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Stopping the Line: Training Staff to 'Speak Up' for Safety

More than four of five surveyed nurses expressed serious concern about the occurrence of dangerous clinical shortcuts, as well as displays of practitioner incompetence and disrespect for colleagues. But fewer than half told a manager of these concerns, and fewer than a third spoke directly to the problem individuals.[1] This reluctance to "speak up and stop the line" not only places patients at risk, it also creates the potential for litigation and consequent financial loss, as well as reputational harm and diminished morale.[2]

Consider the following hypothetical situation, set in a busy ambulatory surgery clinic:

> A patient is scheduled for surgical arthroscopy of the left knee and ligament reconstruction. She has a history of heart valve replacement, two carotid surgeries and several underlying medical conditions, including clotting disorders, asthma and new-onset diabetes. The attending orthopedic surgeon is a designated "high-volume" producer, based upon the large number of operations he performs annually at the for-profit clinic. Past utilization reviews of the surgeon's records raised red flags as to the medical appropriateness of many procedures, earning him a reputation among staff for hasty decision-making and inadequate documentation of patients' suitability for ambulatory surgery.
>
> During a routine preoperative check, a nurse notes that the patient has discontinued taking aspirin and blood thinners. Subsequent examination of the healthcare information record reveals that the patient's cardiologist has not been consulted regarding suspension of the blood thinners or other issues involving surgical readiness. On the morning of surgery, the patient presents with a slight decrease in blood pressure, a pale complexion and shortness of breath. The nurse then questions a supervisor about whether the operation should proceed. In response, the supervisor quips, "You don't want to go there; those decisions are above our pay grade." The questioning nurse says nothing more. The patient undergoes surgery as planned and codes postoperatively due to a pulmonary embolism. She is transferred to a nearby hospital, where she lapses into a coma and subsequently dies.

As this scenario demonstrates, silence can be fatal. Even the soundest of safety protocols are of little use if physicians, nurses, mid-level providers and ancillary staff are unwilling to confront team members when they see them disregard rules, take risky shortcuts, exhibit incompetence or impairment, or behave in an unprofessional or unethical manner.

All healthcare professionals should be ready to speak up and stop the line when they believe, based on their training and experience, that to proceed as planned may place a patient at risk. The willingness to take action becomes more important as economic and scheduling pressures increase in healthcare settings, resulting in a higher volume of procedures and an ever-quickening pace.

A well-managed healthcare facility is one where both professionals and patients feel free to speak openly about quality, safety and behavioral concerns, thus minimizing the potential for errors and maintaining a healthy, collegial atmosphere. This edition of *inBrief*® features a readiness checklist designed to aid ambulatory care organizations in implementing a Speak Up/Stop the Line program or enhancing an existing one. Such an initiative, when complemented by a formal incident reporting system, can help transform a culture of silence, fear and denial into one of candor, confidence and accountability.

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1 The work cited above builds upon a 2005 research study that, while older, remains relevant and continues to be cited in the patient safety literature.

2 *Speaking up* and *stopping the line* are two aspects of the same basic patient safety initiative, defined by the U.S. Department of Veterans Affairs as an effort to "encourage employees to report behaviors, action or *in*action that might result in errors or patient harm" without fear of repercussions.

Speak Up Campaigns: A Readiness Checklist

MEASURES	STATUS (CHECK IF PRESENT)	COMMENTS
ORGANIZATIONAL COMMITMENT		
1. **The goal of sustaining a culture of safety is fully embraced by senior leaders,** who lead by example and do all in their power to encourage and reward openness and accountability.		
2. **The qualifications of medical staff applicants are thoroughly investigated by the governing board,** with the focus on education, training, licensing and medical malpractice history, as well as overall professionalism.		
3. **An oversight committee is established by the governing board** to respond to expressed concerns and ensure that medical staff and mid-level providers practice within authorized privileges.		
4. **A supportive, non-punitive environment is fostered across the organization,** whereby providers and staff can admit mistakes, request help and seek input without negative consequences.		
5. **Staff are encouraged by leaders and supervisors to convey their concerns to teammates** and to respond to issues and questions raised by others in a civil, professional and fact-centered manner.		
6. **A Speak Up program for patients is established,** and patients and their advocates are actively encouraged to communicate concerns about their care. (See page 4 for more information about soliciting patient feedback.)		
7. **A formal Stop the Line policy is in place** to halt procedures whenever questions arise and help team members arrive collectively at a reasonable solution to potential problems. (See page 29 of the above link for guidance on the "two-challenge rule.")		
8. **Periodic focus-group sessions are held with staff members to identify commonly ignored lapses and abuses,** such as the following:		
- Failure to adhere to written admissions criteria.		
- Noncompliance with organizational policy and procedure.		
- Circumvention of safety protocols.		
- Medical incompetence and skill deficits.		
- Recurrent errors in clinical judgment.		
- Practicing beyond legally defined competencies.		
- Unprofessional behavior, e.g., incivility, lack of collegiality, uncooperative or bullying attitude.		
- Verbal abusiveness and insensitivity, e.g., name-calling, swearing, making rude or insulting remarks.		
- Threats and intimidation by individuals in positions of authority.		
9. **Clinical high-risk areas where silence is potentially most damaging are identified,** such as operating and recovery rooms, procedure and infusion suites, urgent care settings and discharge bays.		
10. **Confidential staff surveys are used to identify major obstacles to open communication,** including fear of retaliation, misplaced loyalty and anxiety about disrupting work relationships.		
11. **The organization's Speak Up/Stop the Line initiative and reporting protocol are actively promoted online** and via posters and infographics displayed in clinical settings and staff areas.		

MEASURES	STATUS (CHECK IF PRESENT)	COMMENTS
SUPERVISORY TRAINING/DUTIES		
1. **Training sessions are scheduled for supervisors, which focus on cultivating a healthy workplace culture** characterized by open communication, willingness to listen, accountability at every level, a non-punitive atmosphere, and a bedrock dedication to patient safety and continuous improvement.		
2. **In performance reviews, supervisors are assessed for their success in promoting Speak Up/Stop the Line program goals** and creating an environment where all staff members can be heard.		
3. **Supervisors are expected to raise concerns to other clinicians when appropriate,** thus modeling proper conduct and demonstrating their own commitment to eliminating silence and not looking the other way.		
4. **Time is allotted in every staff meeting to discuss patient safety, communication and incident reporting concerns;** to share information and ask questions about clinical situations and events; and to seek advice and feedback from supervisors and peers.		
STAFF TRAINING/EDUCATION		
1. **Staff members are regularly reminded of the importance of adhering to the organization's admission, monitoring and discharge criteria,** and of their role in maintaining rules and standards.		
2. **Staff training sessions are conducted periodically to reinforce safety awareness and accountability,** discuss questionable practices and behaviors, and teach sound communication techniques for use in conflict situations.		
3. **In training sessions, staff members are taught how to identify and react to various problematic clinical situations** via realistic role-playing scenarios and other evidence-based techniques, such as TeamSTEPPS strategies and tools.		
4. **Staff are trained to engage the chain of command** when practitioners provide care outside their privileges, fail to respond to requests, exhibit impairment or place patients in jeopardy through unprofessional behavior.		
5. **The protocol for handling a non-responsive chain of command is explained to staff,** including reporting to the medical director, administrator, risk manager or other departmental or organizational leaders.		
6. **Detailed records are maintained of all training sessions,** including topics, dates and names of attendees.		
7. **Podcasts, videos, websites and other online instructional tools are employed on an ongoing basis** to educate staff about the potential consequences of staying silent in the face of clinical incompetence or ethical breaches, and also to demonstrate proper responses to such situations.		

MEASURES	STATUS (CHECK IF PRESENT)	COMMENTS
REPORTING POLICIES/PROCEDURES		
1. **A formal protocol for documenting and reporting errors, near-misses and staff concerns is developed and implemented,** in order to ensure that organizational leadership is accurately and thoroughly apprised of safety issues.		
2. **Incident reporting parameters and other documentation requirements are contained within the protocol,** as well as a delineation of the chain of command.		
3. **Staff members are permitted to report their concerns anonymously** if they have reason to feel less than safe or comfortable speaking directly to others about them.		
4. **Once information about an incident has been gathered, a root cause analysis is conducted** to reveal unsafe practices, underlying process issues and staff noncompliance, as well as to suggest practical improvements.		
5. **Reported concerns are responded to in a timely and constructive manner,** in order to prompt needed changes and strengthen staff members' trust in the reporting system.		
6. **A debriefing session is convened after incidents are reported and resolved,** and examples of staff members speaking up are acknowledged and documented.		
7. **Staff members who voice reasonable concerns through proper channels are rewarded** in the form of favorable performance reviews, letters of commendation and other positive reinforcements.		
8. **Written policies are promulgated that prohibit retaliation against or shaming of staff members who report problems,** or who challenge questionable clinical procedures or decisions.		
PATIENTS/FAMILIES AS PARTNERS		
1. **Patients, family members and legal guardians are encouraged to speak up when necessary** and advocate for patient safety and well-being. (See the patient- and advocate-oriented Speak Up™ initiative developed by the Joint Commission, which includes educational and publicity material.)		
2. **Patient feedback is actively and continuously solicited,** and the organization's Patient Bill of Rights (also known as the Patient Care Partnership) expressly lists the right to ask questions and speak openly about quality and safety concerns.		
3. **An informational brochure is offered to patients upon their initial visit** that explains their rights and responsibilities, and encourages them to become active and informed participants in their own care.		
4. **Discussions about patient rights and self-advocacy are documented** in the patient health information record, as is distribution of informational brochures and other educational materials.		

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