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In the latest Tom Hanks movie, Pilot Sully was a hero as he landed the aircraft on the Hudson River, saving all on board. Crash investigators, however, questioned whether he had made an error of judgement, and whether he could in fact have landed safely at a nearby airport.

As nurses, we often have to make split-second judgments, only to be reprimanded later by seniors who inform us of how things could have been done better.

In the movie, well-rehearsed flight simulators prove that Sully's decision may not have been the wisest – until a 35 second delay is added to the simulator to represent the addition of 'humanity to the cockpit', and the plane crashes. By humanity, they mean the feelings of fear, desperation and momentary delay that can occur as a well-trained professional is exposed to an apparent perfect storm of events that threaten to overwhelm and undermine their thinking.

In nursing, I have witnessed overworked, undertrained, under-resourced and fearful staff make decisions that have later resulted in disciplinary action by management. At the time, however, the nurse was doing a good deed, and the accusers might do well to add humanity to their thinking before administering punishment. Here are some of the stories.

The overworked nurse

My colleague had to attend court to explain why she had not stayed in the toilet with a neurosurgical patient who had subsequently fallen to the floor and banged her head; she was also looking after six other seriously ill neurosurgical patients on the ward at the time. Accident investigators may well point out her error of judgement, but what other calamity may have occurred if she had left her other patients unattended?

My sister, also a nurse, was reprimanded for not recording blood pressures every 15 minutes on an acutely ill patient; she had seven other poorly patients too. Another nurse is currently suspended and being investigated for sleeping during her 30 minute break on her seventh night shift. My sister could have focussed more on the sicker patient; my colleague could have worked through her tiredness – who knows the outcome?

I was disciplined for allowing a husband of a patient to borrow my swipe card to access the cafeteria behind the ward. The accusers rightly explained to me the breach of security that I had allowed: true indeed, but the man was well known to me as his wife had just been admitted for removal of a third brain tumour. The malnourished patient was tempted by the thought of hot chips, the husband didn't want to leave his wife for the 20 minute walk that would be required without the staff access, and I made my decision.

The undertrained nurse

One brave colleague works for a nursing agency and is sent to work in care homes across the county. Attending one particularly chaotic home, he struggled to locate the medicines in the drug trolley. Having found most of them, but unable to find a particular laxative and iron tablet, he made the decision to carry on with his other more important clinical duties, and document the missing medication. He has been severely disciplined for this "medication error" despite receiving no training in understanding their haphazard system of drug storage.

Another nurse was called to account for deciding to use the wrong type of dressing on a leg ulcer, despite having not been offered wound care training for years.

The under-resourced nurse

At the nursing home where I work, we are often searching for appropriate wound dressings, begging to borrow blood-taking equipment from the surgery next door and chasing medication orders that seem to take days to arrive. On each shift, we must decide which are the most important orders (from a very long list) to chase. Senior management, meanwhile, are quick to call us in for questioning when the dressing of a wound, a blood test or the administration of medication is delayed.

The fearful nurse

On one not so unusual shift, one nurse was left to do the work of two nurses due to sickness. The wise decision, made with retrospect, would be to refuse to take on such an unsafe workload. Through fear of leaving patients unattended, and through fear of senior management, the nurse bravely attempted to achieve the impossible. The recognition for her compassion and effort? A disciplinary hearing for the omission of some non-essential medicines and administrative tasks.

Decisions, decisions

Most nurses are trying to make good decisions in a bad situation. When adverse events are the result, the accident investigators might do well to consider the context. And sometimes miracles do happen, as they did for Pilot Sully, and as they have done in the clinical setting, when good care is given despite adversity.

Sometimes, wrong decisions are made. I once used the wrong syringe for insulin. It was one of the worst drug errors that I could have made, but after involving the senior medics, no harm was done. Neurosurgeon Henry Marsh wrote an inspiring lecture entitled "All my worst mistakes". Medicine is built on mistakes. Millions of decisions are made in the clinical setting everyday: we can do well to learn from the wrong ones and be slower to suppose that good decisions could have been better.

We are excited to share the news that Helen's blogs for the Hippocratic Post have been nominated for the UK Blogging Awards 2016. Please support Helen by registering your vote here! ***[2]***

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