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Lisa Harton

*Loyola University Chicago*, lharton1@luc.edu

Lisa E. Skemp

*Loyola University Chicago*, lskemp@luc.edu

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# Medical–surgical nurse leaders' experiences with safety culture: An inductive qualitative descriptive study

Lisa Harton PhD, RN, FACHE, Chief Quality Officer |  
Lisa Skemp PhD, FGSA, FAAN, Professor

Marcella Niehoff School of Nursing, Loyola University Chicago, Chicago, Illinois, USA

## Correspondence

Lisa Harton, 1016 BVM Hall, Marcella Niehoff School of Nursing, Lake Shore Campus, 1032 W. Sheridan Road, Chicago, IL 60660, USA.  
Email: [lisalharton@yahoo.com](mailto:lisalharton@yahoo.com)

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## Abstract

**Aim:** The aim of this study is to describe safety culture as experienced by medical–surgical nurse leaders.

**Background:** Safety culture remains a barrier in safer patient care. Nurse leaders play an important role in creating and supporting a safety culture.

**Methods:** We used an inductive qualitative descriptive study using semistructured interviews, document review and observations in a Midwestern community hospital in the United States.

**Results:** Results of the study are as follows: making sure nurses are keeping patients safe, making sure nurses have nursing interventions in place, expecting nurses to stop unsafe acts or escalate when they feel uncomfortable, making sure nurses have what they need to provide safe care, organization prioritizes patient safety and making sure nurses are learning and growing emerged as themes describing safety culture.

**Conclusions:** Nurse leaders made sure patients were safe by making sure everyone was doing their best to provide safe care. Insufficient time, too many priorities, insufficient resources, poor physician behaviours and lack of respect for their role emerged as barriers to leading a safety culture.

**Implications for Nursing Management:** Organizations must remove barriers for nurse leaders to develop and lead a safety culture. Nurse leaders must learn to advocate successfully for safe nursing care and professional work environments.

## KEYWORDS

acute care, nurse manager, patient safety, safety culture

## 1 | BACKGROUND

The Institute of Medicine (IOM, 2000) seminal report on preventable patient harm identified 44,000–98,000 deaths annually from avoidable medical errors. Health care system leadership and researchers responded to this problem by studying systems that led

to errors to create safer care processes while also addressing safety culture (Gandhi et al., 2016). Despite efforts to improve patient safety, one in 20 patients continue to experience preventable harm (Panagioti et al., 2019). Delivering safe care requires leaders to establish, lead and sustain safety as a core value resulting in improved safety culture (Gandhi et al., 2016). Safety culture is the product of

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individual and group values, attitudes, perceptions, competencies, and patterns of behavior that can determine the commitment to, and the style and proficiency of an organization's health and safety management plan (Health and Safety Commission Advisory Committee on the Safety of Nuclear Installations, 1993, p.339). A positive safety culture in hospital nursing units resulted in fewer reported adverse patient outcomes including decreased patient falls, medication errors, pressure injuries, hospital associated infections and higher patient satisfaction (Alanazi et al., 2022).

Leader expectations, support, prioritization and commitment to patient safety, accountability, sharing data, daily management practices, focusing on safety behaviours, teamwork and communication, learning and improvement and executive rounding positively impact safety culture (Campione & Famolaro, 2018; Churruca et al., 2021; Frush et al., 2018). A systematic review identified that organizational safety cultures are underdeveloped or weak in regard to staffing, nonpunitive response to errors, handovers and transitions of care and teamwork across units (Reis et al., 2018). Failure of leadership to prioritize and support patient safety has been associated with poor patient safety outcomes (Patient Safety Advisory Group [PSAG], 2017).

Efforts to develop a safety culture have not had a significant impact. For example, the Agency for Health care Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture (SOPS) 2021 trending report identified a 1% decrease in overall perception of patient safety and 40% of hospitals reported a 5-point or more decrease in management support for patient safety (Famolaro et al., 2021). Nurse leaders (NLs) are a subset of administration and management respondents that have the most favourable safety culture perceptions. They lead Registered Nurses (RNs), a subset of nurse respondents within the AHRQ SOPS survey, who, in contrast, have the least favourable perception of safety culture.

Nurse leaders play an important role in creating and supporting a safety culture and leading a professional nursing work environment. A professional nursing work environment has been associated with better safety culture and patient outcomes (Lee & Dahinten, 2020; Olds et al., 2017). Adequate staffing, managerial support for nurses and good nurse-physician relations contribute to a professional nurse work environment (IOM, 2004). Hospital manager behaviours that promote patient safety and transformational leadership styles influence and predict nurse-perceived patient safety (Anderson et al., 2019; Campbell et al., 2021; Ferreira et al., 2022; Lee & Dahinten, 2020; Weaver et al., 2017). Transformational leadership had a significant indirect effect on adverse patient outcomes through structural empowerment (Boamah et al., 2018). Structural empowerment explains how leaders can influence employees to accomplish their work effectively by providing access to information, support, resources and opportunities (Kanter, 1993).

Transformational leadership is a relational leadership style in which followers have trust and respect for the leader and are motivated to do more than is formally expected of them to achieve organizational goals (Bass, 1985). Transformational leadership consists of four core dimensions. Idealized influence describes a leader who is an exemplary role model, sets high standards of conduct and articulates

the vision of the organization. Inspirational motivation occurs when leaders articulate a compelling vision. Intellectual stimulation occurs when leaders solicit a variety of opinions perspectives in making decisions and empower employees to constantly be learning, looking for and acting upon opportunities (Bass, 1985). Finally, individualized consideration occurs when leaders coach or mentor to the individual differences in needs of employees to help them reach their full potential (Avolio et al., 1999).

Assessing safety culture in health care has relied predominantly on quantitative methods that measure varying dimensions of a safety culture but lack an understanding of cultural assumptions and behaviours (Churruca et al., 2021). Through a better understanding of nurse leader experiences within the situational context of a medical-surgical unit, safety culture perceptions will be better understood, behaviours described and facilitators and challenges identified to provide insight into areas for prioritization or improvement. Therefore, this study aimed to describe medical-surgical nurse leader experiences with safety culture in a Midwestern United States hospital to inform factors that support leading a safety culture in nursing. This study is part of a larger study describing the similarities and differences in safety culture experiences between RNs and nurse leaders.

## 2 | METHODS

### 2.1 | Design and participants

An inductive qualitative descriptive study was used for data collection and analysis. A purposive sample of nurse leaders with at least 6 months experience supporting the medical-surgical units were recruited through flyers, a recruitment email and during hospital safety huddles. Safety huddles or short, stand-up meetings occurred each morning between nurse leaders and their staff allowing teams to actively manage quality and safety by looking back at performance and looking ahead to proactively discuss safety concerns (AHRQ, 2017). Data saturation was reached at 10 nurse leader participants. Nurse leaders were at a minimum bachelor's prepared RNs that had 24 h accountability for a direct care unit or units.

### 2.2 | Data collection

Informed consent was obtained. Data were collected through a semi-structured interview guide. Interviews were conducted by the first author, a nurse researcher with over 15 years of leadership experience in acute care settings. Interviews were conducted in secure and comfortable locations chosen by the participants and lasted, on average, 1 h. Confidentiality was maintained by using pseudonyms during transcription. Audio tapes of interviews were transcribed verbatim, reviewed line-by-line and compared with the audio recordings to ensure accuracy. The second author, a nurse researcher with expertise in qualitative research, reviewed a sample of audio recordings and all transcripts to validate transcriptions. Key policies, protocols and

documents discussed in interviews were collected and reviewed to enhance the credibility of data collection. Observations of 16 safety huddles allowed the researcher to observe group safety behaviours and were captured in field notes.

## 2.3 | Data analysis

Data analysis was conducted by two qualitative nurse researchers. Inductive qualitative content analysis was applied to analyse and summarize data resulting in six themes (Sandelowski, 2000). Analysis was manual and occurred concurrently with data collection using a five-step process (Miles et al., 2014). First, data were managed and organized into secure files. Second, data were read and re-read while memoing emergent ideas to capture phrases and words to identify initial codes. Third, in vivo coding allowed clustering of similar data using first cycle coding that was continuously revised to accommodate new data. Then, pattern codes were generated through second cycle coding to identify emerging themes. Subthemes provided rich description of participant experiences by providing quotes, emotions and context to ensure that the voices, feelings, meanings and actions of the participants were described in sufficient detail. In the fourth step, interpretations were developed and assessed. Fifth, results were validated by member checking and by researcher triangulation through consensus. Findings were compared with what is known in the literature.

## 2.4 | Rigour

Rigour was established by adhering to the four criteria described by Lincoln and Guba (1985). Credibility was ensured by pilot testing the interview guide, flexible, systematic, purposive sampling, ensuring participants had the freedom to provide rich information, participant-driven data until saturation was reached, triangulation of data collection through multiple sources, accurate and timely transcription, data-driven coding with member checking, investigatory triangulation and on-going attention to context. Confirmability was ensured through bracketing personal bias, investigator triangulation and member checking. Dependability was ensured through a documented extensive, detailed audit trail. Transferability or fittingness of the results is determined by the reader.

## 2.5 | Ethical considerations

The study was approved by the University IRB and the study site research ethics review committee.

## 3 | RESULTS

The 10 participants were female and held at minimum a bachelor's degree in nursing as was required for the role. There was variation in

age (28–62 years of age) and years of experience as a nurse leader (2–21 years). All nurse leaders worked at least 40 h a week predominantly on the day shift (90%) (Table 1).

Six themes described nurse leader experiences with safety culture. Within the themes, 16 subthemes provided rich description of the meaning of those experiences (Figure 1). This resulted in nurse leaders making sure patients were safe by making sure everyone was doing their best to provide safe care.

## 3.1 | Making sure nurses are keeping patients safe

Nurse leaders set expectations and held RNs accountable for gathering information from and about their patients and ensuring a

**TABLE 1** Demographics

Characteristic	NL (n = 10)	
	%	n
Gender		
Male	0	0
Female	100	10
Role		
Supervisor	40	4
Manager	50	5
Director	10	1
Age		
20–29	10	1
30–39	50	5
40–49	30	3
50–59	10	1
Highest education level completed		
Bachelor's	90	9
Master's	10	1
RN, number of years		
4–5	10	1
6–10	20	2
> 10	70	7
Years as a nurse leader		
2–3	20	2
4–5	10	1
6–10	40	4
>10	30	3
Hours worked per week		
0–24	30	3
25–40	70	7
Shift most often worked		
Days	90	9
Nights	0	0
Rotating	10	1

Themes	Subthemes
Making sure nurses are keeping patients safe	<ul style="list-style-type: none"> <li>Knowing the patient by reviewing the electronic medical record</li> <li>Bedside shift report to know the patient and catch things upstream</li> <li>Risk assessments to determine patient risks</li> </ul>
Making sure nurses have nursing interventions in place	<ul style="list-style-type: none"> <li>Setting expectations and holding nurses accountable for following nursing interventions</li> <li>Checklists, alarms, warnings, and safety checks</li> <li>Workarounds</li> </ul>
Expecting nurses to stop unsafe practices or escalate when they feel uncomfortable	<ul style="list-style-type: none"> <li>I expect direct conversations about safety</li> <li>Get the right eyes on the patient</li> <li>We don't have great relationships with our physicians</li> </ul>
Making sure nurses have what they need to provide safe care	<ul style="list-style-type: none"> <li>Balancing financially responsible staffing with patient needs is challenging</li> <li>Supplies and working equipment aren't always available to keep nurses at the bedside</li> </ul>
Organization prioritizes patient safety	<ul style="list-style-type: none"> <li>Establishing goals and providing transparency</li> <li>Communicate, listen to understand, and respond to nurse concerns</li> </ul>
Making sure nurses are learning and growing	<ul style="list-style-type: none"> <li>Nonpunitive response and follow through</li> <li>Support nurse knowledge and education</li> <li>Learning through audits and stories</li> </ul>

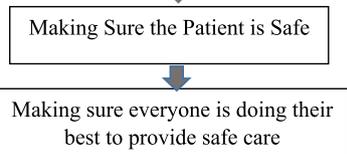


FIGURE 1 Results

collaborative plan to proactively keep patients safe. The subthemes described knowing the patient by reviewing the electronic medical record, bedside shift report to know the patient and catch things upstream and risk assessments, when completed, determined patient risks. This was described as the safest day.

When the patient is admitted there is collaborative, effective communication with all care team members. There's a plan of care to keep the patient safe whether it's preventing falls, preventing any kind of harm. To make sure that we have the best standards in place to prevent harm from that patient. (RNL04)

Nurse leaders described RNs as spending a lot of time looking for information that was not always accurate and did not transfer from most settings outside of the hospital. Bedside shift report facilitated knowing the patient and involving them in the plan of care which helped RNs catch things upstream by validating the patient's condition and ensuring safety interventions were in place. Although they shared stories to help RNs understand the benefits of bedside shift report and conducted audits to increase compliance, they were not done consistently or accurately.

Handover is mind-boggling to me that people have trouble getting nurses to buy into it because [I] can give examples that demonstrate from a patient perspective what that means. I talk to my nurses about

the position they can put you in if you do not do it right. You did not do handover and the IV rate is wrong, you have an infiltrated IV. All these things that the previous nurse maybe was part of and now you cannot even ask those questions. Now you have got to explain the situation to the patient and doctor, and you do not have the background. (RNL02)

Finally, nurse leaders described risk assessments, when completed, determined patient risks to inform a clear plan to keep patients safe. A review of a risk assessments confirmed that prevention interventions were recommended based on a calculated risk score. However, NLs described that RNs not having time and being too busy were barriers to completing risk assessments.

### 3.2 | Making sure nurses have nursing interventions in place

Nurse leaders set expectations and held RNs accountable for having nursing interventions in place. Nursing interventions were defined as policies and protocols developed using professional standards and evidence-based practice for RNs to follow to guide safe patient care. The subthemes described setting expectations and holding staff nurses accountable for following nursing interventions: checklists, alarms, warnings and safety double checks and workarounds to keep patients safe.

The IV policy is a reference that my nursing team utilizes. Recently there was another unit that wanted to transfer a patient who was on a nitro drip for high blood pressures that needed to be titrated. Currently our team is not competent in that, nor are we staffed to take care of that acuity to make sure that we are monitoring that patient safely. So, they were able to use that policy and stop it right there and figure out a different plan to keep that patient safe. (RNL02)

Nurse leaders could not agree on how prescriptive nursing interventions should be to support the use of nursing judgement. They acknowledged that RNs did not always follow nursing interventions placing patient safety at risk. Nursing interventions were not followed because they were too complicated, confusing, unrealistic, ever-changing, not easily accessible at the point of care, outdated and were too open to interpretation. 'You're trying to coach on fall prevention to the 17-page policy. By the time you get around to every nurse to personally coach them, they've changed it' (RNL04). Key policies were reviewed to confirm this result. During a safety huddle observation, a NL took over 15 min to explain a 17-page safety policy that RNs still found confusing and unreasonable. The organization had shared governance councils and improvement teams to incorporate RN input into nursing interventions; however, nurse leaders described a lack of RN engagement to participate. They also described not enough RN representation, members not trained on how to use evidence-based practice to develop nursing interventions and no training on managing group conflict as barriers.

Nurse leaders made sure RNs understood expectations through consistent, clear communication, auditing, rounding and feedback to ensure learning and compliance. They acknowledged inconsistency in how they set expectations and held RNs accountable.

We have hounded on medication safety so much or even bigger is shift handover at the bedside. Finally, we all agreed between the hospital leadership we are really going to hold people accountable. You cannot turn your head. We've got to hold people accountable [slamming fist in hand]. (RNL06)

After tracking and coaching for so long, nurse leaders believed RNs did not follow standards because they lost sight of the patient in all the busyness and being overwhelmed.

Alarms, warnings, checklists and safety checks were supportive when they were working, easily accessible and responded to. Nurse leaders described that RNs did not always respond to alarms because they were too busy or perceived socialization took priority over answering alarms.

A lot of socialization takes priority over patient care. I do not know if it's because half the time they are so busy and rundown that when they are not it's 'I have

to breathe. I do not want to do any work, I just want to be able to chitchat and have some downtime' or if it's just a culture that we have grown. (RNL09)

They described that RNs did workarounds in nursing interventions because of real- or perceived-time pressure, knowledge gaps and lack of accountability.

### 3.3 | Expecting nurses to stop unsafe practices or escalate when they feel uncomfortable

Nurse leaders expected RNs to stop unsafe practices immediately, reach out to others with more expertise when they were in unfamiliar situations, and escalate, or reach up to the nurse leader or the rapid response team, to meet immediate patient needs. The subthemes described expecting direct conversations about safety, getting the right eyes on the patient and we do not have great relationships with our physicians.

No fear. I [RN] would not think twice about stopping somebody from doing something if I felt it wasn't the right thing. I hear people talk about it, somebody will tell me I saw so-and-so do this and I'll say how did they react when you let them know. Of course, the answer I get is 'I did not'. Not having that fear would be a safety culture. They have the power to do it, I do not think they always believe they have the power. (RNL01)

Direct conversations about safety occurred when a RN would speak up immediately to anyone at any time to keep the patient safe by stopping unsafe practices, poor practices or disrespectful behaviour. Nurse leaders described RNs as struggling to have direct conversations and stopping unsafe practices that have resulted in patient harm.

Sometimes they do not [speak up]. A lot of times that is due to hierarchy, poor relationships that they have, and some of it is based out of fear because they do not want the provider mad or to get yelled at. There's opportunities in pockets and opportunities for collaboration across the organization. (RNL10)

Nurse leaders coached, trained and encouraged direct conversations and stopping unsafe practices by recognizing and rewarding these behaviours. They also sought to empower RNs by promoting patient advocacy, reminding the RN of their duty and engaging the CEO in advocating for the important role of the RN in the organization. Nurse leaders had an open-door policy and followed up on RN concerns to model how to have direct conversations. Fear, lack of leader availability and lack of RN confidence were identified barriers. Fear was attributed to not wanting to look incompetent or challenging to physicians.

Nurse leaders believed RNs used their resources to keep patients safe in situations where they lacked experience or were unable to get what they needed to keep the patient safe. Resources included leaning on each other, other specialties, escalating to a nurse leader or calling a rapid response team that brought additional resources such as respiratory therapy and an intensive care unit nurse to the bedside to assist. The charge nurse was the most valuable resource when they were not busy and were approachable.

Nurse leaders described that resources were not available, barriers not removed and negative experiences when escalating a situation caused RNs to delay or question escalating, thereby placing patients at risk. In particular, a pattern of poor behaviours from physicians and other disciplines that was never addressed.

If it's a one-time thing, you are having a bad night our nurses do not care. Everyone has a bad day. It's when it's a consistent repetitive [physician] behaviour that we have tried to address. It's just a slap in the face from the provider and honestly the organization because you are told we should not have to deal with this and to have it consistently ignored on all levels is just like a slap in the face. (RNL09)

Nurse leaders explained that RNs on their unit work well together as a team, however, described challenges working with other departments. Aligned goals, positive attitudes, being approachable and reliable, good communication and leading by example facilitated working together. They explained that developing relationships with other departments, disciplines and each other while learning to appreciate each other's unique roles facilitated a safety culture.

The medical director is very engaged in providing education and answering questions, teaching on new procedures. That's good collaboration. That not only helps with patient safety because they are an integrated part of the care team but, they are helping develop nursing along the way. (RNL10)

They believed there were some RNs that just did not care, were too busy and burned out, prioritized socialization over helping and chose to not speak up as barriers to working together.

Nurse leaders identified that poor relationships with physicians contributed significantly to unsafe care.

The most pressing thing to be addressed is a way to develop and foster relationships between these two [RNs and physicians]. If we do not have a foundational relationship, then we cannot respectfully work side-by-side and learn from each other. (RNL01)

Unsafe delays in care were related to a lack of or unprofessional response from physicians when RNs advocated for their patients' health and safety needs. A nurse leader described 'If the nurse feels

belittled, they aren't going to bring something up that someone is going to put down because they don't feel comfortable based on responses they received in the past' (RNL03). As such, nurse leaders focused on the RNs and worked with them to cultivate relationships and professional, respectful communication between physicians and RNs by role modelling. On the other hand, reported poor physician behaviours were not addressed.

### 3.4 | Making sure nurses have what they need to provide safe care

Nurse leaders secured appropriate resources to keep RNs at the bedside. The subthemes described that balancing financially responsible staffing with patient needs is challenging, and supplies and working equipment are not always available to keep RNs at the bedside. Inadequate staffing contributed to the most unsafe day.

If we do not have staff and there's patients that need help you are in a bind. The organization is here to serve the community, but if there is not nurses to take care of them, what do we do? It's been just take more patients and that makes a nurse feel like it's unsafe. Where do you stop? (RNL07)

Although nurse leaders described appropriate nurse-patient ratios, they acknowledged skill mix, inability to transfer high acuity patients to a higher level of care, geographic patient placement on the unit, patient and family dynamics, frequent discharges and admits and patients that required multiple RNs to assist in their care as barriers.

When we are short staffed, I'm seeing patients not ambulating in the hallway, call lights going off which put our patients at risk of falling. Yesterday there was a dressing change that was supposed to take place in the morning, but it did not happen until the afternoon so risk for infection. The interventions need to be completed but they aren't because they just cannot get to them. (RNL03)

Low RN turnover, decreased vacancies, RNs helping each other, having and enforcing unit admission guidelines, dispersing acuity among assignments and support such as a transport team so the RN could focus on nursing care all facilitated safe care. They addressed staffing shortages by being available to help, forcing RNs to stay over their shift, calling in extra help, agency or travel RNs, showing appreciation for RNs that pick up extra shifts and using technology to supplement patient monitoring and responding to patient needs.

Nurse leaders acknowledged that supplies and working equipment were not always available to keep RNs at the bedside due to a lack of support from departments they depended on for delivery and repair. Nurse leaders felt disrespected as they were

unable to use their authority or influence to get resources to keep RNs at the bedside.

I do not feel that I am respected. I was trying to work with our inventory supply to make sure that we had the right supplies at the right time for our nurses so we are not running around. He kept on going to the directors to get approval for things I wanted to try on my unit. So, it was very frustrating. (RNLO2)

### 3.5 | Organization prioritizes patient safety

The organization prioritized patient safety by communicating to all departments and members of the health care team that patient safety was the overarching priority. The subthemes described establishing goals and providing transparency and communicating, listening to understand and responding to nurse concerns.

It's everyone having the same understanding of what a culture of safety is. What does it look like, feel like and then having shared outcome goals to help pull that care team together more so that everyone's on the same page on providing that kind of care for that patient. When everybody is on the same page about safety it looks beautiful. (RNLO2)

The CEO communicated and supported a vision of zero preventable harm. Then, patient safety goals were developed and aligned across all roles within the organization with routine transparency of outcomes.

Being able to focus on the quality of care and having them be our metrics for the year has helped so the nurses know we are not just focusing on financials we are focusing on your patient and how we can prevent any harm. (RNLO3)

Facilitators included an online incident reporting system, safety huddles and frequently reviewed visible patient safety dashboards. There was variation between departments of what safety as a priority for everyone meant, which left nurse leaders feeling disrespected and unable to remove barriers for RNs.

My team members probably can speak to how I lead and how I speak about it and share what their thoughts are, but I believe from the actions from other departments that people do not share the same passion like we do. It's very frustrating and very sad because it's like banging your head on a wall. (RNLO2)

Too many priorities and frequently changing priorities due to frequent turnover in executive leadership were barriers leaving nurse leaders feeling as if they were not doing anything good at all.

There's so many quality indicators that we are trying to focus on and there's no support for any of that so it relies on me. You cannot focus on all of them every day and you feel like you aren't doing anything good at all. (RNLO4)

Sometimes I feel like we are firefighting. We're not preventing before it happens which then does not make it feel like a safety culture. You have to prioritize and it's very hard to understand where my focus needs to be. I know patient safety is the number one focus but with everything else coming at me what can I set aside to really be able to do what I need to do. (RNLO3)

They prided themselves in communicating, listening to understand and responding to RN concerns. They described:

It's always being open to listen and saying I appreciate you talking this through and just please be honest with me. I think some of that is just being open and having my door open and always letting people know that I'm here if you need anything. (RNLO5)

Nurse leaders communicated through staff meetings, weekly updates, emails, daily rounds and daily huddles. They identified the barriers of inconsistent messaging among nurse leaders, a lack of sharing among nurse leaders to spread learnings and a lack of time for nurse leaders to spend time listening, communicating, and responding with RNs. Although they described themselves as advocates for RNs, they identified a disconnection between system expectations and what was happening at the bedside with an inability to effectively lead or advocate on behalf of RNs. They described how 'I think that there's sometimes a disconnect between what we'd like to do as a system and where we are right at the bedside ... The communication chains are not always consistent and robust, and we don't share very well' (RNLO6). Furthermore,

If we could just get consistent leadership...it feels like we are always starting over and having to build new relationships. There's a lot of fear because of the lack of relationships and trust because no one really trusts anybody anymore because they do not know the people. You have to run things by them, notify them, versus just moving things faster because I do not want to get in trouble. (RNLO4)

### 3.6 | Making sure nurses are learning and growing

There was a structure and process to learn from internal threats to patient safety and through formal programs to develop RN skills. The

subthemes described a nonpunitive response and follow through, supporting nurse knowledge and education and learning from audits and stories.

If something happens, we do not point fingers and discipline you, we put in an incident report, gather data and then we build off of that, because it only makes everybody stronger instead of just pointing fingers. (RNL07)

Building trusting relationships with RNs and respectful coaching facilitated reporting of safety events.

Relationship with your team is so important because they need to find comfort in their leader. I have said so many times how to get ahold of me when I'm not here. Daily connections provide comfort to nurses. They need as much information that pertains to them as possible because I think that reduces anxiety. (RNL04)

Providing real-time, nonjudgmental feedback helped RNs learn. At safety huddles, nurse leaders were observed following up by bringing issues back for learning. Meeting with individuals and other departments, sharing learnings through newsletters, debriefing in real time and supporting root cause analysis to identify and change system issues were facilitators.

Then RNs learned through an online learning system and through financial support for certification and conferences; however, nurse leaders acknowledged that RNs did not participate because on-going education was not required. They were concerned with RNs' ability to provide safe care because of the orientation process. Nurse leaders identified both role conflict and overload. For example, they did not feel qualified to develop their own orientation process and struggled finding competent preceptors to train new RNs. They also struggled with the lack of leader training or development for themselves. 'There is lack of orientation for leaders. You're trying to develop yourself, develop your team, maintain day-to-day practice, and then still make sure your team feels like you're available and there to support them' (RNL04). They also shared stories about clinical situations to create a learning environment. Finally, they audited key processes and shared the results and impact of not following key processes as a mechanism for learning.

## 4 | DISCUSSION

The role of the nurse leader is to provide the vital link between the organization's strategy and the frontline nurses (American Organization of Nurse Executive [AONE], 2015). Nurse leaders described that experiences with safety culture provided context to understand what is influencing safety culture perceptions. The organization aligned the vision to support patient safety; however, support for nurse leaders to deliver on this was lacking.

Nurse leaders described significant barriers in developing a safety culture including a lack of time, role overload, organizational constraints, inability to effectively lead, lack of power, role conflict and lack of respect for their role. Lack of time prevented nurse leaders from spending the time they wanted to build relationships with RNs. This left them feeling frustrated, disrespected and as if they were not doing anything good at all. Chronic fatigue associated with 24 h accountability and intense role expectations has been associated with nurse leader intent to leave the role (Steege et al., 2017). To address nurse leaders being too busy, recommendations include shifting from busy work to focused, strategic work through an energy preservation framework to promote vitality that drives engagement, productivity and innovation (Shirey & Hites, 2015). However, empirical support of nurse leader tactics to promote prioritization and accomplishment of duties is lacking. To retain nurse leaders and change the trajectory of safety culture in nursing, attention needs to be paid to these experiences which will require different organization understanding and support of the nurse leader role.

Nurse leaders need to be able to incorporate all dimensions of the transformational leadership framework to positively impact safety culture (Avolio et al., 1999) while being able to lead a professional work environment (IOM, 2004). Nurse leaders could not inspire and motivate through transformational leadership because of lack of power and inability to influence a professional work environment. This rendered them ineffective and led to unintended consequences including emotional stress and feelings of inadequacy. For example, they described a clear, compelling patient safety vision and multiple methods to communicate that vision and listen to RNs; however, they were unable to effectively address issues that were raised. Although they wanted to support RNs, they were unable to influence adequate staffing, could not obtain resources to keep RNs at the bedside and lacked power or organizational support to address poor physician behaviours. They also provided information and some levels of support but the inability to provide resources prohibited RNs from engaging in decision making and professional development, all components of structural empowerment (Kanter, 1993). Nurse leaders must become skilled at advocating for a professional work environment. The lack of power to create and sustain a healthy work environment must be further studied. One cannot empower others and expect them to perform beyond minimal requirements if basic resources are not available and if nurse leaders are not empowered themselves. The role of structural empowerment and a professional work environment in developing a safety culture should be further explored. Organizations must also take a stand and not tolerate poor behaviours from any members of the health care team.

The desire to support RNs to provide safe care within a positive safety culture without the power or ability to do so left nurse leaders feeling frustrated, disrespected, emotionally distressed and inadequate. These results suggest that nurse leaders' safety culture experiences are conflicting with or may be diluted by combining their results with nonnursing administrative and management participant results of the AHRQ SOPs. Isolating nurse leader results in addition to research focused on understanding the nurse leader role in creating a safety

culture to redesign or support differently the role is necessary to change the trajectory of safety culture in nursing.

## 5 | LIMITATIONS

A pandemic was experienced after three interviews; however, the hospital did not experience a surge of patients until the final validation of results. The researcher served in a leadership role at the organization without any formal or matrixed authority over the participants. While this research was conducted in one hospital in the Midwestern United States, research on how leadership and safety culture in different contexts nationally and internationally is needed to further enrich our understandings of safety culture in acute care. Although these results are not intended to be generalizable, the rich description will support the reader in determining the transferability of the results within their own practice.

## 6 | CONCLUSION

This study provided important insights into nurse leader experiences with safety culture and safe patient care within medical-surgical units in an acute care hospital. Nurse leaders described many barriers in developing and leading a safety culture and providing safe care. If nurse leaders are accountable for safe nursing care, they need to be able to use their knowledge, influence, power and authority to advocate for safe nursing care and a healthier professional work environment. Organizations must support differently or consider a fundamental redesign of the nurse leader role to support and empower nurse leaders as they are the connection between system strategy and safe execution at the bedside.

### 6.1 | Implications for Nursing Management

Safety culture is facilitated when organizational leadership is deeply involved with and attentive to issues frontline workers face and have an understanding of the established norms and hidden cultures that guide behaviours (AHRQ, 2019). Although nurse leaders described many processes for understanding issues RNs experienced in providing safe patient care, they described not having the ability or influence to advocate successfully on the behalf of RNs to resolve those issues. Nurses readily embrace advocating for the patient; however, advocating on behalf of the profession, oneself or the work environment although clearly outlined in nursing standards of practice and code of ethics must also be prioritized. Nurse leaders need to gain advocacy skills and engage in activities that promote the profession including teaching, mentoring, peer review, involvement in professional associations and knowledge development and dissemination (American Nurses Association, 2015).

Nurse leaders are influential in creating a professional environment and fostering a culture where interdisciplinary team members

are able to contribute to optimal patient outcomes and grow professionally (AONE, 2015). However, these nurse leaders found themselves overwhelmed with too many priorities and not having enough time to effectively lead and achieve a safety culture. Nurse leaders were busy with too many priorities that prevented them from spending time developing RNs, facilitating relationships and assuring adequate resources for making sure patients were safe. Nurse leaders must incorporate all elements of transformation leadership into their practice while focusing on and prioritizing the elements of structural empowerment and creating a healthy professional work environment (American Association of Critical Care Nurses (AACN), 2016; Shirey & Hites, 2015). To do this, system level change is critical, change that clearly situates nurse leaders as transformational leaders who have the power and administrative support to lead. Furthermore, given the discrepancy between nurse leaders and RN perceptions of safety culture (AHRQ SOPS citation), research on RNs perceptions of safety culture is needed to more fully understand the acute care safety culture context to then improve nursing effectiveness and promote safe patient care.

### CONFLICT OF INTEREST

The authors disclose no conflict of interest.

### ETHICS STATEMENT

This study was approved by the Loyola University, Chicago Research Ethics Committee (approval number 212782). Informed consent was obtained from all participants in the study.

### DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from IRB restricted access. Restrictions apply to the availability of these data, which were used under licence for this study. Data are available from the author(s) with the permission of IRB restricted access.

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