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Brivael Hémon, Estelle Michinov, Dominique Guy, Pascale Mancheron,
Antoine Scipion

► To cite this version:

Brivael Hémon, Estelle Michinov, Dominique Guy, Pascale Mancheron, Antoine Scipion. Speaking Up About Errors in Routine Clinical Practice: A Simulation-Based Intervention With Nursing Students. *Clinical Simulation in Nursing*, Elsevier, 2020, 45, pp.32-41. 10.1016/j.ecns.2020.03.003 . hal-02922217

HAL Id: hal-02922217

<https://hal.univ-rennes2.fr/hal-02922217>

Submitted on 18 Jul 2022

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Speaking up about errors in routine clinical practice: A simulation-based intervention with
nursing students

Brivael Hémon¹, MPsy, Estelle Michinov¹, Ph. D. Professor, Dominique Guy^{2,3}, Nurse
educator, Pascale Mancheron^{2,3}, Nurse educator, Antoine Scipion³, Nurse and simulation
technician

¹ Univ Rennes - LP3C (Laboratoire de Psychologie : Cognition, Comportement,
Communication), Rennes, France

² Institut de formation en soins infirmiers – Pôle de formation des professionnels de santé du
CHU de Rennes, France

³ CHU de Rennes, France

Manuscript type: Original paper

Word count: 4051 words (excluding the abstract, table, figures and references)

Funding: No funding

Conflict of Interest: The authors declare that they have no conflict of interest.

Authors' notes: The authors are particularly grateful to the managers and trainers of the
nursing school who contributed to the simulation session.

Please address any correspondence regarding this manuscript to: Brivael Hémon, Université
Rennes 2, Département de psychologie, Place du Recteur Henri le Moal, 35043 Rennes Cedex
(France). E-mail: brivael.hemon@gmail.com

Estelle Michinov: estelle.michinov@univ-rennes2.fr

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Abstract

Background: There has been little use of simulation to investigate speaking-up behaviors in response to routine clinical errors. We designed a simulation-based intervention to study the communication skills of nursing students.

Methods: The content of debriefings was coded to identify the barriers, enablers and strategies used to voice concerns in 17 groups. Questionnaires assessed students' attitudes before and after the simulation ($N = 98$).

Results: The most commonly perceived barriers were the students' status, the presence of the patient, and fear of consequences. Openness of the supervisor, risk assessment and team familiarity were the most frequently mentioned enablers. The main strategy was asking naïve questions. Teamwork climate was rated lower after the simulation training.

Conclusion: Nursing students tend to remain silent or to use inefficient strategies in response to violations of standard precautions. The simulation session had an impact on nursing students' attitudes.

Keywords: Speaking up, Teamwork, Simulation-based training, Patient safety, Nursing education.

Keypoints:

- Nursing students mainly reported that they remained silent when presented with opportunities to prevent errors, due to their status within the team, and in order to maintain the trust relationship between the patient and the team, and to avoid negative consequences both on their evaluation and on professional relationships.

- 24 • Nursing students reported using strategies to avoid such hurdles, namely asking
25 naïve questions and delaying the communication.
- 26 • Information sharing bias and effective communication strategies should be
27 included in nursing education curricula, through courses and simulation
28 interventions.
- 29

30 **Speaking up about errors in routine clinical practice: A simulation-based intervention**
31 **with nursing students**

32 **Introduction**

33 Communication is a major aspect of error management in healthcare settings, and is
34 essential to ensuring the safety and quality of care (Flin, O'Connor, & Crichton, 2008; Hull et
35 al., 2012). [Communication failures have been investigated, notably within operating room](#)
36 [\(OR\) teams](#) (Gawande et al., 2003; Lingard et al., 2004), [leading to the development of tools](#)
37 [to foster effective information sharing, such as the WHO preoperative checklist](#) (Haynes et
38 [al., 2017, 2009\)](#) or [SBAR method](#) (Haig et al., 2006). Nevertheless, healthcare workers
39 (HCW) might hesitate before speaking up, a behavior defined as the sharing of critical
40 information in order to enhance the safety of a situation (Kolbe et al., 2013; Noort et al.,
41 2019). Speaking-up behavior is associated with higher technical performance (Kolbe et al.,
42 2012), and a failure to speak up is mentioned in 23% of root cause analysis reports of
43 communication failures in hospitals (Rabøl et al., 2011), indicating various hurdles to
44 effective information sharing, including fear of reprisal, hierarchical structure, and avoidance
45 of conflict (Raemer, Kolbe, Minehart, Rudolph, & Pian-Smith, 2016).

46 In order to encourage speaking up, a range of procedures has been proposed, notably
47 simulation-based interventions. These simulations, usually featuring a confederate making an
48 error endangering patient safety, are useful for studying the factors that affect the ability to
49 challenge a decision made by a superior, such as the behavior of the superior (Barzallo
50 Salazar et al., 2014) or gender of the superior (Pattni et al., 2017). Most studies have focused
51 on OR teams facing critical events, with anesthesia or surgical trainees as participants (Pattni
52 et al., 2018).

53 To our knowledge, no study using simulation has been conducted in order to examine
54 speaking up about routine healthcare errors, such as failing to comply with hand hygiene
55 guidelines. Indeed, while HCWs often fail to comply with standard precaution guidelines,
56 increasing the risk of hospital acquired infections (Erasmus et al., 2010), non-compliance with
57 hygiene guidelines is less likely to be raised than issues such as medication errors
58 (Schwappach & Gehring, 2014). It therefore seems important to investigate the conditions
59 that enable HCWs to raise such concerns in order to prevent the risk of infection. As
60 suggested by Oner et al. (2018), speaking-up training could mostly benefit HCWs who are at
61 higher risk of remaining silent. This seems to apply particularly to nursing students who have
62 learned the guidelines for best practice, but who are likely to stay silent due to their
63 subordinate status (Bickhoff et al., 2017).

64 Although the relationship with the patient is a fundamental aspect of nursing, little is
65 known about the impact of the patient's presence and behavior on the ability of HCWs to
66 speak up during clinical procedures. Indeed, patients are increasingly encouraged to
67 participate in the care process, and to ask questions if they have doubts concerning the
68 procedure such as hand hygiene compliance or medication errors (Entwistle et al., 2010;
69 Longtin et al., 2010; McGuckin & Govednik, 2013; Seale et al., 2015). However, the impact
70 of the patient's behavior (asking questions, being proactive) on HCWs' decisions to speak up
71 has never been studied.

72 Therefore, the aims of the present study were to explore the barriers and enablers of
73 speaking up among nursing students during routine clinical practice and the strategies they
74 use to voice concerns, and to evaluate the impact of simulation interventions on students'
75 attitudes to safety and teamwork. We thus developed a simulation program to enhance nursing
76 students' awareness of the importance of speaking up about errors in routine clinical practice.
77 Nursing students' speaking-up behaviors were observed during the simulation sessions. Their

78 comments during the debriefing were recorded and analyzed to identify barriers and enablers
79 of speaking up, and the strategies used. The impact of the simulation session on attitudes to
80 safety and teamwork was assessed two weeks later.

81 **METHODS**

82 **Ethical approval**

83 This study was conducted at the simulation center of a nursing school during a
84 simulation-based training session in November 2017. Given the educational benefit and low
85 risk to participants, ethical approval of the study was not formally required by the ethics
86 committee of the University Hospital to which the school of nursing is attached. However, the
87 study complied with the ethical standards laid down by the international community, and was
88 approved by the ethical review committee of the school of nursing. Participation was
89 voluntary and confidential. All the participants were informed of the aim of the study and the
90 nature of data collection. They gave their written consent to be involved in the study and for
91 the simulation sessions and debriefings to be video-recorded. Two of the researchers who
92 were also teachers at the nursing school were involved in the simulation, but they did not
93 participate in coding either the students' behavior, or the barriers, enablers and strategies of
94 speaking up.

95 **Intervention design**

96 **Recruitment of participants**

97 The intervention design is represented in Figure 1. Participants were volunteers
98 recruited during a lecture on non-technical skills and human factors in healthcare teams. A
99 total of 98 out of 148 third-year nursing students agreed to participate in the study ($M = 22.51$
100 years; $SD = 4.23$, range 19 to 46 years, 81 women, 66.22% participation rate). On this basis,
101 18 groups of four to eight students ($N = 98$) were formed. In France, nursing students take a

102 three-year cooperative training course, alternating between course work at the school of
103 nursing and clinical placements in care units. At the time of the study, the students, who were
104 all in their final year, had carried out five clinical placements in care units, and seven
105 simulation sessions in the school of nursing. Previous simulations targeted technical skills
106 (e.g. blood transfusion) and interpersonal skills.

107 ****Insert Figure 1 about here****

108 **Simulation-based training sessions**

109 **Briefing**

110 Each simulation group attended a session that lasted about two hours. Sessions were
111 led by a nursing instructor trained in simulation-based education who laid down a number of
112 rules prior to the session (confidentiality, right to err, safety climate). In each group, two
113 students were chosen to take part in the simulation, while the other group members observed
114 the video of the scenario shown in the debriefing room. The instructor presented the scenario
115 to all the members of the group, as follows: the two students are on their second day working
116 in a department of internal medicine. Due to the increase in catheter-associated urinary tract
117 infections, the head of department has decided that nursing students should observe a
118 catheterization procedure before being authorized to perform it. The students' clinical
119 supervisor must insert a urinary catheter in an 85-year-old male patient suffering from
120 oligoanuria. As requested by the head of department, the supervisor asks the two students to
121 observe the intervention. *After presentation of this clinical vignette to observers and*
122 *participants, the supervisor was introduced to the two participants.*

123 **Simulation scenario**

124 The scenario was designed in accordance with previous research: a series of errors are
125 made by a confederate playing the role of the clinical supervisor, providing opportunities for

126 the participants to speak up (Pian-Smith et al., 2009; Raemer et al., 2016; Sydor et al., 2013).
127 The scenario was pre-tested with a group of three second-year students, and a few minor
128 changes were made. Specifically, given the short duration of the simulation in the pretest, a
129 discussion phase was added at the start of the simulation, in which (1) the supervisor and the
130 students introduced themselves, and (2) the supervisor reminded the two participants of the
131 procedure for placing a bladder catheter.

132 *Opportunities to speak up*

133 Two types of error were included in the scenario: errors jeopardizing the patient's safety,
134 and unprofessional behavior (Martinez et al., 2015). Participants had three opportunities to
135 detect errors and speak up:

- 136 • At the beginning of the procedure, the supervisor forgets to wash his /her hands with a
137 hydroalcoholic solution before putting on the sterile gloves that were on the bed.
- 138 • Just before inserting the catheter, the end of the catheter is then contaminated when
139 the supervisor takes the collector tube from the drape to the sterile field
- 140 • Having difficulty inserting the catheter, he/she speaks disrespectfully to the patient.

141 All participants had the ability to detect the errors, irrespective of their clinical experience,
142 as they concerned basic standard precautions, and not specific features of urinary bladder
143 catheterization. All the participants were familiar with the catheterization procedure, which
144 was taught in their fourth semester.

145 *Supervisors' behaviors*

146 Three nursing educators (two men, one woman), not known to the students, played the
147 role of the supervisor. To ensure consistency between groups, a reminder of the technical
148 procedure was sent to the educators before the simulation, together with a script to be
149 followed during the simulation. They also had a training session with the mannequin. To

150 encourage participants to speak up, the supervisor adopted behavior defined as open to
151 discussion, in accordance with Sydor et al.'s (2013) operationalization of “non-hierarchical”
152 behavior. The supervisor introduced him/herself, explained procedural aspects of the
153 intervention, and answered any questions. Participants were specifically told at the outset that
154 they could ask questions whenever they liked.

155 *Patient behavior*

156 The groups were randomly assigned to a “proactive patient” condition (9 groups) or a
157 “passive patient” condition (9 groups). The “proactive patient” showed proactive behaviors,
158 such as being engaged in his treatment and asking the healthcare professional questions. The
159 “passive patient” answered questions briefly and let the healthcare professionals work without
160 asking questions. *The verbal reactions of the mannequin were controlled by a technician*
161 *following a script.*

162 **Debriefing**

163 After the simulation, a debriefing session was conducted in three phases. First,
164 participants reacted spontaneously to the scenario. The instructor raised the question of
165 discrepancies between what the students observed and what they had learned in the nursing
166 school. In this way, the speaking-up issue was addressed, and the instructor highlighted the
167 fact that errors were intentional. The aim of the second phase was to encourage participants to
168 identify the factors that led them to speak up or remain silent, both during the simulation and
169 during their clinical placements. The third phase involved discussion of the participants’
170 internship experience, the strategies they used to voice concerns, and the consequences for
171 them and for the patient.

172 **Second lecture**

173 Two weeks later, the students attended a lecture about teamwork in healthcare,
174 including a description of models of voicing behaviors (Morrison, 2011; Okuyama et al.,
175 2014), and a description of certain structured communication tools of the TeamSTEPPS
176 Program, such as the two-challenge rule and SBAR script (King et al., 2008).

177 **Observation tools and dependent measures**

178 *Nursing students' behaviors during the simulation*

179 Videos of the simulation session were used to observe and code participants'
180 behaviors during the simulation scenario. Behaviors were dichotomized as concerns that were
181 voiced (expression of opinion, suggestion or question related to the error) or not voiced
182 (stayed silent), and were coded immediately after the occurrence of the errors in the scenario
183 by a psychologist trained in human factors.

184 *Nursing students' reactions during the debriefing*

185 To code the barriers and enablers to speaking up, we used the classic grids used in the
186 literature (Bickhoff et al., 2017; Raemer et al., 2016). Three main categories were identified
187 from content analysis of the verbatim records of the debriefing sessions: barriers to speaking
188 up during the care procedure, enablers to speaking up, and strategies used to voice concerns.
189 The categories and elements are described in Table 1.

190 Each video-recorded debriefing was viewed and coded independently by two coders (a
191 psychologist and a post-graduate psychology student). We evaluated inter-rater reliability by
192 calculating Cohen's Kappa (Hallgren, 2012; Landis & Koch, 1977). Overall, kappa values for
193 our observation tool were moderate to substantial: the average Cohen's Kappa were moderate
194 for barriers (0.49) and enablers (0.59), and substantial for strategies (0.74).

195 ****Insert Table 1 about here****

196 *Nursing students' attitudes toward safety and teamwork*

197 Attitudes to safety and teamwork were measured using scales from the Safety Attitude
198 Questionnaire (SAQ, Sexton et al., 2006). The seven items of the safety climate scale refer to
199 the involvement of the organization to ensure the safety of care (“The culture in this clinical
200 area makes it easy to learn from the errors of others”). The six items of the teamwork climate
201 scale refer to the perception of the quality of interprofessional collaboration (“Nurse input is
202 well received in this clinical area”). All items were answered on a five-point Likert scale,
203 from 1 (*disagree strongly*) to 5 (*agree strongly*). Participants were told to base their answers
204 on their last clinical placement, in order to assess the teamwork climate and safety climate in
205 the last unit they worked in. They completed this questionnaire at the end of the first lecture
206 and at the beginning of the second in order to test changes in attitude after the simulation
207 session. It should be noted that students did not have a clinical placement during the time of
208 the intervention. They had just completed a clinical placement in care units when the study
209 started.

210 **RESULTS**

211 **Speaking-up behaviors**

212 Due to a technical problem, the video data of one group were lost. The speaking-up
213 behaviors of 17 groups were thus observed. For the hand hygiene error (error 1), no
214 participant spoke up, irrespective of the patient’s behavior. For the catheter contamination
215 (error 2), a member of one “passive patient” group (i.e. 12.5% of the groups in this condition)
216 and one “proactive patient” group (11%) spoke up. For inappropriate behavior toward the
217 patient (error 3), a member of one “passive patient” group (12.5%), and of two “proactive
218 patient” groups (22%) spoke up.

219 **Barriers and enablers of speaking up**

220 Due to a recording problem during the debriefing, the data of two groups were lost (*N*
221 = 16). The five most frequently mentioned barriers and enablers are presented here. More
222 detailed results are presented in Figure 2 and Figure 3. The first barrier mentioned by
223 participants in all 16 coded groups was their student status. They felt that **nursing students** are
224 not part of the team, and that it is not the role of learners or observers to comment on care
225 procedures. The presence of a conscious patient was mentioned by 14 groups; challenging a
226 professional was perceived as undermining the relationship of trust between a patient and
227 HCWs and could cause the patient anxiety. Fear of reprisal was reported by 14 groups; they
228 expected consequences on their appraisal, possibly jeopardizing validation of their internship.
229 The fear of damaging relationships was mentioned in 13 groups, indicating avoidance of
230 conflict and the need to preserve good relations for the end of their internship and as future
231 colleagues. Thirteen groups mentioned personal characteristics of the erring HCW, such as
232 personality and lack of involvement in mentoring. Not knowing the HCW was reported as a
233 barrier in 9 groups.

234 ****Insert Figure 2 about here****

235 Regarding the most frequently identified enablers, 11 out of 16 groups mentioned the
236 personal characteristics of the erring HCW, such as openness to questions. Ten groups
237 mentioned the evaluation of benefits for the patient and risk for the observer. Eight groups
238 mentioned familiarity with the team, often linked to the ability to anticipate the HCW's
239 reactions. Certainty and self-confidence were mentioned in seven groups. Team climate was
240 raised in 6 groups, indicating the need to be part of the team to voice concerns.

241 ****Insert Figure 3 about here****

242 **Strategies**

243 As we can see in Figure 4, the main strategy for voicing concerns, reported in 15
244 groups out of 16, was to ask “naïve questions” or “play the innocent”. The aims of this
245 strategy were to avoid making the patient anxious, and to stay in line with their “student
246 status” by not questioning the knowledge or practices of the erring HCW. Another strategy,
247 reported in 11 groups, was to put the conversation off till after the intervention or until the end
248 of the day. Again, the main purpose was to avoid challenging the HCW in front of the patient.
249 The notion of risk was sometimes raised as an important factor when deciding whether or not
250 to speak up immediately or wait till later. In nine groups, students said they expressed their
251 concern by referring to the nursing school instructions, in five groups they referred to the
252 patient (i.e. asking about the risks or consequences for the patient), and in four groups they
253 referred to protocols. The last three strategies were often combined with the use of a naïve
254 question.

255 ****Insert Figure 4 about here****

256 **The effect of simulation on students’ attitudes to safety and teamwork**

257 Detailed statistics for the SAQ scale scores are shown in Table 2. To evaluate the
258 effect of the simulation on students’ attitudes to safety and teamwork, paired-sample *t*-tests
259 were performed on the SAQ scale scores before and after the simulation session (see Table 2).
260 On average, participants’ scores on the teamwork climate scale were lower after the
261 simulation ($M = 3.84$, $SE = 0.50$) than before ($M = 3.95$, $SE = 0.52$). This difference, 0.11,
262 95% CI [0.01, 0.21], is significant, $t(72) = 2.463$, $p = .016$, and represents a small effect size,
263 $d = 0.29$. On average, scores on the safety climate scale were also lower after the simulation
264 ($M = 3.88$, $SE = 0.48$) than before ($M = 3.95$, $SE = 0.55$), but this difference is not significant,
265 $t(72) = 1.111$, $p = .270$.

266 ****Insert Table 2 about here****

267

268

DISCUSSION

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The aims of the study were to explore the barriers and enablers of speaking up, the strategies participants used to voice concerns, and to evaluate the impact of the simulation intervention on students' attitudes to safety and teamwork.

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Regarding the speaking-up behaviors during the simulation scenario, few dyads challenged the HCW about the sterility issue or behavior toward the patient. The non-compliance with hand-hygiene guidelines was never challenged. These results could reflect the difficulty of student nurses to speak up, especially regarding hand hygiene. It is of note that although the risk of infection was discussed during the debriefing, the consequences for the patient were underestimated in several groups, and the patient safety issue was not seen to justify the risk of speaking up (“a urinary infection isn’t a life-threatening risk”). The results suggested that the main barriers to speaking up were the students’ status in the team, concerns about challenging an HCW in front of the patient, and fear about the consequences. In a recent literature review, the main barrier to challenging poor practice was seen by students to be their status, viewing themselves as “just a student” (Bickhoff, Sinclair, & Levett-Jones, 2017). That review also highlighted the fear of consequences (both on evaluation and on relationships) as a major hurdle to speaking up. By contrast, in our study the erring HCW’s openness and personality, patient risk assessment, team familiarity, certainty and self-confidence, and team climate were the main factors perceived as enabling the expression of remarks or questions. Not surprisingly, the HCW’s characteristics (personality, openness) were mentioned equally as barriers and enablers. Several studies in healthcare settings have emphasized the role of leader openness in the decision by nurses to speak up (Garon, 2012). Weiss, Kolbe, Grote, Spahn and Grande (2018) demonstrated that speaking up in OR teams is enhanced by inclusive leader language, both implicit (use of “we”, referring to individuals as

292 part of the group) and explicit (invitation to contribute and appreciation of input). Therefore,
293 interventions promoting such behaviors among supervisors, especially explicit inclusive
294 leader language, could ease the sharing of critical information for interns.

295 Although the fear of discrediting an HCW in front of the patient or of making the
296 patient anxious was one of the main barriers, this has rarely been discussed in the literature,
297 probably due to a focus on surgical settings. In oncology, Schwappach and Gehring (2014)
298 observed the use of non-verbal communication to call attention to errors in the presence of
299 patients, especially with regard to [hand hygiene](#). This strategy was rarely mentioned by our
300 participants and was not observed during the scenario. Instead, the dyads who spoke up used
301 indirect forms of speech, such as questions or suggestions. Their main strategies were to ask
302 naïve questions. [Medical residents](#) and nurses also report using this type of communication
303 with a senior (Schwappach & Gehring, 2014). The efficacy of these strategies is questionable
304 and should be discussed during nurse training, along with the advocacy for assertive
305 communication tools.

306 Finally, the results revealed that the students rated the teamwork climate lower after
307 the simulation session than before. This result could seem counterintuitive, but could be
308 interpreted as a rise in the standard of what they considered to be an effective teamwork
309 climate after the simulation session. Although this suggests that the simulation had an impact
310 on the participants' attitudes, the small size effect should be considered. Further simulation-
311 based studies are needed to explore the effect on attitudes to teamwork. [In addition to
312 quantitative data analysis, it would be enlightening to investigate the impact on teamwork
313 attitudes through qualitative analysis of a focus group a few weeks after the simulation
314 sessions. This could help understand how the intervention could affect nursing students'
315 attitudes and possible changes in their behavior with supervisors and healthcare workers
316 regarding communication and patient safety in care units.](#)

317 **Limitations**

318 The present study has a number of limitations. First, the sample was small and all the
319 participants attended the same nursing school. Secondly, to encourage participants to speak up
320 during the simulation, a number of changes could be made to the scenario, especially
321 regarding the type of errors (including errors associated with a higher risk, such as a
322 medication error) and the participant's role (giving a more active role to participants). Finally,
323 the simulation setting could have inhibited the students from speaking up, and thus not reflect
324 real behavior in a clinical environment. For example, non-compliance with standard
325 precaution guidelines could have been seen as irrelevant in this environment. Nevertheless,
326 most participants declared that they would not speak up if they were faced with this situation
327 "in real life".

328 **Practical implications for patient safety and nursing education**

329 We believe that our research has several practical implications for patient safety and
330 nursing education. It provides observational data that support previous evidence about nursing
331 students' reluctance to voice their concerns. The "Big Five" model of teamwork proposed by
332 Salas, Sims, and Burke (2005) suggests that team performance is enhanced by mutual
333 performance monitoring and backup behaviors. However, even if the nursing students
334 engaged in mutual performance monitoring by assessing team members' compliance with
335 standard safety precaution guidelines, most of the time they did not dare to initiate backup
336 behaviors. This tendency to silence could impair team performance and patient safety, as
337 shown in surgical settings (Belyansky et al., 2011; Greenberg et al., 2007; Kolbe et al., 2012).
338 Based on the literature and qualitative data, there appear to be two effective ways to
339 encourage nursing students to speak up for patient safety. First, barriers to speaking up in a
340 clinical environment should be addressed by increasing clinical supervisors' awareness of
341 these issues and advising them how to promote speaking up through the use of inclusive

342 leader language (Weiss et al., 2018). New interventions targeting healthcare workers in units,
343 and especially supervisors, should be implemented in collaboration with the school of
344 nursing. Second, nursing students should be taught to use assertive strategies to voice
345 concerns, such as the two-challenge rule (Pian-Smith et al., 2009), and be given opportunities
346 to regularly rehearse such conversations. To that end, simulation-based training aimed at
347 improving teamwork skills should be developed.

348 **Conclusion**

349 We used a simulation procedure to make nursing students aware of the importance of
350 speaking up about errors in routine clinical situations. Nursing students are likely to remain
351 silent when they observe an error that jeopardizes patient safety. *The main barriers to voicing*
352 *concerns were their student status* and the fear of harming the relationship of trust with the
353 patient, as well as the negative outcomes both on their appraisal and on *collegial relationships*.
354 The supervisor's openness and the risk for the patient were reported as the main enablers.
355 Participants predominantly used naive questions or delayed talking about the errors they had
356 observed until they were outside the patient's room. *Before and after the simulation session,*
357 *participants were asked to evaluate the teamwork and safety climate in their last clinical*
358 *placement. The intervention had an effect on their assessment of the teamwork climate, but*
359 *not on the safety climate.* Future simulation-based studies should investigate how to
360 encourage nursing students to voice concerns regarding standard precaution violations. At the
361 same time, interventions should be developed at the supervisors' level to facilitate the sharing
362 of critical information for patient safety.

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Figure Legends

Figure 1. The steps of the intervention design

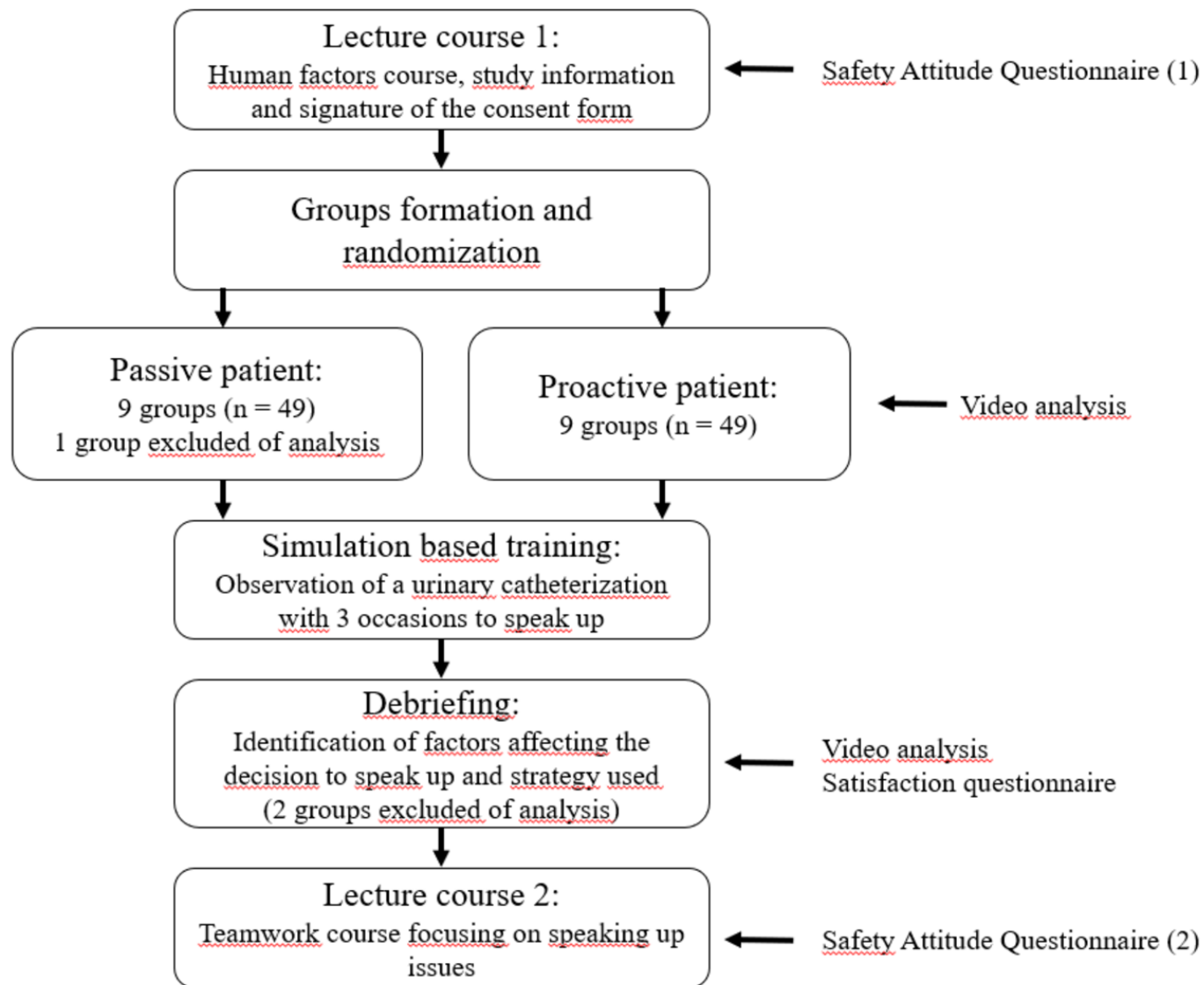
Figure 2. Frequency of communication barriers perceived by the nursing students during the debriefing (number of groups who mentioned the element)

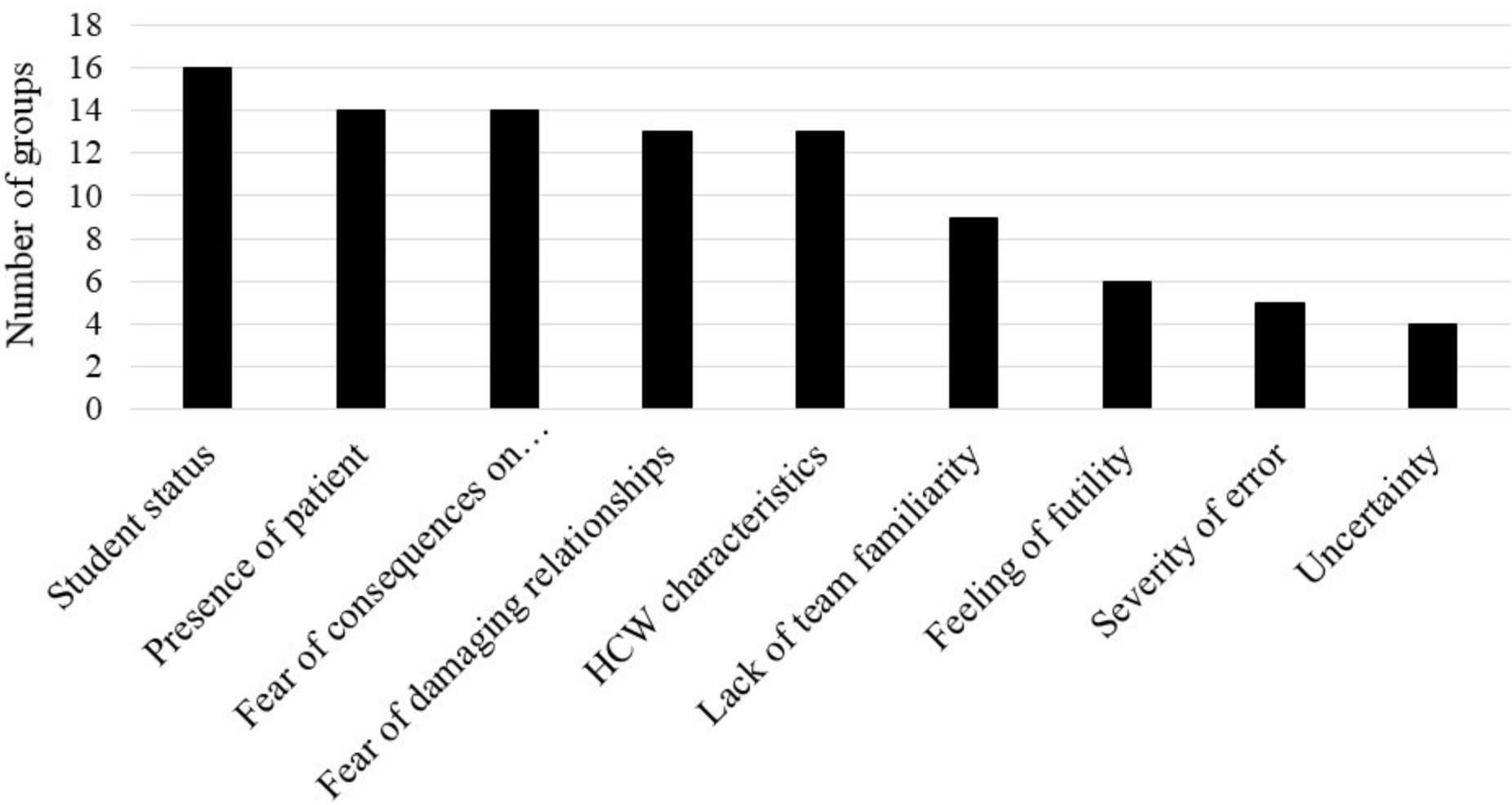
Figure 3. Frequency of communication enablers perceived by the nursing students during the debriefing (number of groups who mentioned the element)

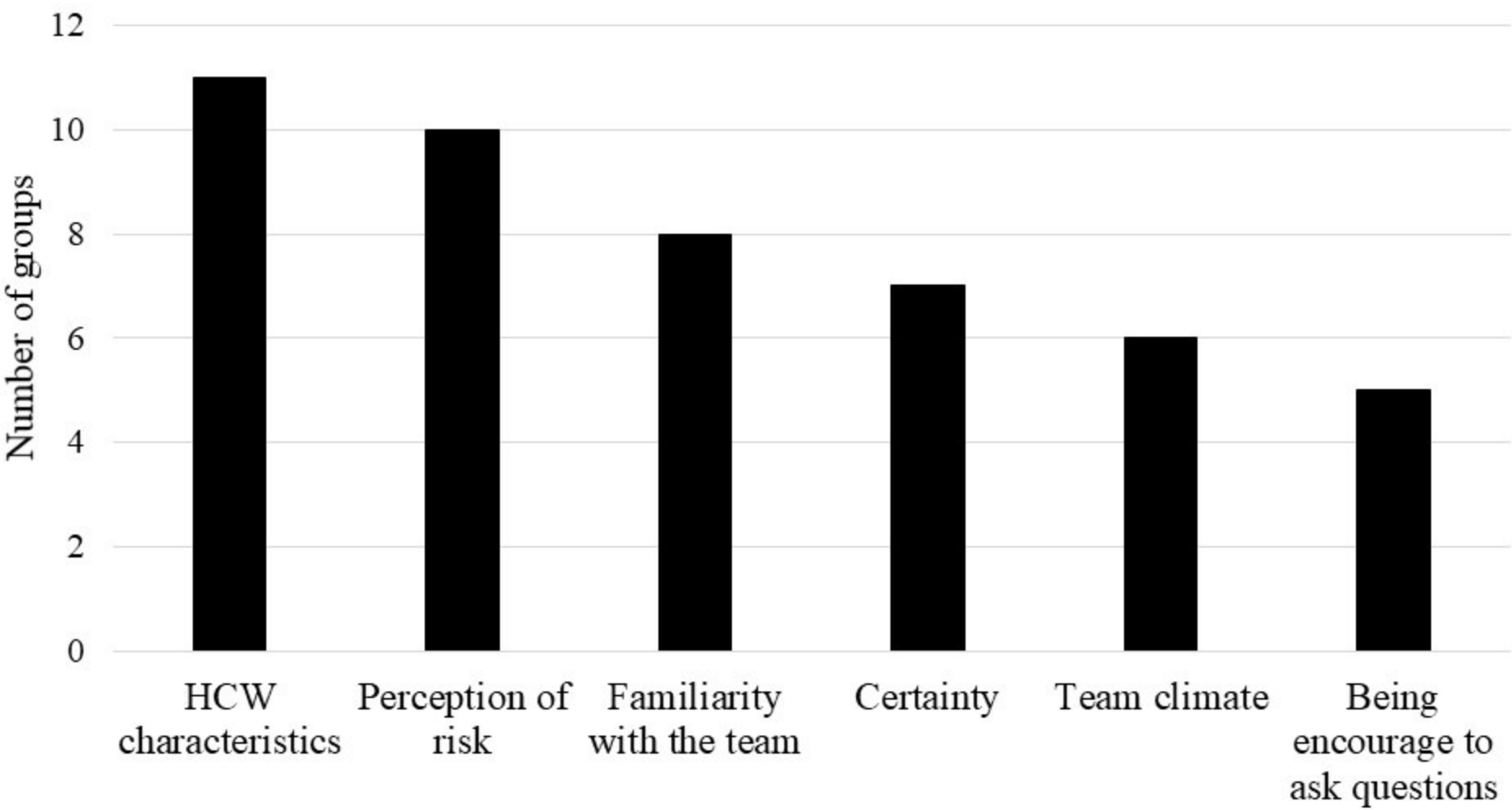
Figure 4. Frequency of strategies used to speak up identified by the nursing students during the debriefing (number of groups who mentioned the strategy)

Table 1. Taxonomy developed for coding barriers, enablers, and strategies used to speak up, including categories, elements, and examples.

Table 2. Descriptive statistics and paired sample t-test statistics at Time 1 and Time 2 for the evaluation of teamwork and safety attitudes with the SAQ (Sexton et al., 2006)







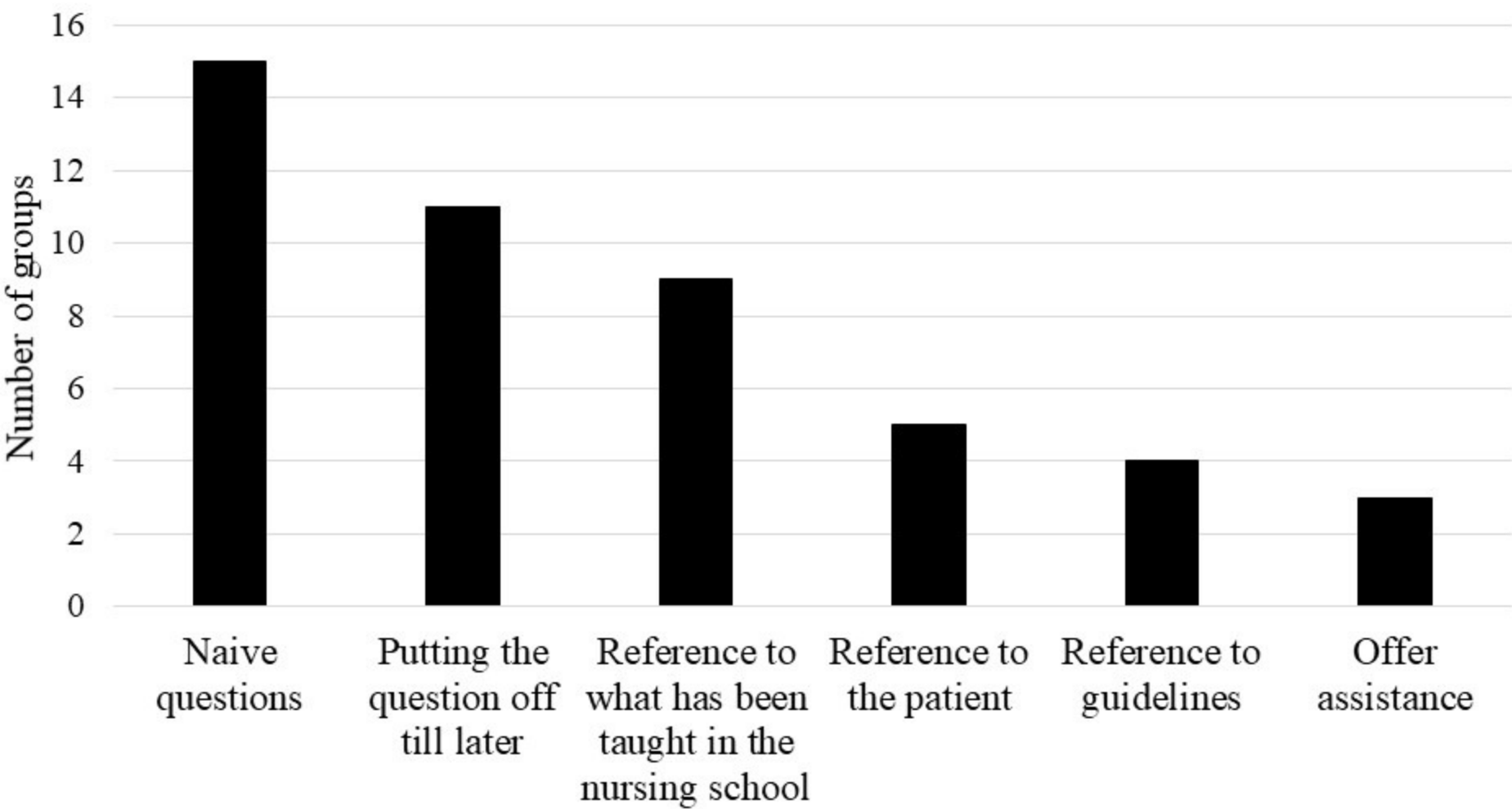


Table 1

Taxonomy developed for coding barriers, enablers, and strategies used to speak up, including categories, elements, and examples

Categories	Elements	Examples
Barriers	Student status	<i>“We are there to learn, it’s not up to us to make an observation”</i>
	Presence of patient	<i>“There is a trust that has been created between the patient and the nurse, and it could break this trust”</i>
	Fear of consequences on evaluation	<i>“Eventually we have to validate our internship. If we don’t, it means we might have six more months to go before we graduate”</i>
	Fear of damaging relationships	<i>“They are our future colleagues too ...”</i>
	HCW characteristics: personality, openness	<i>“With some people you can tell that even if you say it cautiously they won’t allow a comment....”</i>
	Lack of team familiarity	<i>“I don’t think I’d do it the first internship week.... You have to know the professional”</i>
	Feeling of futility	<i>“It goes like this: you try once or twice to share your opinion and then when you notice they’re not opened to comments you give up...”</i>
	Severity of error	<i>“As long as it’s not a critical error, or a real assault to a patient you don’t say anything”</i>
	Uncertainty	<i>“You have to be careful because you might be wrong, you might think it has to be done this way but actually you’re not 100 % sure. It’s not like it’s something you’re an expert of”</i>
	HCW’s characteristics: personality, openness	<i>“I saw from the beginning that she accepted remarks and took them into account”</i>

Enablers	Perception of risk	<i>“You're not going to let the patient take a risk such as a multiplied infection risk...”</i>
	Familiarity with the team	<i>“You feel like you can share your views and be true to what you say, when the caregiver knows you a little, when both parts trust each other...”</i>
	Certainty	<i>“Actually, I was sure of what I was saying, so I preferred to say it rather than seeing it having consequences for the patient”</i>
	Team climate	<i>“It depends on the caregiver, it depends on if you're included enough or not, whether or not you're feeling comfortable within the team... If everything works well in the team and you're feeling included, yes, it's going to be easier”</i>
	Being encouraged to ask questions	<i>« If the conversation was open and everything had been established from the start like, "Feel free to interrupt me if you have any questions" ... It's something that's commonly done”</i>
Strategies	Naïve questions	<i>“You ask a question, but you know the answer”</i>
	Putting the question off till later	<i>“You can tell them later... except if there is an immediate danger”</i>
	Reference to what has been taught in nursing school	<i>“We learn things in school and if I see that the professional do things differently, I tell him: “listen, I don't understand, why you do it this way, because I 've been taught to do it that way...”</i>
	Reference to the patient	<i>“You might want to prioritize the patient in the sense that... Here the patient may have an infection if you don't take action”</i>
	Reference to guidelines	<i>“We can talk about protocols...”</i>
	Offer assistance	<i>“In general, when I see something that bothers me or questions me, I do not say it but I offer assistance”</i>

Table 2

Descriptive statistics and paired sample t-test statistics at Time 1 and Time 2 for the evaluation of teamwork and safety attitudes with the SAQ (Sexton et al., 2006)

Items	Time 1		Time 2		<i>t</i>	<i>p</i>	Mean difference	95% CI		Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				<i>LL</i>	<i>UL</i>	
1. Nurse input is well received in this clinical area	4.35	0.61	4.27	0.63	1.10	.28	0.08	-0.07	0.24	0.13
2. In this clinical area, it is difficult to speak up if I perceive a problem with patient care (<i>inversed</i>)	3.67	1.20	3.37	1.05	2.24	.03	0.30	0.03	0.57	0.26
3. Disagreements in this clinical area are resolved appropriately (i.e., not who is right, but what is best for the patient).	3.74	0.96	3.71	0.83	0.29	.78	0.03	-0.16	0.22	0.03
4. I have the support I need from other personnel to care for patients.	4.07	0.79	3.96	0.68	1.18	0.24	0.11	-0.08	0.29	0.14
5. It is easy for personnel here to ask questions when there is something that they do not understand.	4.10	0.93	3.92	0.70	1.75	.09	0.18	-0.03	0.38	0.20
6. The physicians and nurses here work together as a well-coordinated team.	3.79	0.96	3.81	0.81	-0.12	.91	-0.01	-0.25	0.22	-0.01
7. I would feel safe being treated here as a patient.	4.14	0.69	4.05	0.64	1.00	.32	0.08	-0.08	0.24	0.12
8. Medical errors are handled appropriately in this clinical area.	3.99	0.80	4.00	0.65	-0.16	.87	-0.01	-0.19	0.16	-0.02
9. I know the proper channels to direct questions regarding patient safety in this clinical area.	4.26	0.79	4.04	0.73	1.93	.06	0.21	-0.01	0.44	0.23
10. I receive appropriate feedback about my performance.	4.14	0.89	4.04	0.79	0.82	.42	0.10	-0.14	0.33	0.10
11. In this clinical area, it is difficult to discuss errors.	3.63	1.20	3.42	1.03	1.37	.17	0.21	-0.09	0.50	0.16
12. I am encouraged by my colleagues to report any patient safety concerns I may have.	3.93	0.87	3.90	0.87	0.22	.83	0.03	-0.22	0.28	0.03
13. The culture in this clinical area makes it easy to learn from the errors of others. (<i>inversed</i>)	3.57	0.88	3.71	0.80	-1.26	0.21	-0.14	-0.36	0.08	-0.15
Teamwork attitude scores (mean)	3.95	0.52	3.84	0.50	2.463	.02	0.11	0.02	0.20	0.29
Safety attitude scores (mean)	3.95	0.55	3.88	0.48	1.11	.27	0.07	-0.05	0.18	0.13

Note: SAQ = safety attitude questionnaire; CI = confidence interval; *LL* = lower limit; *UL* = upper limit. Items 1 to 6 refers to the Teamwork scale. Items 7 to 13 refers to the Safety scale. Items were translated to French from “The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research”, by Sexton, J. B., Helmreich, R. L., Neilands, T. B., Rowan, K., Vella, K., Boyden, J., Roberts, P. R., & Thomas, E. J., 2006, *BMC Health Services Research*, 6(1), 44.