The Ultimate Never Event:

Nursing Advocacy

When it Isn't Easy

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The Ultimate Never Event

The participants will be able to:

- ✓ State the ethical and legal requirements concerning nurse advocacy for patients
- ✓ Identify situations that can challenge nurse advocates
- ✓ Analyze measures to facilitate effective nurse advocacy for patient safety

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- *To Err is Human* (IOM, 2000) brought to the forefront the fact that health care systems were causing 100,000 deaths of patients due to errors and mismanagement of care.

- *Keeping Patients Safe* (IOM, 2004) addressed the environment in which nurses work and identified factors that were essential to making that environment safe for patients.

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- *Keeping Patients Safe* highlighted the concept of Culture of Safety and Just Culture
- Health care environments traditionally have been such that people looked the other way taking the position that "bad things will happen" and fear of retaliation if the issue is raised

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- A **Culture of Safety** is an environment where all persons from the top leadership to the least personnel are focused on safety
  - Top down and horizontal
- A **Just Culture** is one in which persons feel free to identify problems without fear of retaliation

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- In the healthcare system, nurses must negotiate – an invisible skill …. or manipulate
- Nurses have to manage the context of patient care, coordinating the services of many people
- The nurse negotiations are most often not recognized or valued

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- This negotiation almost always occurs at an uneven table*
- The great majority of nurses are women and the great majority of administrators and physicians are men
  - Covert and unacknowledged power relationships
  - Control and turf issues
  - Devaluation of nursing knowledge/contribution
  - Rewards for accommodation, not confronting issues
- Phyllis Kritek in Renegotiating Health Care. (1995). Jossey-Bass.

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- Hospital Culture
  - Bottom line issues: sources of income:power
  - Leadership/reporting relationships
  - Licensure and accreditation
  - Regulations: DSHS, CMS, TJC
    - Patient Safety Committee
    - Physician Peer Review
    - Nursing Peer Review
    - Nurse Staffing Committee/Safe Harbor

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- The negotiations for patient safety must be exercised in a Culture of Safety and a Just Culture
- Nurses must be recognized for their knowledge of patient care and advocacy for patient safety
- Systems must be in place to respond effectively to identified threats to patient safety or quality of care

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- How problems arise
  - The system ignores red flags
  - Politics and relationships trump patient safety
  - Excursions outside the normal channels
  - Failure to establish and follow policies
  - Communications issues/overreaction
  - Retaliation in spite of public interest, laws, and ethics

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- The Texas Nurse Practice Act requires that licensed nurses report any threats to patient safety regardless of facility policy or physician orders
  - Lunsford case (1983)
- The ANA Code for Nurses clearly states a nurse's duty to act on concerns about patient safety or quality of care

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- Systems start with the leadership (Governing Board and leadership staff) who must act on patient safety/public interest
- All staff must be free to expressed concerns that are then addressed

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- What went wrong in Winkler County?
  - The nurses followed the appropriate chain of command meeting with the Chief of Medical Staff and the Administrator- No action forth coming
  - External medical peer review was stopped
  - Hospital policy established that no external reports be made without approval of the administrator (violation of hospital licensing law)
  - Patient safety in the hospital and Rural Health Clinic continued at risk

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- As required by law and ethics, three nurses filed reports concerning patient safety with the Texas Medical Board consistent with the law
  - The TMB is HIPAA exempt – consent to release personal health information not required
  - The TMB is responsible for investigating a report to determine if a violation of the MPA exists

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- When a report is received, the TMB contacts the physician in a confidential notice that a complaint has been received.
- The physician is asked to provide information for the TMB's confidential investigation
- Most complaints, upon TMB investigation, are found not be a violation of the MPA or TMB rules and are dismissed

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- If a concern is identified, the TMB will informally resolve the concern or conduct an informal settlement conference, and dismiss the case or offer a Board Order
- If a Board Order is offered and refused, the matter goes to a public hearing by the SOAH
- The TMB is not bound by the SOAH recommendations

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- What happened in the Winkler County case?
  - The physician shared the TMB confidential notice with his friend the Sheriff
  - The Sheriff mislead the TMB to believe he was investigating the physician and secured otherwise confidential information from the TMB
  - The patients in question were interviewed by the Sheriff causing distress and misunderstandings
  - The press and everyone overreacted

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- Continued:
  - The sheriff confiscated the nurses computers and confirmed the source of the report
  - The administrator fired the two hospital employed nurses (against hospital licensing and other whistleblower laws)
  - The District Attorney filed criminal charges against the two hospital nurses (dropping charges against one of the nurses)

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- The case went to trial in February 2010 and the jury found the nurse, Anne Mitchell, "Not Guilty."
- The nurses settled a civil suit out of court
  - It was never about money
  - They did what nurses are required to do
  - They should **never** have been retaliated against
  - They should have been rewarded for patient safety concerns

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This "Never Event' should never have happened!

- How can similar events be prevented?
- Who has responsibility for ensuring that patient safety issues are effectively and appropriately addressed?

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- Governing Boards and leadership must be held accountable to the law and regulation, professional standards of care, and ethics concerning patient safety
- Hospitals must use external medical peer review to ensure objectivity in reviews and respond to findings and recommendations

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- A Culture of Safety and Just Culture must be established in all health care settings by the leadership and for all staff
- Nurses must be encouraged and rewarded for reporting concerns of threats to patient safety and quality of care
- Nurses should participate in the TNA Nurse Advocacy Program and other leadership opportunities

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- Hospitals should pursue Magnet ® and Pathway to Excellence® programs:
  - CNO educational preparation
  - CNO reporting directly to CEO
  - Zero tolerance of abuse
  - Nursing self-governance
  - Performance improvement
  - Midlevel training
  - Life-work balance

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- We must strengthen the laws to protect Whistleblowers
  - Legislators, health professionals, public servants, and the public in general
- Recognize/reward situations where any health provider has addressed patient safety or quality of care issues
  - Promote accountability and responsibility for patient safety and quality of care

Laws passed in Texas 2011

- Extended criminal liability immunity for mandated reporting
- Increased licensing agency fine for retaliation to $25,000 per incident
- Provided a definition of "good faith" per Texas Supreme Court (eliminates "intent" issue)
- Protections for new Nurse Advocacy role
- Extended non-retaliation protections where one nurse advises another nurse about reporting and advocacy
- Provided limited waiver of sovereign immunity for publically employed nurses

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- Provide for Negotiations at Even Tables
  - Governing Boards, leadership and staff
  - Recognize nurses' contributions and expertise
- Promote inter-professional communications

IOM. (2003). Health Professionals Education: A Bridge to Quality

IOM. (2004). In the Nations Compelling Interest

IOM. (2010). The Future of Nursing

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- Our own safety is at risk if we do not act in concert to address what went wrong in Winkler County
- We have opportunities to make change for the future of patient safety in each of our positions

The rest of the story.....

- Texas Medical Board reported to Texas Attorney General concerning the events
  - Illegally securing the complaint to the TMB by claiming to be investigation a licensee of the TMB
  - Retaliation against someone reporting to the TMB as required and essential for patient safety
  - Bad faith action by officials to repress necessary reporting

The rest of the story...

Texas Attorney General arrested and charged the four men involved in the incident:

- Stan Wiley, administrator, for retaliating in violation of the law by firing the nurses
- Sheriff Roberts and County Attorney Scott Tidwell on six counts: misuse of official information and retaliation (3rd Degree Felonies), and official oppression (Class A misdemeanor)
- Dr. Rolando Arafiles on four counts of misuse of official information and retaliation (3rd Degree Felony)

The rest of the story...

- Administrator Stan Wiley was found guilty on two counts of retaliation for firing the two Registered Nurses and served 30 days in jail.
- He pled guilty to "abuse of official capacity" and agreed to cooperate with the Attorney General investigation and prosecution of the other three.

The rest of the story…

- Sheriff Roberts, in a trial by jury, was found guilty on all counts and given:
  - 4 year felony probation
  - $6,000 fine
  - 100 days in jail (four counts to run concurrently) and
  - Surrender of his peace officer license
- Retired with full benefits

The rest of the story…

- County Attorney Scott Tidwell awaits trial in September 2011
- Dr. Rolando Arafiles awaits trial to be set.
- So the rest of the story is yet to be told…

Where do we go from here?

- Nurse advocacy is needed within nursing leadership, middle management, and direct care nurses
- Nurses must advocate for patients but also for themselves and other nurses to support a safe and satisfying work environment
- The ANA Bill of Rights for Registered Nurses and the Code of Ethics for Nurses both support nurse advocacy for ourselves and our peers

Where do we go from here?

ANA Bill of Rights (2001)

- Nurses have a right to a work environment that supports and facilitates ethical practice, in accordance with the Code of Ethics for Nurses and its interpretive statements
- Nurses have the right to freely and openly advocate for themselves and their patients without fear of retaliation
- Nurses have a right to a work environment that is safe for themselves and their patients

Where do we go from here?

The Future of Nursing (IOM, 2010) challenges nurses to

- Fully participate as leaders and innovators in restructuring the health care system
- Remove barriers to practice within the scope of practice (RNs and APRNs)
- Change nursing education to address challenges of the 21st Century

The challenge is on!

Thank you!