hospitals had to fill in over 50 percent of a unit's staff with registry nurses on almost all of their shifts. And another factor: In 28 percent of the hospitals observed, the entire staff on a given unit was composed of registry nurses on at least half of the shifts. (Note: Most California hospitals are no longer using such high



"I believe new approaches to tough situations should be firmly based on research findings," says Genevieve Clavreul (right). "And I gain great satisfaction from producing viable solutions to the difficult situations health care institutions go through during their growth cycles."

Clavreul started learning about health care problems as a licensed vocational nurse. She's worked as a head nurse, assistant director, and director of nurses. She has also taught others solutions to health care problems in three stints as a college professor.

Her business partner, Sue Caviness (left), is a psychotherapist in private practice. Formerly a college instructor, Caviness has a doctorate in social psychology. She has an extensive background in medical sociology.

Clavreul and Caviness combine their expertise to design and conduct research studies in health care facilities, then provide seminars and group counseling to resolve the problems they uncover. Their company, Clavreul-Caviness Management Consultants, is in Los Angeles.

percentages of registry or agency nurses. So this problem may not be as acute as it was when our study was done.)

- *Inadequate orientation.* Despite guidelines from the Joint Commission on Accreditation of Hospitals (JCAH), few hospitals provided orientation for registry nurses. In 72 percent of the hospitals, on almost all shifts, registry nurses were expected to start working without understanding the hospital's philosophy or knowing the location of supplies, emergency equipment, or diagnostic departments.

- *Mixed systems of care delivery.* Providing good patient care was complicated by many hospitals' practices of mixing functional nursing, team nursing, and primary nursing on the same unit.

In units where this occurred, observers reported confused lines of authority and responsibility. On over half the shifts in all hospitals, team leaders also acted as a primary nurse to one or two patients. Confusion—and mistakes—resulted.

- *Mixed nursing schedules.* Patient care also suffered when hospitals used a mixture of shift lengths on the same unit. In units that mixed 8-hour, 10-hour, and 12-hour shifts, the nurses spent more time in report, which took time away from patient care.

Nurses sometimes became confused about patient assignments when shifts overlapped. When this happened, some patients got lost in the shuffle.

This was a particular problem on 3-to-11 shifts. Some patients weren't assigned to a 3-to-11 nurse when the 10-hour and 12-hour people went off duty at 5 p.m. and 7 p.m.

- *Careless screening of outside nurses.* Finally, many hospitals showed a disturbingly careless attitude in checking out registry nurses. Only 35 percent of the hospitals routinely requested proof of licensure from registry nurses. And only 18 percent asked for a driver's license or other identification!

Why were these practices so common?

Our experience as nurse consultants for several hospitals suggests several likely causes of these problems:

- *The nurses didn't realize the practices were wrong.* This is probably

the *least* likely explanation for most of the poor practices we observed.

For one thing, we deliberately chose practices that discontented nurses had described to us. And we have no reason to believe those nurses knew more than the nurses who've kept working.

For another thing, we saw a disturbing pattern in some of the hospitals during our 50-week study. During this time, several hospitals were surveyed by JCAH. During the JCAH survey, hospitals with severe nursing problems would "clean up their acts." After the survey, they'd revert to their former practices.

• *The nursing shortage made good practices impossible.* The shortage clearly played a role in many of the hospitals we observed during our study, although today this problem is less severe. Instead of closing units that had inadequate staffing, hospitals would pull nurses from another unit. This occurred in almost all of the shifts in 80 percent of the hospitals.

These nurses were sometimes unprepared for the work of the unit. Many were angry and frustrated at being pulled. And some took out their anger on the patients.

Staffing shortages probably directly led to some of the practices we observed. For example, leaving the narcotics key out or leaving the medications cart untended in the hall were possibly considered short-term solutions in some understaffed units.

• *Nurses were poorly prepared for leadership positions.* Our study showed that many unit leaders didn't seem to know how to organize an effective unit, how to communicate to their staff, how to assess nurses' strengths or patients' relative needs, or how to distribute work loads.

In our work as management consultants, we frequently see such problems because nurses haven't had adequate management training.

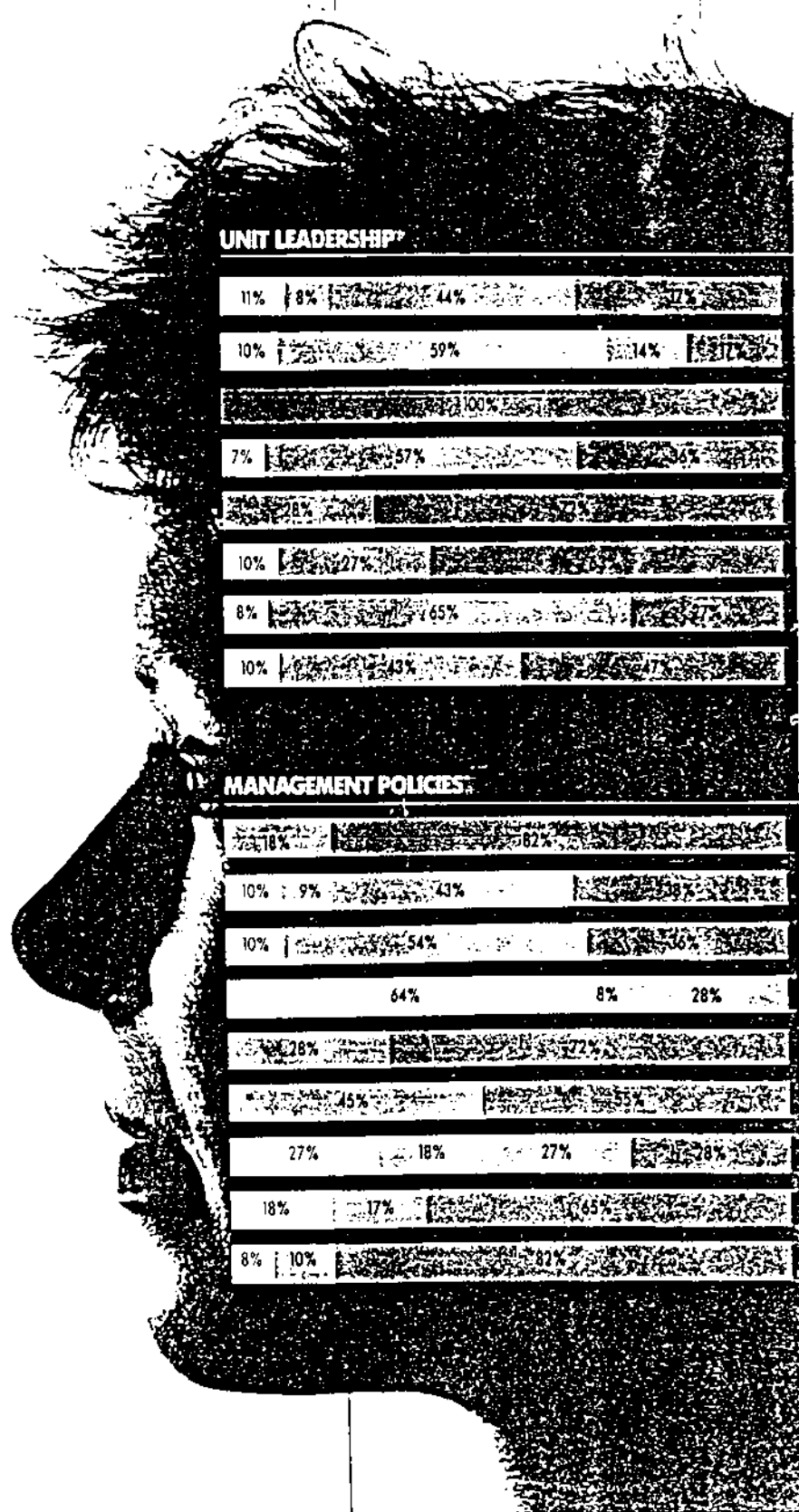
• *The practices arose out of frustration and poor morale.* In a 1980 survey report, Lynn Donovan (*RN*, June 1980) reported that 92 percent of nurse respondents rated a sense of achievement as a very important goal, but only 32 percent felt they'd achieved that goal. Of course, your *feeling* of achievement is related to others' *recognition* of your achievements. Some 45 percent of nurse respondents in that 1980 study said

recognition was poor from their administration.

What happens when the goal of achievement is frustrated over and over? Our studies and others show that some nurses leave nursing. Oth-

ers quit setting goals. They're the nurses who eventually burn out, who quit caring because caring hurts too much.

Psychologists also know that motivational patterns can change as a de-



fense against frustration. And that brings us to our next theory.

- *Nurses need social approval more than they need achievement.*
Nurses

we interviewed in a 1981 study were more motivated by the need for social approval than by the need for achievement. These goals may have shifted because the nurses' need for

achievement was frustrated for so long. Whatever the explanation, a strong need for approval could explain some of the leadership problems we observed.

Unit leaders and staff nurses who have a strong need for approval are less likely to report incidents, make unpopular patient assignments, and require excellence from the staff they supervise.

Some proposals for better patient care

We hope that you'll see our results as a challenge—not as a disparaging look at nursing. We've discussed some serious problems here because they need to be examined.

We need to analyze why they occurred and whether they're symptomatic of larger problems. Then, we need to figure out a better way to handle them.

How can you meet the challenge?

Here are some tips:

- *Look at your own unit in terms of the 27 problem behaviors we looked for in our study.* Which ones do you need to work on? Which must your administration solve?
- *Document the problems, and communicate your findings—to your peers and your supervisors.* Make your comments objective and impersonal to reduce the chance that others will reject your results.
- *Try to analyze why the problem behaviors developed.* Are they attempts to solve other, more basic problems? Are they the consequences of other problems? Or are they poor practices that developed gradually because no one corrected them?
- *Tell your nursing administration what support you need. And offer support to those you supervise.* We've seen dramatic changes in hospitals that provided management training for their nurses—and encouraged the nurses to use management skills. Hospitals that had apathetic, frustrated staffs who displayed many of the undesirable behaviors turned into motivated, professional organizations when communication and support increased.
- *Encourage others to change by changing your own behavior.* You can be not only a good nurse, but a good role model as well.

Initial rounds omitted:

Report delayed at least 30 minutes:

Patient care responsibilities not defined:

Nurses unaware of assignments after report:

Inadequate information given at report:

Registry nurses' skills not assessed:

Patients not assigned to most qualified nurses:

Patient assignments changed during shift:

Unqualified nurses pulled from other units:

Registry nurse put in charge of unit:

Most of unit staffed by registry nurses:

Unit entirely staffed by registry nurses:

Inadequate orientation:

Mixed systems of nursing care delivery on the unit:

Mixtures of nursing schedules used on the unit:

Registry nurses not asked for licensure:

Registry nurses not asked for identification:

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