Talking about safe practice
A way to look after yourself, your colleagues, and your patients

Undertaking this learning activity is equivalent to 45 minutes of professional development. It contributes to maintaining competence by helping you reflect on your responsibilities to provide safe care (including clinical and cultural safety) and manage threats to patient safety, and your involvement in quality activities that address safety issues and improve care for patients and their families/whānau.

See the Nursing Council defined competencies related to ensuring that patients receive safe care for RNs, ENs, and NPs at www.nursingcouncil.org.nz/index.cfm/1,55,0,0,html/Competencies

This learning activity also helps you explore the values underpinning professional conduct—especially integrity—as outlined in Nursing Council’s Code of Conduct for Nurses at www.nursingcouncil.org.nz/index.cfm/1,255,html/Code-of-Conduct-and-Guidelines

A

The questions in this section are designed to help you read the article attentively.

1. Amongst other insights, the patient safety movement supports the idea that:
   - ✔ professional training means clinicians never make errors
   - ❑ poorly designed systems can cause clinicians to make errors

2. Which of these is not given in the article as an explanation for silence around errors?
   - ✔ avoiding ‘blaming and shaming’ as punishment
   - ❑ no compelling reasons to change established practice
   - ❑ team members may feel it is not safe to speak up.

3. Adverse events are defined in this article as:
   - ✔ injuries caused by treatment
   - ❑ idiosyncratic responses to treatment

4. Reasons given in this article for analysing and addressing recurring but seemingly inconsequential disruptions in daily work include:
   - ✔ workarounds take time away from patient care
   - ❑ they can compound to cause a larger failure
   - ❑ they offer safety learning opportunities
   - ❑ all of these factors
   - ❑ none of these factors

B

This section helps you reflect on your learning from reading and relate it to your experience.

Think about a time when you were aware that patient safety was compromised. Which points in the article explain what helped you or others to speak up or take action? Which points in the article explain what inhibited speaking up or taking action?

What are your ‘take home’ learnings? List 3 points from the article

1.

2.

3.

C

The notes you make in this section show how you intend to apply your learning in practice

Please select from ‘Questions this article might prompt…’ the one of most relevance and interest to you. Outline your responses and then make brief notes on what would be most likely to help you and/or your team be open to reconsidering your practice. Note two or three specific attitudes or actions you can take to make it safe for yourself and others to speak up and raise issues in your work team.

Verification by a colleague of your completion of this activity: _____________________________

(Signature)