

Does Workplace Stress Lead to Accident or Error?

Many nurses feel the pressure.

“I’m so stressed out!” Surely, we all have said it at some time on the job. But what does that really mean? And are there critical implications of nurses’ job-related stress?

The National Institute of Occupational Safety and Health defines job stress as “the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker.” Stress can create a fight-or-flight reaction in which neither fight nor flight is perceived to be possible. If persistent, this response can lead to many physiologic, psychological, and behavioral effects, including cardiovascular diseases, musculoskeletal disorders, impaired immunity, depression, and suicide, as well as workplace injury, errors and memory impairment.

Much effort has gone into investigating the sources of workplace stress. In the December 2003 issue of the *Journal of Advanced Nursing*, Andrew McVicar identified six main themes nurses reported to be sources of workplace stress: workload, leadership or management issues, professional conflict with other clinical staff, the emotional demands of caring, shift working, and lack of reward.

Regardless of the work setting, many nurses have felt the pressure associated with too few staff to get the job done, incivility among coworkers or from supervisors,

insufficient resources, and limited shared governance in decision making or policymaking. Other stressors include ever-changing technology, with too little training, excessive paperwork, and inadequate communication.

These workplace characteristics can be stressful for the individual nurse but can also forewarn bigger organizational problems. Although a certain amount of positive stress, often referred to as *eustress*—for example, the energy that takes over when resuscitating a patient—heightens and focuses attention and mental acuity to the task at hand. But there is a point at which stressors no longer improve performance and begin to impair the ability to meet job-related challenges. The fulcrum on which *eustress* swings toward *distress* is specific to each person, but when it does occur there are serious implications for the workplace.

Most important is the risk of accidents and errors. Errors such as the improper use of equipment or failure to use the correct personal protective equipment can lead to injuries to either the nurse or patient. Medication errors also can become easier to make when a nurse is feeling stressed and unable to focus.

All too often these accidents, injuries, or errors are managed by targeting the nurse’s behavior. Common approaches to remedying these incidents usually are framed as employee education or disciplinary action. The unfortunate result of this method is that the underlying problem is often overlooked. As a result, the nurse making the error or having the accident may feel singled out and demoralized and could leave the workplace, further compounding

the problems related to a paltry workforce.

While an individual’s responsibility for an error or accident is inseparable from the event, the social and physical factors of the workplace contribute to the occurrence. A systems-based approach for studying workplace errors suggests that failures (errors) in large systems, such as hospitals, are the result of unanticipated events or factors occurring in many parts of the system. The accumulation of these factors, including the “stressed-out” nurse, leads to accidents or errors.

The best approach to decreasing accidents and errors is for a staff-management team to identify, address, and understand the inherent interweaving of multisystem factors that affect the work environment and the nurse’s ability to perform the job. Not only will this approach help the nurse avoid injury, but it will also decrease the rate of errors and incidents occurring in the entire facility. Steps to prevent accidents and relieve job-related stress include shared governance, team building with mentoring, the fostering of a collaborative work environment, and adequate continuing education. Organizations also should establish multidisciplinary teams that include frontline workers, such as floor nurses, whose charge is to identify and solve issues that precipitate accidents or errors.

In the end, these changes ought to yield improved staff performance, decreased workplace stress, and better individual and organizational outcomes. ▼

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