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Major Learning Experiences Revisited  
[Special Feature]

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The emphasis on learning is even stronger today than when "From Failures to Major Learning Experiences" was published in MCN in 1992. At that time, the focus was on learning from the errors and "failures" that we all experience - just as falls are viewed as exciting attempts at a new growth experience when a baby learns to walk.

Babies do not walk "right foot, wrong foot." Rather, they move both feet, one ahead of the other - sometimes falling and always learning in the process. But at some point in our lives, wonder, creativity, and risk taking are conditioned out of us, and the concept of "failing" is instilled. At that time, the critical ability to take risks - to stumble and fall during the learning process - is lost.

In the 21st century, successful organizations will value risk taking and support those individuals who make mistakes for the learning they attain. However, while it is important to state this approach from a philosophical perspective, it can be very different for an organization to put it into practice.

When a crisis occurs, what is the response? Support? Or is it reprimand and punishment? It is difficult to turn a disastrous event into a learning experience. It is easier to go for the quick solution, to dispose of the "perceived" problem rather than acknowledge the complexity of the situation. But firing one individual will not repair all the different levels of a problem.

Peter Senge, of the MIT Sloan School of Management, states that 21st century organizations will view events as opportunities for learning and growing because superior performance will depend on superior learning (2). The organization that succeeds in harnessing the collective genius of its people will gain the competitive advantage. Employees who continually improve their performance do so by learning from their mistakes and failures. In the learning organization, managers and executives help them succeed in this area.

In hospitals and all other health care settings, managers and advanced practice

nurses can provide this help even when they wish that the mistakes had not taken place or that the mistake, and the person who made it, would simply disappear. As wishes, these reactions are understandable. As solutions, they are neat, simple, and wrong. Such thoughts result from the temptation to smooth the situation over and to "look good," as if no mistake had happened. But the learning organization emphasizes the importance of recognizing mistakes and working with those employees who make them.

When health care institutions and facilities focus on a learning environment, the entire health care team must be included. Problems frequently involve several team members and disciplines, and the solutions will require an interdisciplinary approach. The following incident exemplifies such an approach.

#### The Precipitating Event

A serious medication error was made in a pediatric intensive care unit. A dose 50 times its appropriate amount was given to a small child with devastating results. The chief intensivist, the attending physician, and the director of nursing services were called immediately. Some in administration favored terminating the nurse's employment, but an extensive investigation revealed that:

- \* The resident wrote the order for the incorrect dose.
- \* The pharmacist filled the order.
- \* The nurse, a five-year employee, gave the incorrect dose. Furthermore, review of the nurse's employment record revealed no other warnings or disciplinary actions.

Clearly, a systems problem existed.

A conference was held to involve the nursing administration, the unit director, and the nurse. The nurse was devastated, but she was not fired. Her self-esteem was not further damaged, and her feelings of devastation were not made worse. Instead, she learned from the experience.

Had this nurse been fired, she would have been replaced by someone who lacked the benefit of this learning experience and might make the same mistake in the future. No one could guarantee that this would not happen.

The conference was followed by an emergency staff meeting, at which copies of the article "From Failures to Major Learning Experiences" were distributed. Staff members expressed concern about how their colleague was coping and empathized with her. They knew that all health care providers make mistakes at one time or another, as they are all human, and they wanted reassurance that they would not suffer correction by "crucifixion" or termination if, at some time in the future, they were in her place.

There was discussion about the hopelessness of hiding mistakes and the potential for learning from an examination of mistakes. Emphasis was on the systems aspects of the problem, rather than on blame for the resident, the pharmacist, or the nurse.

Of course, the resident was also devastated. The attending physicians, who remembered their own mistakes, worked constructively with him. Having read "From Failures to Major Learning Experiences" themselves, they decide to discuss

mistakes at the next Grand Rounds.

#### Mortality and Morbidity Monthly Conference

Approximately 100 attending physicians, residents, and medical students, in addition to nurses and allied health care providers, attended the Grand Rounds. The topic was clearly of interest to physicians.

For the conference, the chief pediatric intensivist created scenarios about specific incidents that had happened either to him personally or to colleagues in other settings. Along with the scenarios, he presented questions to stimulate discussion. (See Morbidity and Mortality Monthly Conference.) In addition, he provided copies of the article for all to read.

The intensivist opened the proceedings with the statement, "If nothing like these experiences has ever happened to you, then you have not been practicing medicine long enough." The ensuing discussion was lively, reflecting divergent opinions and resulting in a special sharing of the humbling yet human aspects of practicing medicine. Attending physicians shared experiences in which mistakes were "lessons," sometimes painful ones. Cure is not always a possibility, but when it is a mistake that causes a cure to be impossible, then that clinical event is particularly painful for the provider.

The physicians were supportive of each other, the students, and those in other disciplines - chaplains, lawyers, pharmacists, and nurses. All left with a new understanding of the sense of shared responsibility and disappointment when errors are made or when it becomes impossible to conquer disease.

Even without errors, clinicians suffer. But errors that harm or kill patients also undermine the confidence they need to continue their work. In the event that an error occurs, the successful organization will respond with psychosocial or spiritual interventions to help those who are intimately involved.

In this way, barriers between special interests and disciplines will be broken down, and the mythology surrounding specific groups as omnipotent or powerful will be eliminated. No one is perfect. We all make mistakes. But those of us who are most successful - organizations as well as individuals - will learn from mistakes and support one another.

#### MORBIDITY AND MORTALITY MONTHLY CONFERENCE FAILURES AND MISTAKES IN CLINICAL PRACTICE

##### CASES:

1. A four-year-old boy was admitted to the emergency department with status asthmaticus. The resident asked for a syringe of aminophylline and injected 1 mg/kg. During the bolus, the child's heart stopped and he could not be resuscitated. After the resuscitation attempt, a full syringe of aminophylline and an empty syringe marked KCL were discovered.

2. A six-month-old girl was admitted to the hospital with meningitis at 4 A.M. (the 11th of 12 admissions that night). Ampicillin was ordered by the on-call resident. He was awakened by a call the next night from the subsequent on-call resident informing him that the dose of ampicillin he had ordered had been 10 times the recommended dose. Three doses had been given.

3. While closing the chest after a coronary artery bypass graft procedure on a

43-year-old woman, a blood transfusion was ordered by the surgeon. Shortly thereafter, the patient went into shock, had a cardiac arrest, and could not be resuscitated. The empty bag of blood was found to be labeled for a patient two operating rooms away.

4. A six-year-old boy was recovering from craniofacial surgery. At shift change, his nurse noted the IV bag contained 30 meq of KCL/l rather than the 10 meq KCL that had been ordered.

#### QUESTIONS:

In each of these cases:

1. What, if anything, should the patient, patient's family, and/or patient's parents be told?
2. Who, if anyone, should do the "telling"?
3. Who, if anyone, should be present at the "telling"?
4. Who, if anyone, should be notified of the event?
5. What should happen to the "mistake maker"?
6. What are our moral and legal responsibilities in these instances?
7. Are the answers different for each case?
8. What is the trust our patients have for us as care providers based on?
9. What is the job of "risk management"?
10. What is the impact on performance of such factors as fatigue?

#### REFERENCES

1. Senge, P.M. The Leader's New Work: Building Learning Organization. Sloan Management Review Reprint Series, Vol. 32, No. 1, Fall 1990.
2. Senge, P.M. The Fifth Discipline: The Art and Practice of the Learning Organization, New York, Doubleday Dell Publishing Group, 1990.

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