The Silent Treatment:
Why Safety Tools and Checklists Aren't Enough to Save Lives

Frequently Asked Questions

Q: Why did AACN, AORN, and VitalSmarts conduct this study?

A: In 2010, the American Association of Critical-Care Nurses (AACN), the Association of periOperative Registered Nurses (AORN), and VitalSmarts conducted *The Silent Treatment* study to examine the effectiveness of safety tools in reducing avoidable errors. The study calculated decisions nurses make to not speak up when they observe actions that could compromise patient safety—even when safety tools alert them to potential harm.

Aware of the impact communication breakdowns have on patient safety and employee morale, the healthcare community has made substantial investments in the past five years to systems designed to reduce unintentional slips and errors such as handoff protocols, checklists, and computerized order entry systems.

It has been widely documented by The Joint Commission, the Institute of Medicine, and others, that poor communication between caregivers can lead to avoidable errors in healthcare delivery. In 2005, AACN and VitalSmarts conducted a study called *Silence Kills*. The study found that 84% of doctors observed colleagues who took dangerous shortcuts when caring for patients and 88% worked with people who showed poor clinical judgment. Despite the risks to patients, less than 10% of physicians, nurses, and other clinical staff directly confronted their colleagues about their concerns. *The Silent Treatment*, also serves as a five-year follow-up study to *Silence Kills*.

Q: What were the study's objectives?

A: The purpose of the study was to show how caregivers' failure to speak up when risks are known undermines the effectiveness of current safety tools. The goal was to identify specific concerns healthcare professionals have that consistently remain "undiscussable". The study uncovered three concerns: dangerous shortcuts, incompetence, and disrespect.

The Silent Treatment tracks the frequency and impact of these communication breakdowns and then uses a blend of quantitative and qualitative data to determine the actions individuals and organizations can take to resolve avoidable breakdowns.

Q: What are the key findings?

A: The prevalent culture of poor communication and calculated decisions to not speak up among health professionals undermines the effectiveness of current safety tools and contributes significantly to continued medical errors. Additionally, dangerous shortcuts, incompetence, and disrespect result in communication gaps that can cause harm to patients.

It is critical that healthcare organizations create healthy work environments and cultures of safety where healthcare workers can safely and candidly approach each other about their concerns.

Among the study's key findings:

Dangerous shortcuts:

- 84% of respondents say 10% or more of their colleagues take dangerous shortcuts.
- Of those people, 26% say these shortcuts actually harmed patients.
- Despite these risks, only 31% shared their full concerns with the person.

Incompetence:

- 82% say 10% or more of their colleagues are missing basic skills 19% say they have seen harm come to patients as a result of incompetence.
- However, only 21% spoke to the incompetent colleague and shared their full concerns.

Disrespect:

- 85% of respondents say 10% or more of the people they work with are disrespectful and therefore undermine their ability to share concerns or speak up about problems.
- And yet, only 24% confronted their disrespectful colleagues and shared their full concerns.

Results from nurse managers:

- 41% of the nurse managers reported that they spoke up to the person whose dangerous shortcuts create the most danger for patients.
- Only 28% spoke up to the person whose missing competencies created the most danger for patients.
- Only 35% spoke up to the person whose disrespect had the greatest negative impact.

Q: What role do safety tools play in reducing medical errors?

A: Of the nurses surveyed, 85% said a safety tool warned them of a problem the team might have otherwise missed at least once, and 29% 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.

The Silent Treatment data documented, however, that the effectiveness of these safety tools is undercut by undiscussables. Fifty-eight percent of the nurses who earlier expressed that they had been in situations where the tool worked also 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% of these nurses said they were in this situation at least a few times a month.

Q: What stops nurses from speaking up about problems flagged by checklists and safety tools?

A: The study found checklists and safety tools are effective in warning caregivers of potential problems. However, warnings only create safety when the caregiver who is warned can speak up and influence others to act. Less than half (42%) of the nurses surveyed spoke up in an effective way about their concerns.

Three in four incidents involved confronting physicians, two in three involved standing up to a group, and half involved disrespect, threats, and anger.

The study also shows that nurses are more likely to take their concerns to a manager than to speak directly to the person they are concerned about. 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.

Q: What are the key recommendations from *The Silent Treatment*?

A: The study reveals how healthcare organizations can tackle cultures of silence using a multifaceted change management approach to achieve substantial improvements. The recommendations employ principles from the Influencer model, a change management strategy named the "Change Management Approach of the Year" by *MIT Sloan Management Review*.

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 team works with staff and physicians to identify crucial moments when problems occur, vital behaviors that if enacted in crucial moments would solve the problem, and strategies within six sources of influence—personal motivation, personal ability, social motivation, social ability, structural motivation, and structural ability.
2. **Identify Crucial Moments.** There are 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 label these crucial moments so that people will recognize when they are in them. An example of one of these crucial moments is when the ICU team hands off a critical patient to the surgical team, the surgery schedule has been 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.
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 described in the full report. This plan is captured in a playbook that can be disseminated throughout an organization.

In addition to the recommendations above, AACN and VitalSmarts recommend organizations do the following:

- Adopt the AACN "Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence." These standards focus on core competencies of communication, collaboration, decision making, staffing, recognition and leadership as a framework to create an environment that ensures patient safety and enhances staff recruitment and retention.
- Use AACN's free online assessment tool to evaluate the health of your work environment and access available online resources available at www.aacn.org/hwe to develop an individualized improvement plan.
- Establish a baseline and a target for improvement on the seven crucial conversations identified in the study.
- Focus on the problem areas where conversations aren't happening, often in high-stress, high impact areas such as ICUs, progressive care units, and emergency departments.
- Implement comprehensive training programs that engage organizational leaders; use high quality, relevant materials and receive the sustained attention of healthcare professionals.

AORN recommends that organizations:

- Focus on the crucial moments where conversations are not occurring and where they are occurring in a disrespectful manner.
- Review the AORN Position Statements that focus on the management's responsibility to establish and promote a safe work environment and strive to use the best practice models for transparent and respectful communication free of retaliation which are:
    - Workplace safety
    - Creating a Patient Safety Culture
    - Key Components of a Healthy Perioperative Work Environment
    - Patient Safety
- Utilize the following AORN Tool Kits to assist in developing training programs to assist in changing the culture in the Perioperative environment:
    - Just Culture
    - Human Factors in Health Care
- Develop "red rules" that identify the situations where any member of the team can stop the procedure until all patient safety concerns are resolved.

Q: What does a multifaceted approach look like?

A: Entrenched organizational problems require a multifaceted change-management solution. An effective solution involves everyone in the work environment. A helpful way to think about this multifaceted solution is to use the following six sources of behavioral influence.

- **Source 1—Personal Motivation.** If it were up to the individual, would s/he want to speak up? Does it feel like a moral obligation or an unpleasant annoyance?
- **Source 2—Personal Ability.** Does the individual have the knowledge and skills needed to handle the toughest challenges of speaking up?
- **Source 3—Social Motivation.** Do those around him/her encourage the individual to speak up about concerns? Do the people s/he respect model speaking up?
- **Source 4—Social Ability.** Do others step in to help when an individual tries to speak up? Are others supportive afterward so the risk doesn't turn against the individual? Do those around him or her 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 skilled communication 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 health professionals are encouraged to speak up? Does the organization measure how often people hold or do not hold these conversations—and use these measures to keep management focused on this aspect of patient safety?

Q: What was the design and methodology for the study? How did you gather the data?

A: Two survey instruments were employed in 2010: 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 of the 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. Data from the nurse managers was reviewed separately from the non-supervisory nurses.

Q: How did you select and recruit the participants for the study?

A: Members of AACN and AORN were invited via e-mail to participate in the study. The e-mail invitation included an online link that randomly assigned respondents to one of the two instruments. Those who responded were informed that replying to the questionnaire indicated their consent to participate.

Q: How do the 2005 and 2010 study differ?

A: In general, the results from *The Silent Treatment* 2010 study are in-line with the *Silence Kills* 2005 data. However, a few differences should 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 represent primarily the differences in the two samples.

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

When the 2010 nurses were compared to the 2005 nurses who worked in critical care and perioperative settings, their levels of concern and patient harm were similar. But one aspect points to a hopeful difference.

The 2010 critical care and perioperative nurses speak up more often. They are nearly three times more likely to have spoken directly to the person and shared their full concerns. The authors of the 2010 study believe this increase represents notable progress and may be influenced by the increased focus that healthcare organizations now place on creating cultures of safety.

Q: What do the 2005 and 2010 studies reveal about specific links between better communication in the workplace and improved outcomes?

A: The 2005 study reported that caregivers who speak up and resolve undiscussables observe 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 study does not prove that failure to speak up *causes* safety problems, but it does confirm a strong relationship between the two. In fact, the statistical correlations—some more than .4—are very strong. The second important number is the “p” value, which shows less than a one in one-thousand likelihood that this strong correlation is due to chance. The clear message of the data from 2005 is that failure to speak up and poorer health outcomes are strongly related.

The 2010 study identified a relatively small number of nurses who spoke up when they observed dangerous shortcuts, incompetence, or disrespect. These exceptional nurses described 284 incidents in detail through the Story Collector. By studying these successful outliers, the study helps us better

understand the behavior of nurses who were able to prevent avoidable medical errors and protect patients when they observed dangerous situations and spoke up.

Q: What are the AACN Healthy Work Environment Standards?

A: AACN's "Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence" provides a specific framework to promote core competencies that ensure patient safety, enhance staff recruitment and retention and maintain an organization's financial viability. The standards are a call to action for nurses, health professionals, and healthcare organizations to fulfill their obligation of creating healthy work environments where safety becomes the norm and excellence the goal.

Specifically, the standards are:

- **Skilled Communication:** Nurses must be as proficient in communication skills as they are in clinical skills.
- **True Collaboration:** Nurses must be relentless in pursuing and fostering collaboration.
- **Effective Decision Making:** Nurses must be valued and committed partners in making policy, directing and evaluating clinical care, and leading organizational operations.
- **Appropriate Staffing:** Staffing must ensure the effective match between patient needs and nurse competencies.
- **Meaningful Recognition:** Nurses must be recognized and must recognize others for the value each brings to the work of the organization.
- **Authentic Leadership:** Nurse leaders must fully embrace the imperative of a healthy work environment, authentically live it and engage others in its achievement.

Q: What are the AORN Standards?

A: AORN's standards are:

- **Collaboration:** The organization fosters a collaborative environment and recognizes the value of each provider's contribution to comprehensive healthcare.
- **Ethics:** Perioperative nurses use ethical principles to determine decisions and actions.
- **Resource Utilization:** Nurses consider factors related to safety effectiveness, efficiency, and the environment, as well as the cost in planning, delivering, and evaluating patient care.
- **Leadership:** Perioperative nurses hold self and team members accountable to the patient, the organization, and other internal and external stakeholders.
- **Communication:** Perioperative nurses use team building, negotiation, and conflict resolution skills to promote teamwork to build partnerships within and across healthcare systems.
- **Culture of Safety:** A just culture provides an environment of trust where all members of the perioperative team are encouraged to provide safety related data and are acutely aware of the distinction between acceptable and unacceptable behavior.

Q: What are some practical ways healthcare organizations can apply these standards?

A: AACN encourages nurses and health professionals to embrace their personal obligation to participate in creating healthy work environments and calls on healthcare organizations to establish the organizational systems and structures required for successful education, implementation, and evaluation of the standards. AACN continues to lead the way in developing practical and relevant resources to support individuals and organizations in standards implementation.

AORN encourages nurses to establish a culture of safety where all members of the perioperative team can openly discuss errors, process improvements or system issues without fear of reprisal. Characteristics of a culture of safety include the following:

- Communication is open and honest.
- Emphasis is on the team rather than an individual.
- Standards and practices are developed in a multidisciplinary framework.
- Staff members are helpful and supportive of each other.
- Surgical team members have a friendly, open relationship emphasizing credibility and attentiveness.
- The environment is resilient, encourages creativity, and is patient outcomes –driven.
- The focus is on workflow and process.
- These attributes are supported by an informed culture that learns from incidents and near misses.

Q: What are VitalSmarts' training recommendations?

A: Healthcare organizations that achieve substantial improvements in communication and candor use a six-source influence plan called the Influencer model, which was named the "Change Management Approach of the Year" by *MIT Sloan Management Review*.

The six-source plan includes Crucial Conversations® Training, which enables nurses to address "undiscussables" and speak up when safety tools alert them to potential harm.

- After Crucial Conversations® Training, managers at Maine General Health System showed an 85% improvement in speaking up about poor teamwork, a 66% improvement in addressing poor initiative, and a 43% improvement in addressing incompetence.
- Maimonides Health System in New York City saw a 39% improvement in employees confronting violations of respect and a 54% improvement in how leaders handled disrespectful behavior.
- Two months after incorporating a six-source influence plan from Influencer Training™, Spectrum Health System in Michigan achieved a 90% hand hygiene compliance rate when the national average was 60%. A year later, Spectrum was tracking at an unprecedented 95% compliance.