

## ORIGINAL RESEARCH

By Lisa M. Black, PhD, RN, CNE

# Tragedy into Policy: A Quantitative Study of Nurses' Attitudes Toward Patient Advocacy Activities

THE STUDY FINDINGS LEAD TO NEW LEGAL PROTECTIONS FOR NEVADA WHISTLEBLOWERS.

## ABSTRACT

**Background:** In 2007 and 2008, 115 patients were found to be either certainly or presumptively infected with the hepatitis C virus through the reuse of contaminated medication vials at two southern Nevada endoscopy clinics. A subsequent joint investigation by federal and state agencies found multiple breaches of infection control protocols. There was also strong anecdotal evidence that among clinic staff, unsafe patient care conditions often went unreported because of a general fear of retaliation. At the request of the Nevada legislature's Legislative Committee on Health Care, a study was conducted to examine Nevada RNs' experiences with workplace attitudes toward patient advocacy activities. This article presents the study findings and reviews how one public health tragedy led to the creation of effective health care policy.

**Methods:** A study questionnaire was developed and tested for reliability and validity. Questionnaires were then sent to an initial sample of 1,725 Nevada RNs, representing 10% of all RNs in the Nevada State Board of Nursing database with active licenses and current Nevada addresses.

**Results:** The response rate was modest at 33% (564 respondents). Of those who responded, 34% indicated that they'd been aware of a patient care condition that could have caused harm to a patient, yet hadn't reported it. The most common reasons given for nonreporting included fears of workplace retaliation (44%) and a belief that nothing would come of reports that were made (38%).

**Conclusions:** The study findings underscore the need for a shift in organizational culture toward one that encourages clear and open communication when patient safety may be in jeopardy. These findings were ultimately used to support the passage of whistleblower protection legislation in Nevada.

**Keywords:** Las Vegas hepatitis C outbreak, patient advocacy, whistleblower.

Although the Centers for Disease Control and Prevention (CDC) reports that an estimated 3.2 million Americans are living with chronic hepatitis C, in southern Nevada fewer than four cases of acute hepatitis C are confirmed annually.<sup>1, 2</sup> So when six people who had recently undergone endoscopic procedures were diagnosed with acute hepatitis C within a six-month period (July 2007 to December 2007), alarms were sounded.<sup>1</sup> Ultimately, more than 62,000 patients who had undergone endoscopic procedures at either of two southern Nevada endoscopy clinics would be notified that they might have been exposed to bloodborne pathogens, including hepatitis B virus, hepatitis C virus (HCV), and HIV, as a result of unsafe injection practices.<sup>3</sup> In total, seven patients would be confirmed as having clinic-associated HCV infections that were genetically linked to source patients; two more had clinic-associated HCV infections that could not be so genetically linked; and an additional 106 patients were presumptively diagnosed with "possible clinic-associated HCV infection."<sup>3, 4</sup> This appears to be the largest nosocomial patient exposure to a bloodborne pathogen in the United States ever documented in the literature.

## BACKGROUND

In January 2008, the CDC, the Nevada State Health Division, and the Southern Nevada Health District began a joint epidemiologic investigation. The investigators found multiple breaches of infection control and record-keeping protocols at the two Las Vegas-area clinics, including the reuse of syringes, medication vials,

bite blocks (devices placed in the mouth during upper endoscopies), and other equipment intended for single use.<sup>4,5</sup> At one clinic, the staff reported that “the rule was to reuse single-use equipment three times if possible.”<sup>5</sup> The clinic staff also reported that they were “only allowed to use four bite blocks per day per procedure room,” regardless of the number of procedures performed, and were “directed to reuse syringes”; purchasing records supported both statements. The investigators themselves observed “the reuse of ‘single-use’ [medication] vials for multiple patients.”

It bears emphasizing that single-use items aren’t designed for reuse on another patient. The Society of Gastroenterology Nurses and Associates has stated that “critical medical devices” (devices introduced into the bloodstream or other sterile areas of the body) that are intended for single use should not be reused.<sup>6</sup> They note that original equipment manufacturers must conduct rigorous testing to verify that a *reusable* item can be reliably cleaned and if necessary sterilized; and that the Food and Drug Administration requires equipment reproducers to demonstrate that a reprocessed device is “substantially equivalent” to a newly manufactured device.<sup>6,7</sup>

civil, administrative, and criminal proceedings, many details aren’t publicly available; whether direct retaliatory activities were taking place at the clinics cannot yet be verified. That said, there’s strong anecdotal evidence that a general fear of retaliation existed such that unsafe practices were not reported.<sup>8</sup>

#### WHAT THE LITERATURE REVEALS

While several government reports have urged the open reporting of concerns about the quality and safety of patient care,<sup>9-11</sup> underreporting of quality problems and adverse events is common.<sup>12-17</sup> The antecedents and consequences of whistleblowing, as well as the beliefs and values of whistleblowers, haven’t been well described in the literature. Nor is there a single accepted definition of whistleblowing. Bolsin and colleagues offer this: “the attempt, in good faith and in the public interest, to disclose and resolve in a reasonable and non-vexatious manner, but in the face of significant institutional or professional opposition, a significant deficiency in the quality or safety of health care.”<sup>13</sup>

McDonald and Ahern noted in 2000 that the bulk of nursing research specific to whistleblowing has been theoretical in nature rather than empirical,<sup>18</sup> and

---

## Nurses risk “moral compromise” when there’s a conflict between their duty to advocate patient safety and real or perceived pressure from an employer to do otherwise.

---

The investigators concluded that the Las Vegas–area nosocomial hepatitis C outbreak likely resulted from the use of contaminated syringes to reaccess single-use medication vials; the syringes were then used to administer procedural sedation to subsequent patients.<sup>4</sup>

The specific failures in this situation didn’t seem to stem from a lack of knowledge about proper infection control practices. On the contrary, one RN reported to the investigators that he had observed the reuse of contaminated syringes on multiple occasions and had complained to clinic management about the practice.<sup>5</sup> Another RN reported quitting after one day of work because of concerns about equipment reuse.<sup>5</sup> She stated that when she voiced complaints about this and faulty record-keeping practices at the clinic to other staff members, she was told that was “how things were done there.”

Nurses who were employed at the clinics told the executive director of the Nevada Hepatitis C Task Force that they feared being “fired, mistreated, or black-balled” if they were to report unsafe practices.<sup>8</sup> Because the events at the clinics remain the subject of ongoing

that has remained true over the past decade. Still, there are some valuable findings. McDonald and Ahern’s survey of nurses in western Australia found numerous negative professional consequences of whistleblowing, including demotion, pressure to resign, and referral to mental health providers.<sup>18</sup> A study by Attree, conducted with British RNs, identified fear of repercussions, an unsupportive organizational climate, labeling, and blame as barriers to nurses’ reporting both actual and potential threats to patient safety.<sup>12</sup> Nurses also risk what’s been termed “moral compromise” when there’s a conflict between their duty to advocate patient safety and real or perceived pressure from an employer to do otherwise in order to remain employed.<sup>12, 19</sup> Studies also indicate that nurses have not reported patient safety threats because they believed their concerns would be ignored.<sup>20</sup> And Ray attributed an instance of external whistleblowing to the organization’s failure to meet its ethical obligations, and argued for an organizational infrastructure that fosters ethical and effective policymaking.<sup>21</sup>

**Fears of reprisal** are frequently described in the literature that discusses professional consequences of whistleblowing<sup>18,22</sup> and explores nurses' reasons both for reporting poor practice and for failing to do so report.<sup>20,23,24</sup> Such fears may be further fueled by media coverage of nurses who have been persecuted and even prosecuted for reporting practices and situations potentially dangerous to patients. One striking recent example was the case of Texas whistleblowers Vicki Galle and Anne Mitchell, two RNs who were criminally prosecuted in 2009 for "misuse of official information," a felony, after they reported a physician to the Texas Medical Board out of concern that his practices were

below the acceptable standard of care. Although the charges against Vicki Galle were dismissed one week before the February 8, 2010, trial date, and although Anne Mitchell was swiftly acquitted, they told the *New York Times* that the case had "derailed" their careers and "stained their reputations and drained their savings."<sup>25</sup> The expenses they incurred and the damages to their reputations and employment prospects understandably give other nurses reason to be wary when making similar reports. (For details of the case and its aftermath, see Winkler County Nurses Update at <http://bit.ly/hly9kE>.)

The American Nurses Association's *Code of Ethics for Nurses with Interpretive Statements* calls on nurses to be accountable professionals; yet it fails to acknowledge that few protections exist for those who report unsafe patient care conditions.<sup>26</sup> Indeed, although the Texas case marks the first time that nurses have been criminally prosecuted for reporting patient care concerns, cases in which nurses have been sanctioned, fired, or otherwise retaliated against have been commonly reported.<sup>12,18</sup> Such reports notwithstanding, nurses remain under mandate to protect patients from threats of which they are aware. Failure to do so is often considered to be unprofessional conduct by state boards of nursing.<sup>27</sup>

**A catch-22.** While nurses have a legal and moral imperative to protect patients from harm, they may also face the very real threat of employment loss for reporting unsafe practices. This is particularly true in states like Nevada where employment is "at will." Under the employment-at-will doctrine, employment is noncontractual and of indefinite duration; employees can be terminated for "good cause, bad cause, or no cause at all."<sup>28</sup> Such terms place nurses who witness unsafe practices in a difficult catch-22: if they report unsafe practices, they risk losing their jobs; if they don't, they risk losing their licenses. Nurses can find themselves forced to gamble with patient safety in order to keep their jobs and reputations, especially when they lack confidence in their facility's reporting system.<sup>12</sup>

The findings of the joint investigation into the Las Vegas hepatitis C outbreak strongly suggest that many nurses were aware of unsafe practices that hadn't been reported.<sup>1,5</sup> Ultimately, 22 RNs and LPNs were investigated in connection with the outbreak; several are still under investigation by the Nevada State Board of Nursing (NSBN) for alleged violations that included failure to safeguard a patient, failure to properly document care, falsification of documentation, and failure to conform to customary standards of practice (Debra Scott, NSBN executive director, e-mail communication, September 7, 2010). At least two certified registered nurse anesthetists were also found to have actively engaged in unsafe practices.<sup>3</sup> Nurses who knowingly failed to safeguard patients from the "incompetent, abusive or illegal practice of any person" were in violation of the Nevada Nurse Practice Act's Unprofessional Conduct Regulation,<sup>29</sup> and were subject to licensure sanction by the NSBN. It remains unclear exactly how

**TABLE 1. Sample Demographics (N = 564)**

| Demographic characteristics  | n (%)                | NSSRN (2004) NV Data Comparison (%) |
|--|----------------------|-------------------------------------|
| Gender   |                      |                                     |
| Male   | 32 (5.7)             | 6.7                                 |
| Female   | 513 (91)             | 93.2                                |
| Racial/ethnic background   |                      |                                     |
| American Indian  | 2 (0.4)              | 0.4                                 |
| Asian  | 76 (13.5)            | 12.6                                |
| Black/African American   | 1 (0.2)              | 2.4                                 |
| Hawaiian/Pacific Islander  | 6 (1.1)              | 0.5                                 |
| Hispanic/Mexican   | 9 (1.6)              | 2.6                                 |
| White/Caucasian  | 448 (79.4)           | 79.3                                |
| Other  | 21 (3.7)             | 2.2                                 |
| Marital status   |                      |                                     |
| Now married/partnered  | 403 (71.5)           | 69.6                                |
| Widowed/divorced/separated   | 109 (19.3)           | 20.5                                |
| Never married  | 33 (5.9)             | 8.5                                 |
| Dependents living in the nurse's home                                      |                      |                                     |
| No dependents at home  | 279 (49.5)           | 43.1                                |
| Children under age 6 at home   | 81 (14.4)            | 15.7                                |
| Children between ages 6–18 at home   | 124 (22.0)           | 29.9                                |
| Other dependent adults living at home                                      | 117 (20.7)           | 18.5                                |
| Highest level of nursing education   |                      |                                     |
| Diploma  | 65 (11.5)            | 11.0                                |
| Associate's degree   | 171 (30.3)           | 34.1                                |
| Bachelor's degree  | 241 (42.7)           | 40.6                                |
| Master's degree  | 63 (11.2)            | 9.2                                 |
| Doctorate  | 5 (0.9)              | 0.8                                 |
| Holds specialty certification  | 223 (39.5)           |                                     |
| Continuous variables   | Mean (SD)            | Median (SD)                         |
| Age of the nurse in 2008 (yr)  | 49.38 (11.4)         | 48 (11.3)                           |
| Number of years since graduation from nursing school (initial preparation) | 22.7 (12.4)          | 19.1 (12.8)                         |
| Number of hours worked per week  | 37.7 (12.2)          | 33.5 (21.1)                         |
| Number of unscheduled overtime hours per week                              | 2.7 (5.6)            | 5.3 (3.1)                           |
| Annual gross income from primary nursing position                          | \$64,579 (\$24,527)  | —                                   |
| Annual gross household income  | \$108,915 (\$48,970) | —                                   |

NSSRN = National Sample Survey of Registered Nurses; NV = Nevada; — = data doesn't permit valid comparison.

many nurses were aware of unsafe practices, which practices they were aware of, and when they became so aware, but the lives of these nurses and their patients have been forever changed.

### WHISTLEBLOWER PROTECTIONS

Patient advocacy policies and statutes that protect nurses who report illegal or unsafe patient care practices or situations are commonly known as “whistleblower protections.” At this writing, 21 states have legislated some form of whistleblower protection, though the laws vary from state to state in terms of their enforcement mechanisms and levels of recourse for employees who have experienced reprisals.<sup>30</sup> To protect whistleblowers, legislation “should provide mechanisms to report unsafe practices without reprisal, allow for adequate response time internally, allow for an external process when internal processes fail, and deter false claims.”<sup>31</sup>

satisfaction with nurses’ primary nursing position and with nursing as a career were measured to allow for cross-tabulation with reporting activities.

The Registered Nurses’ Workplace Support for Patient Advocacy Activities Study questionnaire was developed for the purposes of the study. (*Editor’s note:* The study was eventually renamed the Patient Advocacy Activities of Registered Nurses in Nevada study.) The questionnaire included 16 questions about a respondent’s experiences with patient advocacy activities. There were also 13 statements about the respondent’s perceived ability to report unsafe patient care situations, answerable using a 4-choice Likert agreement scale that ranged from “strongly agree” to “strongly disagree.” Four additional questions, answerable by yes or no, asked whether the respondent worked in a position requiring an RN license, whether she or he worked in an acute care hospital, whether she or he

---

## Findings of the investigation into the Las Vegas hepatitis C outbreak strongly suggest that many nurses were aware of unsafe practices that hadn’t been reported.

---

### WHAT PROMPTED THIS STUDY

Anecdotal reports of retaliatory activities against whistleblowers in Nevada hospitals had previously been described to policymakers, collective bargaining representatives, and professional organization leaders, though systematic investigations of such reports hadn’t been conducted. Legislative leaders of the Nevada Nurses Association (NNA) anticipated that the culture of fear described in the investigation of the two endoscopy clinics wasn’t unique to those clinics. NNA representatives appeared before the Nevada legislature’s Legislative Committee on Health Care in the summer of 2008 to formally request that the committee sponsor legislation to provide specific statutory protection for nurses who report patient safety concerns both within their facilities and to government agencies as might be appropriate. The Legislative Committee on Health Care requested that the NNA conduct a study examining Nevada RNs’ experiences with workplace attitudes toward patient advocacy activities, in order to provide data with which to shape policy. I was the principal investigator of this study; the results are presented here.

### METHODOLOGY

This study aimed to collect data from RNs licensed to practice in Nevada regarding work setting, reporting unsafe patient care practices or conditions, experiences with prior reporting activities, and attitudes toward reporting concerns about patient safety. Levels of

was represented by a labor union in the nursing workplace, and whether she or he worked in a facility that was seeking recognition as a magnet facility. Demographic data were collected for comparison to such data on Nevada RNs in national data sources, in order to determine the representativeness of the study sample. Approval of the survey tool and permission to conduct the study were obtained from the institutional review board of the University of Nevada, Reno, before data collection began.

A priori power analysis showed that a minimum sample size of 405 respondents would be required to detect a medium effect size (0.3;  $df = 32$ ). A random sample of 1,725 RNs, representing 10% of all RNs with active licenses and current Nevada addresses, was drawn from the NSBN database. Content validity of the questionnaire was obtained by expert panel review, and the survey tool was pilot tested with acute care RNs in Nevada.

To ascertain whether this study sample was demographically representative of Nevada nurses, its demographic data were compared with such data for Nevada nurses from the 2004 National Sample Survey of Registered Nurses (NSSRN).<sup>32</sup> (The NSSRN is the most extensive and comprehensive source of statistics for RNs in the United States. It uses a very large sample, which minimizes sampling error, nonresponse error, and sampling bias; this contributes substantively to the validity of the data derived from its analysis.) The demographic data for this study’s sample generally

mirrored the Nevada-specific 2004 NSSRN data, which suggests that this study's sample is reasonably representative of the Nevada RN population. Reliability testing of the study tool demonstrated a high degree of internal consistency ( $r = 0.93$ ) for the Likert-scaled items (items 21 through 33). This suggests that, taken together, these items measure a single unidimensional construct: specifically, whether the participant believed she or he could report threats to patient safety without fear of reprisal.

The survey was distributed by U.S. mail on September 8, 2008; respondents could complete it either online or by filling out and returning the paper survey. Responses were allowed through October 31, 2008.

---

## Knowing a nurse who experienced workplace retaliation was strongly associated with not reporting a patient safety concern.

---

### RESULTS

A total of 564 valid responses were received, representing a 33% response rate. The number of responses to any one item varied, as most respondents left one or more items blank. Unless otherwise noted, percentages were calculated using the total overall number of respondents ( $N = 564$ ) and thus might not add up to 100%.

**Demographic data** for the study sample are reported in Table 1 and in questions 1, 2, 19, and 20 in Table 2. The average respondent was 49 years old and had graduated from a basic (prelicensure) program of nursing education 23 years before data collection. On average, respondents worked slightly less than 38 regularly scheduled hours and three unscheduled overtime hours each week. Ninety-one percent (513) of the respondents were female, 79% (448) identified as white, 72% (403) were married or had a domestic partner, and just over half (322) had at least one dependent living in their home. Ninety-four percent (529) of the respondents reported that they worked in a position that required an RN license, and 62% (349) worked in an acute care facility. Forty percent (223) of the respondents reported holding certification in their practice specialty, 31% (173) reported being represented by a labor union in their primary nursing work setting, and 39% (218) worked in a facility that was seeking designation as a magnet facility.

**Reporting activities.** Responses to yes-or-no questions about previous reporting activities are shown in Table 2. While 73% (412) of respondents stated that they'd previously reported an unsafe patient care

situation to people whom they felt would be able to correct it (question 3), 34% (194) stated that they'd been aware of a situation that could have caused harm to a patient, yet did not report it (question 5). Whether a participant had been aware of an unsafe patient care situation that wasn't reported differed by work setting ( $\chi^2 = 62.3$ ;  $P < 0.001$ ): 38% of nurses working in acute care settings (134 of 349 nurses) and 29% of nurses working in non-acute care settings (60 of 210 nurses) responded that they were aware of an unsafe patient care situation that wasn't reported. Responses to questions 3 and 5 did not significantly differ according to a nurse's educational level.

Respondents who had reported an unsafe patient care situation were asked to whom it was reported. Of those who answered, 93% (368) reported the situation to a nurse manager or nursing supervisor. Only a few nurses reported such situations to the medical director of their facility, the NSBN, or a collective bargaining organization; none reported them to the Nevada State Board of Medical Examiners (NSBME).

Respondents who had been aware of an unsafe patient care situation and hadn't reported it were asked to "choose the *most important* reason that you did not report this concern." Of those who answered, 44% (79) indicated that they were concerned about experiencing retaliation for having made a report, while 38% (68) reported that they didn't think anything would come of the report. Fewer nurses indicated that they didn't know how or to whom to report the situation, didn't have the time to report, or felt the situation was "none of my concern."

Respondents indicated having been involved in a variety of reporting activities. Nearly two-thirds of respondents reported having been involved in reporting the actions of a staff nurse (62%; 352) or a physician (64%; 362) to a nursing supervisor. Approximately one-quarter of respondents indicated they'd been involved in reporting the actions of a nursing supervisor (27%; 153) or a physician (27%; 154) to a higher level of management. Fewer respondents indicated that they'd reported a colleague's actions to the NSBN or the NSBME.

Sixty-one percent (342) felt that they could report a patient safety concern without experiencing workplace retaliation. But many respondents indicated having experienced such retaliation for reporting the actions of a nurse (18%; 88) or a physician (15%; 76). Forty-one percent (230) indicated that they knew, or knew of, a nurse who had experienced workplace retaliation after reporting the actions of another staff nurse. Nearly one-third of respondents knew, or knew of, a nurse who had experienced workplace retaliation for reporting the actions of a nursing supervisor (30%; 170) or a physician (30%; 167).

Knowing or knowing of a nurse who experienced workplace retaliation after reporting a patient safety concern was strongly associated with not reporting a patient safety concern oneself ( $\chi^2 = 131.96$ ;  $P < 0.0001$ ). Sixty-two percent of respondents (142) who knew a

**TABLE 2.** Responses to Yes-or-No Questions About Reporting Activities (N = 564<sup>a</sup>)

| Question   | Yes<br>n (%)            | No<br>n (%)              |
|--|-------------------------|--------------------------|
| 1. Are you currently working in a position that requires an RN license?  | 529 (93.8)              | 30 (5.3)                 |
| 2. In your primary nursing position, do you work in an acute care hospital?  | 349 (61.9)              | 210 (37.2)               |
| 3. Have you ever reported an unsafe patient care condition to people you felt would be able to correct the situation?  | 412 (73)                | 141 (25)                 |
| 4. If you reported an unsafe patient care condition (n = 395), who did you report it to? (n [% <sup>b</sup> ])   |                         |                          |
| Nurse manager/nursing supervisor   | 368 (93)                |                          |
| Collective bargaining organization   | 1 (0.2)                 |                          |
| Medical director   | 22 (5.6)                |                          |
| Nevada State Board of Nursing  | 4 (1)                   |                          |
| Nevada State Board of Medical Examiners  | 0 (0)                   |                          |
| 5. Have you ever been aware of a situation that could cause harm to a patient that you did not report?   | 194 (34.4)              | 362 (64.2)               |
| 6. If you did not report an unsafe patient care situation about which you were aware (n = 181), please choose the <i>most important</i> reason that you did not report this concern. (n [% <sup>b</sup> ]) |                         |                          |
| I did not have the time.   | 15 (8.3)                |                          |
| It was none of my concern.   | 2 (1.1)                 |                          |
| I didn't think anything would come of the report.  | 68 (37.6)               |                          |
| I didn't know how or to whom to report the situation.  | 17 (9.4)                |                          |
| I was concerned about experiencing retaliation for having made a report.   | 79 (43.6)               |                          |
| 7. Have you ever reported or been involved in the reporting of the actions of a staff nurse to a nursing supervisor?   | 352 (62.4)              | 208 (36.9)               |
| 8. Have you ever reported or been involved in the actions of reporting a nursing supervisor to a higher level of management within your facility?  | 153 (27.1)              | 405 (71.8)               |
| 9. Have you ever reported or been involved in the reporting of the actions of a nurse to the Nevada State Board of Nursing?  | 70 (12.4)               | 491 (87.1)               |
| 10. Have you ever reported or been involved in the reporting of the actions of a physician to your nursing supervisor?   | 362 (64.2)              | 197 (34.9)               |
| 11. Have you ever reported or been involved in the reporting of the actions of a physician to the medical director of your facility?   | 154 (27.3)              | 407 (72.2)               |
| 12. Have you ever reported or been involved in the reporting of the actions of a physician to the Nevada State Board of Medical Examiners?   | 20 (3.5)                | 541 (95.9)               |
| 13. If you have reported the actions of a nurse, did you experience retaliation for having done so?  | 88 (17.8 <sup>b</sup> ) | 407 (82.2 <sup>b</sup> ) |
| 14. If you have reported the actions of a physician, did you experience retaliation for having done so?  | 76 (15.3 <sup>b</sup> ) | 422 (84.7 <sup>b</sup> ) |
| 15. Do you know or do you know of a nurse who has experienced workplace retaliation after having reported the actions of another staff nurse?  | 230 (40.8)              | 325 (57.6)               |
| 16. Do you know or do you know of a nurse who has experienced workplace retaliation after having reported the actions of a nursing supervisor?   | 170 (30.1)              | 386 (68.4)               |
| 17. Do you know or do you know of a nurse who has experienced workplace retaliation after having reported the actions of a physician?  | 167 (29.6)              | 386 (68.4)               |
| 18. If you were to be aware of a situation that might harm a patient, could you report that situation without experiencing workplace retaliation?  | 342 (60.6)              | 198 (35.1)               |
| 19. Are you represented by a labor union in your nursing workplace?  | 173 (30.7)              | 385 (68.3)               |
| 20. Is the facility in which you work seeking recognition as a magnet facility?  | 218 (38.7)              | 312 (55.3)               |

<sup>a</sup> Not all respondents answered each question, so some rows may total less than 564; percentages were calculated using N = 564 and thus may not total 100%.

<sup>b</sup> Percentages were calculated using the actual number of respondents.

nurse who experienced retaliation for reporting the actions of another nurse indicated that they were aware of a patient safety concern yet hadn't reported it. In comparison, only 15% (48) of respondents who didn't know or know of a nurse who had experienced workplace retaliation indicated that they were aware of a patient safety concern yet hadn't reported it. Similar results were seen when respondents were asked whether they knew or knew of a nurse who had experienced workplace retaliation after reporting the actions of a physician. Nurses who knew of such instances were nearly twice as likely not to report a patient safety concern than were those who had no such knowledge.

Results for items that were answerable using a Likert agreement scale are shown in Table 3. Nearly all of the respondents (90%; 508) agreed or strongly agreed with the statement "I know how to report an unsafe patient care situation." Sixty-two percent (351) felt that the facilities they worked in were supportive of nurses, and 76% (429) felt their facilities encouraged nurses to report conditions that might cause harm to patients. Yet more than a third of respondents (36%; 200) felt that their facilities were not supportive of nurses, and nearly a quarter (23%; 127) felt their facilities did not encourage nurses to report conditions that might cause harm to patients. More than one-quarter of respondents didn't feel that they could report the actions of another nurse to either the facilities' administration (28%; 158) or the NSBN (27%; 154) without experiencing workplace retaliation.

---

## Internal reports of unsafe patient care practices must be encouraged.

---

Nearly half of respondents (44%; 250) disagreed or strongly disagreed with the statement "I could report the actions of my nursing supervisor without experiencing workplace retaliation." One-third felt that they could not report the actions of a physician to their facility's medical director (33%; 188) or to the NSBME (38%; 213) without experiencing workplace retaliation. Forty-two percent of respondents (236) disagreed or strongly disagreed with the statement "I could report a nurse staffing concern without experiencing workplace retaliation."

While the majority of nurses surveyed were satisfied both with their current nursing position (71%; 398) and with nursing as a career (75%; 423), there was a very strong relationship between a nurse's level of satisfaction with her or his nursing position and the likelihood that she or he would report a patient safety concern ( $F = 128.4$ ;  $P < 0.001$ ).

Of the nurses who strongly agreed with the statement "I am satisfied with my current nursing position,"

only 15% (25) indicated that they had been aware of a patient safety concern and hadn't reported it. However, of those who strongly disagreed with the statement, 72% (28) had been aware of a patient safety concern and had not reported it.

### DISCUSSION AND IMPLICATIONS

Both the Las Vegas-area hepatitis C outbreak that prompted this study and the study findings have clear implications for nursing practice. First, the nosocomial spread of hepatitis C to what might have been as many as 115 patients serves as a sobering reminder of the importance of safe injection practices. In particular, in accordance with CDC guidelines, nurses and other health care providers are cautioned to remember that single-use syringes and vials must be disposed of immediately after use and must never be used on more than one patient.<sup>33,34</sup>

Second, the findings of this study illustrate the importance of a workplace culture based on openness, not fear. The study found that many nurses are afraid of workplace retaliation if they report patient safety concerns, and that a sizable number had already either personally experienced such retaliation or knew a nurse who had. This is consistent with the findings of McDonald and Ahern, who found that whistleblowing nurses experienced "severe professional reprisals" for reporting misconduct that posed a risk to patient safety.<sup>18</sup> That more than a third of RNs in our study indicated that they'd been aware of a situation that might have harmed a patient and had not reported it is of grave concern and must be addressed.

Although not all of the nurses in this study who reported an unsafe patient care situation experienced workplace retaliation, the fact that about one in six did cannot be dismissed. Moreover, nearly half of the respondents in this study knew of a nurse who had experienced such retaliation. These results provide support for the existence of what has been called a "culture of fear" in the workplace<sup>22</sup>—one that influences nurses not to report known safety violations that could (and sometimes do) result in direct and irrevocable patient harm. This culture of fear is a consistent theme in the whistleblowing literature and has been described by various authors who have explored the reasons nurses do and do not report unsafe patient care practices<sup>20,23,24</sup> and the professional consequences nurses often face when they do.<sup>18,22</sup> Our findings underscore the need for a shift in organizational culture toward one that encourages clear and open communication when patient safety may be in jeopardy.

Respondents who had reported an unsafe patient care situation were asked to whom they reported it; the overwhelming majority (93%; 368) indicated they reported it internally to their nursing supervisor. Far fewer nurses reported such situations to other authorities, with just five nurses reporting externally, four to the NSBN and one to a collective bargaining organization. It's generally expected that nurses will report safety concerns internally first, and it's possible that a sizable number of these internally reported concerns were resolved after the initial

report. But it's also possible that a culture of fear in the workplace discouraged those nurses whose concerns remained unresolved from pursuing matters further with an external agency. The study tool did not address that possibility; further investigation is needed.

While some progress has been made toward fostering organizational cultures that encourage open reporting of patient safety threats, much remains to be done. As the Institute of Medicine's 2004 report *Keeping Patients Safe: Transforming the Work Environment of Nurses* noted, there have been incidents "in which nurses who were involved in the commission of an error but found blameless by a number of independent authoritative bodies were unjustly disciplined by state regulatory agencies."<sup>11</sup> It's crucial that health care organizations and regulatory agencies address the systemic flaws that permit such injustice. If we accept the proposition that external whistleblowing marks an organization's failure to meet its ethical obligations,<sup>21</sup> then creating organizational infrastructures that support whistleblowers and foster ethical decision making must be part of any solution. Internal reports of unsafe patient care practices must be encouraged and welcomed, in order to identify opportunities for systemic, as well as individual, improvement.

More than a third of the respondents who had known about but not reported a patient safety concern

indicated that they "didn't think anything would come of [such] report." This finding is supported by the results of a survey of British nurses, which found that 58% cited "nothing will be done" as a top reason for not reporting a patient safety concern.<sup>20</sup> The same survey also found that of nurses who *had* reported a patient safety concern, 47% felt that "the matter had been handled 'badly', with their concern being overlooked" and 23% said that the reported concern had gone on to cause harm to patients. Greater organizational transparency is needed so that nurses can see their facility's commitment to addressing patient safety concerns, as evidenced by its support for whistleblowers and swift response to any contributing systems failures.

**Limitations.** This study had limitations that must be considered when interpreting and extrapolating from its findings. The initial sample size was relatively small—1,725 Nevada RNs, representing 10% of all RNs in the NSBN database with active licenses and current Nevada addresses—and response was modest at 33% (564 respondents). Although the study sample was randomly chosen, a potential response bias exists: nurses who'd had a negative workplace experience might have been more likely to complete the questionnaire than those who had not, thus potentially creating an inflated representation of the severity

**TABLE 3.** Responses to Statements Using a Likert Agreement Scale (N = 564<sup>a</sup>)

| Statement  | Strongly Agree<br>n (%) | Agree<br>n (%) | Disagree<br>n (%) | Strongly Disagree<br>n (%) |
|--|-------------------------|----------------|-------------------|----------------------------|
| 21. The facility in which I work is supportive of nurses.  | 118 (20.9)              | 233 (41.3)     | 145 (25.7)        | 55 (9.8)                   |
| 22. The facility in which I work encourages nurses to report conditions that might cause harm to patients.                               | 180 (31.9)              | 249 (44.1)     | 83 (14.7)         | 44 (7.8)                   |
| 23. I know how to report an unsafe patient care situation.   | 266 (47.2)              | 242 (42.9)     | 44 (7.8)          | 4 (0.7)                    |
| 24. I could report the actions of another nurse to my facility's administration without fear of retaliation.                             | 165 (29.3)              | 231 (41)       | 118 (20.9)        | 40 (7.1)                   |
| 25. I could report the actions of another nurse to the Nevada State Board of Nursing without experiencing workplace retaliation.         | 156 (27.7)              | 241 (42.7)     | 111 (19.7)        | 43 (7.6)                   |
| 26. I could report the actions of my nursing supervisor without experiencing workplace retaliation.                                      | 125 (22.2)              | 172 (30.5)     | 186 (33)          | 64 (11.3)                  |
| 27. I could report the actions of a physician to my nursing supervisor without experiencing workplace retaliation.                       | 146 (25.9)              | 252 (44.7)     | 114 (20.2)        | 36 (6.4)                   |
| 28. I could report the actions of a physician to the medical director of my facility without experiencing workplace retaliation.         | 130 (23.0)              | 222 (39.4)     | 156 (27.7)        | 32 (5.7)                   |
| 29. I could report the actions of a physician to the Nevada State Board of Medical Examiners without experiencing workplace retaliation. | 127 (22.5)              | 194 (34.4)     | 164 (29.1)        | 49 (8.7)                   |
| 30. I personally know or I know of a nurse who has been retaliated against for reporting a nurse.  | 119 (21.1)              | 138 (24.5)     | 182 (32.3)        | 104 (18.4)                 |
| 31. I could report a nurse staffing concern without experiencing workplace retaliation.  | 123 (21.8)              | 199 (35.3)     | 148 (26.2)        | 88 (15.6)                  |
| 32. I am satisfied with my current nursing position.   | 167 (29.6)              | 231 (41)       | 118 (20.9)        | 39 (6.9)                   |
| 33. I am satisfied with nursing as a career.   | 235 (41.7)              | 188 (33.3)     | 113 (20)          | 20 (3.5)                   |

<sup>a</sup> Not all respondents answered each question, so some rows may total less than 564; percentages were calculated using N = 564 and thus may not total 100%.

and frequency of such experiences. For this reason, caution must be used when generalizing from these study findings to nurses outside the study sample. The data collection tool did not differentiate between different types of unsafe situations or between different levels of retaliation. It's possible that respondents varied in how they interpreted survey terms such as "unsafe patient care condition" and "retaliation." Still, regardless of how individual interpretations might have differed, a nurse's perceptions about reporting (or not reporting) unsafe patient care conditions and about retaliation are noteworthy, as they help to better understand how workplace culture affects patient safety.

#### **RESEARCH INTO PRACTICE: BIRTH OF A WHISTLEBLOWER LAW**

If needed changes in organizational culture are to occur, state and federal policymakers must assist health care organizations in creating effective ways for detecting and preventing practices and situations that gravely threaten patient safety, such as those that led to the Las Vegas-area hepatitis C outbreak. As requested by the

final legislative language was reached. The bill provides the means for supporting nurses in a workplace environment that encourages "good faith" reporting of patient safety concerns; it also supports the employers' need to protect patients by retaining the means by which employers can discipline nurses whose actions pose a threat to patient safety. The bill was passed unanimously by the Nevada Assembly and with only one dissenting vote in the Nevada State Senate, and was signed into law on May 29, 2009.

The specific protections of Nevada's new whistleblower statute were codified into Nevada state law as NRS 449.205 and NRS 449.207. NRS 449.205 creates a policy structure that encourages open reporting of patient safety concerns by extending protections for any nurse or nursing assistant who

- in good faith reports "any concerns regarding patients who may be exposed to a substantial risk of harm" as a result of the failure of a facility or an employee "to comply with minimum professional or accreditation standards or applicable statutory or regulatory requirements"

---

## State and federal policymakers must assist health care organizations in creating ways for detecting and preventing practices that threaten patient safety.

---

Nevada legislature's Legislative Committee on Health Care, the findings of this study were presented to multiple legislative committees during the 75th regular session of the Nevada legislature in the spring of 2009, as was follow-up testimony.

Representatives from the NNA met with key stakeholders over the months preceding and during the legislative session to garner support for the bill (AB10; for details, visit <http://bit.ly/hPQLHd>). The bill was actively supported by the NSBN and by all labor unions in Nevada that were legislatively active. The NSBN is charged with protecting the public; providing nurses with a mechanism by which they can advocate the public's safety certainly falls within the realm of that charge. The support of the labor unions was also crucial. Other key supporters included the Nevada State Medical Association and the Nevada Department of Health and Human Services. Over the months that the bill was debated in both the state assembly and the state senate, the NNA and other stakeholders worked closely with key legislators to reach consensus on the final language of the bill. The NNA also worked closely with the Nevada Hospital Association to ensure that hospitals had a mechanism to protect patients in the event that a nurse was found to be practicing unsafely. After five months of negotiations, consensus on the

- refuses to engage in conduct that would violate the nurse's duty to protect patients from actual or potential harm
- refuses to engage in conduct that would violate Nevada's Nurse Practice Act or would subject the nurse to disciplinary action by the NSBN
- reports any information concerning the willful conduct of another nurse that would violate Nevada's Nurse Practice Act or is subject to mandatory reporting to the NSBN
- reports "any other concerns regarding the medical facility... that reasonably could result in harm to patients"

In the event that a nurse does experience workplace retaliation after having made a report to any external agency, NRS 449.207 stipulates that the victim can file a civil action and may be awarded compensatory and punitive damages. (For the full text of both statutes, visit [www.leg.state.nv.us/nrs/NRS-449.html](http://www.leg.state.nv.us/nrs/NRS-449.html).)

#### **CONCLUSIONS**

While it's unfortunate that an event as tragic as the largest nosocomial hepatitis C exposure in U.S. history served as the catalyst for this study, the findings provide an empiric view of a professionally and socially charged phenomenon that's typically discussed only

anecdotally. The study has served as an impetus for effective policy change. The resulting legal protections for nurses who blow the whistle on unsafe patient care conditions are essential first steps in creating a workplace atmosphere in which nurses can carry out their moral imperative: to prevent harm to patients whenever possible and to report potential or actual causes of such harm. It is vital that professional organizations, health care institutions, regulatory agencies, and legislative bodies work together to create environments that encourage and facilitate open reporting of anything that threatens patient safety, so that such threats can be promptly addressed. In doing all we can to avert potential and possibly irrevocable harm to our patients, all of us stand to gain. ▼

For 18 additional continuing nursing education articles on professional issues, go to [www.nursingcenter.com/ce](http://www.nursingcenter.com/ce).

Lisa M. Black is an assistant professor at the Orvis School of Nursing, University of Nevada, Reno. Funding to conduct this study was provided by the Nevada Nurses Association and the Arthur L. Davis Publishing Agency; project support was provided by the Nevada State Board of Nursing. Contact author: [lblack@unr.edu](mailto:lblack@unr.edu). The author has disclosed no significant ties, financial or otherwise, to any company that might have an interest in the publication of this educational activity.

## REFERENCES

- Centers for Disease Control and Prevention (CDC). Acute hepatitis C virus infections attributed to unsafe injection practices at an endoscopy clinic—Nevada, 2007. *MMWR Morb Mortal Wkly Rep* 2008;57(19):513-7.
- Centers for Disease Control and Prevention (CDC). The ABCs of hepatitis. Atlanta; 2010.
- Labus B. Outbreak of hepatitis C at outpatient surgical centers. *Public health investigation report*. Las Vegas, NV; 2009 Dec. <http://www.southernnevadahealthdistrict.org/download/outbreaks/final-hepc-investigation-report.pdf>.
- Fischer G, Schaefer M. *Epi-Aid trip report (2008-019): investigation of acute hepatitis C among patients who underwent procedures at clinic A: Nevada 2007*. Carson City, NV; 2008 May 15. [http://health.nv.gov/PDFs/Hepatitis/FinalEpi2\\_20080515.pdf](http://health.nv.gov/PDFs/Hepatitis/FinalEpi2_20080515.pdf).
- Southern Nevada Health District Outbreak Investigation Team. *Interim report on the Endoscopy Center of Southern Nevada hepatitis C investigation*. Las Vegas, NV; 2008 Mar 28. <http://www.southernnevadahealthdistrict.org/download/outbreaks/interim-hepc-investigation-report.pdf>.
- Society of Gastroenterology Nurses and Associates. *Position statement: reuse of single-use critical medical devices*. Chicago; 2008 Aug. <http://www.sgna.org/Portals/0/Education/Position%20Statements/SUDPositionStatement.pdf>.
- Schultz D. Statement of Daniel Schultz, M.D., Director, Center for Devices and Radiological Health, before the Committee on Government Reform, House of Representatives Sep 26, 2006. <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/ReprocessingofSingle-UseDevices/ucm121067.htm>.
- Assembly Committee on Health and Human Services, Senate Committee on Health and Education. Minutes of the joint meeting, seventy-fifth session, February 21, 2009. Las Vegas, NV: State of Nevada 2009.
- Committee on Identifying and Preventing Medication Errors, et al., editors. *Preventing medication errors*. Washington, DC: National Academies Press; 2007. Quality Chasm series [http://www.nap.edu/catalog.php?record\\_id=11623](http://www.nap.edu/catalog.php?record_id=11623).
- Kohn LT, et al, editors. *To err is human: building a safer health system*. Washington, DC: National Academy Press; 2000. <http://books.nap.edu/openbook.php?isbn=0309068371>.
- Page A, editor. *Keeping patients safe: transforming the work environment of nurses*. Washington, DC: National Academies Press; 2004. [http://www.nap.edu/catalog.php?record\\_id=10851](http://www.nap.edu/catalog.php?record_id=10851).
- Attree M. Factors influencing nurses' decisions to raise concerns about care quality. *J Nurs Manag* 2007;15(4):392-402.
- Bolsin S, et al. Practical virtue ethics: healthcare whistleblowing and portable digital technology. *J Med Ethics* 2005;31(10):612-8.
- Firth-Cozens J, et al. *Confronting errors in patient care. Report on focus groups*; 2002. [http://www.haps.bham.ac.uk/publichealth/psrp/documents/PS002\\_Final\\_Report\\_Firth\\_Cozens.pdf](http://www.haps.bham.ac.uk/publichealth/psrp/documents/PS002_Final_Report_Firth_Cozens.pdf).
- Meurier CE. Understanding the nature of errors in nursing: using a model to analyse critical incident reports of errors which had resulted in an adverse or potentially adverse event. *J Adv Nurs* 2000;32(1):202-7.
- Nuckols TK, et al. Contributing factors identified by hospital incident report narratives. *Qual Saf Health Care* 2008;17(5):368-72.
- Nuckols TK, et al. Comparing process- and outcome-oriented approaches to voluntary incident reporting in two hospitals. *Jt Comm J Qual Patient Saf* 2009;35(3):139-45.
- McDonald S, Ahern K. The professional consequences of whistleblowing by nurses. *J Prof Nurs* 2000;16(6):313-21.
- Joel LA. Moral compromise: burnout revisited. *Am J Nurs* 1997;97(10):7.
- Waters A. Nurses fear their concerns about care will be ignored. *Nurs Stand* 2008;22(37):12-3.
- Ray SL. Whistleblowing and organizational ethics. *Nurs Ethics* 2006;13(4):438-45.
- Independent Nurse. Culture of fear over whistleblowing. 2009 May 15;12.
- Gallagher A. Whistleblowing: what influences nurses' decisions on whether to report poor practice? *Nurs Times* 2010;106(4):22-5.
- Lachman VD. Whistleblowers: troublemakers or virtuous nurses? *Dermatol Nurs* 2008;20(5):390-3.
- Sack K. Nurse to stand trial for reporting doctor. *New York Times* 2010 Feb 6. <https://www.nytimes.com/2010/02/07/us/07nurses.html>.
- American Nurses Association. *Code of ethics for nurses with interpretive statements*. Silver Spring, MD; 2001.
- National Council of State Boards of Nursing. *NCSBN model nursing practice act and model nursing administrative rules*. Chicago; 2010 Aug. [https://www.ncsbn.org/Model\\_Nursing\\_Practice\\_Act\\_081710.pdf](https://www.ncsbn.org/Model_Nursing_Practice_Act_081710.pdf).
- Muhl CJ. The employment-at-will doctrine: three major exceptions. *Monthly Labor Review* 2001;124(1):1-11.
- Nevada State Board of Nursing. *NAC 632.890. Unprofessional conduct regulation*. Reno, NV n.d.
- American Nurses Association. *Whistleblower protection*. 2009. [http://www.nursingworld.org/MainMenuCategories/ANAPoliticalPower/State/StateLegislativeAgenda/Whistleblower\\_1.aspx](http://www.nursingworld.org/MainMenuCategories/ANAPoliticalPower/State/StateLegislativeAgenda/Whistleblower_1.aspx).
- Black L. Testimony before the Nevada Assembly Committee on Health and Human Services in support of Assembly Bill 10. Nevada Nurses Association; Feb 21, 2009. <http://www.leg.state.nv.us/75th2009/Exhibits/Assembly/HH/AHH184D.pdf>.
- Health Resources and Services Administration, Bureau of Health Professions. *The registered nurse population: findings from the 2004 National Sample Survey of Registered Nurses*. Washington, DC: U.S. Department of Health and Human Services 2006 Jun. <http://bhpr.hrsa.gov/healthworkforce/rnsurvey04>.
- One and Only Campaign. Safe injection practices under standard precautions. 2009.
- Siegel JD, et al. *2007 guideline for isolation precautions: preventing transmission of infectious agents in healthcare settings*; 2007. <http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf>.