Chapter

# Patient Safety without Patient Advocacy is Improbable, as They are Synonymous: Is There a Theory-Practice-Ethics Gap?

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## Abstract

The aim of a culture of safety in healthcare is to reduce and/or eliminate the risk of harm to patients. However, despite a universal stance towards patient safety, since the Institute of Medicine’s landmark report of 2000, *“To Err is Human*, *building a safer health system”* there remains a disturbing escalation in the healthcare errors among hospitalized patients. This underscores trepidations about healthcare professionals and providers’aptitude as effective and caring patient advocates to provide high quality, safe care. In the context of these healthcare mistakes, the “*Theory-Practice gap”* is often cited as an offending perpetrator. Within this exemplar, there is often a disparity between theoretical knowledge and its application in practice. Evidence relating to the non-integration of theory and practice makes the assumption, that educational dynamics may affect learning and practice outcomes and hence, the “*Gap*”. Whatever you call them, healthcare mistakes, medical errors, faults, or miscalculations. This exemplar, acknowledges that healthcare professionals and providers are provided with theoretical knowledge and prepared with skills to practice competently and safely. Yet, these same healthcare professionals and providers continue to be noncompliant with the recommended evidence-based practices which creates an ethical dilemma. Therefore, to bridge the gap between theory and practice, a “*Theory-Practice-Ethics gap*” must be considered when appraising the unacceptable outcomes in healthcare practices, and the failure of healthcare professionals and providers to fulfil their moral duty of care, as patient advocates.

One of the defining characteristics of a patient advocate is to ensure patient safety. By convention, patient advocacy is an integral philosophy in healthcare, and an obligation which is expected to be fulfilled by healthcare professionals and providers in the course of discharging their duties. *Primum non nocere* ‘*above all*, *do no harm*’ is a fundamental concept within the healthcare model. However, there is evidence of a failure to implement of this moral concept which relates to a patient’s safety and the advocacy role expected from healthcare professionals. Healthcare professionals declare that this is because of the ambiguity associated with the comprehension of the advocacy concept in relation to the safety role. In addition to the challenge of role acceptance within a patient safety forum as a misunderstood and unappreciated responsibility. The analytical exploration of patient advocacy related to patient safety and the concept of a “*Theory-Practice-Ethics gap*”will be presented within this chapter, to reinforce the importance of their synonymous relationship for trustworthy healthcare practices. Healthcare professionals and providers need to be mindful of the importance of patient advocacy and the utilization of a safety science which leads to a higher quality of safe patient care.

**Keywords:** advocate, ethics, medical error, quality, safety,
theory-practice-gap

## Key Points

### Quality Patient Care

The Institute of Medicine defines quality patient care as “*the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.*”

### A Culture of Safety

Is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviours that determine the commitment to, and the style and proficiency of, an organization’s health and safety management!

### Patient Safety

Is the prevention of errors and adverse effects to patients associated with health care!

### Advocacy

The American Nurses Association deems that advocacy is a pillar of nursing. Nurses instinctively support and protect their patients, in their workplaces, and in the community.

### Healthcare Ethics

Autonomy, beneficence, non-maleficence, justice are the fundamental healthcare principles which bioethicists often denote when evaluating the ethical issues related to healthcare procedures and health care decisions.

### Theory-Practice-Ethics Gap

A process of noncompliance to ethical evidence based practices despite having the relevant knowledge.

## Introduction

The basis for this chapter is to provoke nurses and other healthcare professionals and providers to consider a dilemma which affects patient care and safety. A dilemma in the literature which has been cited as a “*Theory-Practice-Ethics gap*”(Mortell et al., 2013).Patient safety and high quality of care are essential aspects of all healthcare practices. When people are admitted to hospital, they expect to have their illness, disorder or disease treated effectively, and receive safe, high quality care during the process. They do not expect to be put at risk or be harmed, since the principal goal of healthcare is to maximize care, safety and wellbeing, and so optimize the quality of people’s lives ([Leape, 2015](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4954916/#ref38); Wilson et al., 2009).

Nursing has been termed the caring profession, and as such, a nurse as a healthcare professional and provider is often required to perform multidimensional roles. One of those roles is as a patient advocate, a responsibility which is often challenging due to composite interactions between nurses, patients, professional colleagues, and the community (Mortell et al., 2017). Nevertheless, despite the demands of the role, nursing has embraced advocacy as a professional paradigm. Advocacy has numerous meanings and conventions, but in nursing it is generally depicted as representing another, whilst endeavouring to protect the health, safety, and the rights of the patient(Mathews, 2012; American Nurses Association, 2010). The nurse as a patient advocate therefore, plays a key role to keep patients safe throughout their encounters within the health care systems. As a vocation, nursing is a demanding undertaking, and the added responsibility of patient advocacy is particularly strenuous for nurses given the intricacy of their duties in the healthcare setting. In addition to the procedural care responsibilities which maybe complex, nurses also have the added responsibility for patient safety, which is often subject to ethical and moral challenges (Monterosso et al., 2005). Therefore, nurses have an ethical obligation to keep the patient safe to prevent harm (Joint Commission International, 2010; Institute of Medicine, 2000).

The word ethics has Greek origins; Ta Ethika: into good and evil; Ethos: personal character. A code of ethics defines basic principles to determine what constitutes “*right*” behaviour, united with a moral duty and obligation. Ethics are moral values and behaviours that express ideals for other human beings, comprising of commitments to remove harm and/or promote benefit (Twomey, 2010). The fundamental principles for patient safety management, “P*rimum non nocere*” (first do no harm) and “*In dubio abstine*” (in case of doubt, do not intervene) go back to ancient times. Historically, Hippocrates, a Greek physician born circa 460 BC is acknowledged as the father of medicine and was concerned with alleviating human suffering whilst pledging ethical values and moral conduct. He conceived the Hippocratic Oath to remind physicians to practice medicine ethically, ensure safe and effective care and never do any harm.

In similarity, the nursing profession and hence nurses abide by an equivalent oath, referred to as the Nightingale pledge. This pledge reminds nurses of their obligations to the patient, as perceived by Florence Nightingale more than 150 years ago. Her expressed concern was that the greatest threat to patient safety were the “*frailties of the human condition*, *complacent attitudes and unconscious behaviours*” (Reid, 2011). These are patient safety practice issues and concerns which remain applicable in today’s healthcare climate.

Therefore, patient safety and high quality of care are and remain essential aspects of all healthcare practices, and whilst the medical profession focuses on the clinical, scientific and ethical competence aimed at curing and healing those people who are unwell. The Nursing profession concentrates on the moral and ethical work of the health experience for a human-being by caring for them physically, emotionally, and spiritually. Both the Hippocratic Oath and the Nightingale pledge for all intents and purposes promote patient advocacy and safety.

## A Culture of Safety in Healthcare

Safety is a fundamental facet of healthcare and an organizational ethos for the patient’s wellbeing acknowledges strategies such as leadership; teamwork; evidence based practice; communication; education; just culture; and patient centeredness for successful outcomes (Sammer, 2010). However, the time-honoured literature cautioned that despite the placement of well-defined safety strategies, the incidence of healthcare errors may not decrease due to the high incidence of violations by healthcare professionals and providers which create patient safety issues (O’Shea (1999). This caveat appears to be validated by the Institute of Medicine’s report of 2000, that despite the application of organizational safety strategies, healthcare errors continue to occur frequently which compromises patient care and safety (Makary, & Daniel, 2016; Leape 2015; Institute of Medicine, 2006). These enduring healthcare errors, could be explained by the healthcare professionals and provider’s behavioural attitudes toward the recommended safe practice organizational strategies, non-compliance, or deliberate violations regarding administrative guidelines (Dean et al. 2008; Lachman, 2007).

In the context of healthcare errors, the “*Theory-Practice gap*”is often cited by academics as the offending educational perpetrator due to outdated information (Mahmoud, 2014). Within this “*Theory-Practice*”paradigm there is often a gap between theoretical knowledge and its application in practice, which will affect learning and practice outcomes (Saifan et al., 2015). Yet, education programs which were introduced following the Institute of Medicine report (2000) to improve healthcare professionals and provider’s knowledge, and practices to decrease healthcare errors, have demonstrated negligible improvement with continuing practice violations (Makary, & Daniel, 2016; Schneider, 2006). Therefore, from a perspective of healthcare errors, as organizations adopt more complex strategies to improve patient safety, success of these strategies will still depend on professional responsibility, accountability, and practice ethics. Hence, to bridge the gap between “*Theory and Pract*ice” an additional factor called “*Ethics*” is required, and must be considered (Mortell, 2009).

The nursing literature also implies a crisis of ethicswhere “*Theory and Pract*ice” integrate, and that we as healthcare professionals and providers are failing to full fill our duty as patient advocates (Mortell et al., 2017; Mortell, 2017; 2012). Endeavours must therefore be made to encourage ethical practices and have healthcare professionals and providers reflect on their moral duty, as advocates to provide safe, quality patient care. Only by creating a culture of ethical care as patient advocates can we hope to decrease the ‘*Theory-Practice-Ethics gap*’and preserve patient safety.

## Perceptions of Patient Advocacy

Despite the recurring use of the term “*advocacy*” in the health sciences literature, and its presence in academic curricula, there remains a contrasting opinion about advocacy and the role for nurses. The patient advocate is often perceived as that of being the patient “*protector*” *or* “*defender*”, which is endorsed by numerous authors (Kupperschmidt, 2014; American Nurses Association, 2010). Nurses consider themselves foremost as the “*protectors*” of vulnerable patients (White et al., 2014). These nurses as “*protectors*” often have patient safety concerns related to the unnecessary, insensitive and often inhumane care, which do not advocate for the patient (Kupperschmidt, 2014; Jowers-Ware et al., 2011). A fundamental prerequisite that obligates nurses to act as an advocate is patient vulnerability (White et al., 2014).

Traditionally, the epitome of a nurse was defined as a champion of the sick, a healer, a counsellor and health educator. Nursing has been defined as “*the protection*, *promotion*, *and optimization of health and abilities*, *prevention of illness and injury*, *alleviation of suffering through the diagnosis and treatment of the human response*, *and advocacy in the care of individuals*, *families*, *communities and populat*ions” (American Nursing Association, 2003, p. 6). Curtin (1983) humorously declared, that the nurse as a patient advocate is “*a combination lawyer-theologian-psychologist-family counsellor and dragon slayer wrapped in a white uniform*” (p. 154). Advocacy has also been depicted as an “*ethical ideal*” (Davis et al. 2003) with a fundamental criterion that requires nurses to act as a patron for the vulnerable patient, whether in terms of individual vulnerability due to illness or injury or as a consequence of intrinsic risks which may be encountered within the healthcare system (Bu et al., 2006). Nurses therefore perform a fundamental role as a patient advocate to ensure that the treatment and care offered is apt and safe (Selanders & Crane, 2012). However, the obstacles that challenge nurses as patient advocates are often problematic and well documented in the literature (Davoodvand, Abbaszadeh & Ahmadi, 2016; Black, 2011; Sack, 2010). Despite the acknowledged importance of the advocacy role, it has also been conceded that the role may have both positive and negative consequences. While it provides patient benefits, such as quality care and enhanced safety, it exposes the patient advocate to various potential challenges. This is especially true when the nurse advocate’s duty of care requires intervention interacts with power structures within the multidisciplinary healthcare team and the employing organisation (Mortell et al., 2017).

The obvious benefits of patient advocacy include dependable, safe patient care, enhanced liaison with the patient and family and greater cooperation with allied multi-disciplinary healthcare professionals (Kupperschmidt, 2014; Thacker, 2008). In addition to empowerment of the patient, protection of their rights and values, and ensuring that patient autonomy is preserved (Bu et al. 2006). Nurse researchers such as Vaartio & Leino-Kilpi, (2004) reported that advocacy interventions by nurses provided unquestionable positive health outcomes, especially in the context of vulnerable, at risk age populations, such as infants and the elderly. For nurses the identified advocacy benefits included that society regarded nurses as dependable, honest, and reliable, which has enhanced the communal image and professional status of nurses and the nursing profession (Bu et al., 2006).

However, there were also various detriments and aftermaths from nurse colleagues, other healthcare professionals and providers and the employing organisation for nurses choosing to act as patient advocates (Mortell et al., 2017; Mallik, 1997a, 1997b, 1997c). Nurses as patient advocates have been labelled as trouble makers by colleagues, accused of insubordination, and have suffered loss of self-esteem, friends, reputation, and career advancement (Mortell et al., 2017; Bu et al., 2006; Vaartio & Leino-Kilpi, 2004). The logic for these negative outcomes was that a nurse’s advocacy actions could threaten the nurse-doctor relationship, especially if their actions countered the physician’s patient care decisions. In addition to identified advocacy issues which contradicted organizational ideals. Healthcare organisations normally require employees to adhere to administrative policies and procedures. Nurses that attempted to fulfil their ethical obligation as a patient advocate could find their actions challenging, demoralizing and intimidating. In such cases, the nurse is often subjected to the forfeiture of their professional reputation, loss of their self-esteem, the absence of career promotion, or employment dismissal, with subsequent ostracism by co-workers and friends (Mortell et al., 2017; Mallik, 1997a, 1997b, 1997c).

Regardless of the perceptions of advocacy, the significance of advocacy is an undeniable prerequisite to achieving the goalof effective quality patient care and to ensure that patients are safe when they require healthcare. Consistent with one of the most frequently cited views concerning advocacy, Vaartio & Leino-Kilpi (2004) stated that the advocacy must be appreciated in terms of quality health and care, which includes protecting patients from harm (p. 704).

## Consider a “*Theory - Practice - Ethics Gap*”

A fundamental element essential for patient care and safety which is not emphasized enough in nursing or healthcare is “*ethics*”. This is a moral obligation as a healthcare professional and provider to the patients and their families to ensure that they receive safe, quality care. Although numerous studies have discussed patient advocacy in nursing, and a “*Theory-Practice gap*”, this chapter discloses concerns that relate to patient safety, non-compliance amongst healthcare professionals and providers as patient advocates, and the possibility of a “*Theory-Practice-Ethics gap*”.

The following two case studies will provide the reader with an opportunity to reflect on their own clinical practices and serve as prudent reminders that everything we do as healthcare professionals and providers has potential ramifications for the patient. In addition to the reflecting on the reality that all healthcare professionals and providers are patient advocates and that all patients regardless of their religion, race, culture, age or gender are entitled to trustworthy, safe, quality care.

### Case Study 1

A 46-year-old male was referred from a cardiology clinic to a cardiac surgical clinic with severe refractory angina pectoris with suspected coronary artery disease. Successive investigations confirmed triple vessel coronary artery disease, which would require open chest surgery and coronary artery bypass grafts. The obstructive pathophysiology involved the left anterior descending artery 95%; Left circumflex artery 100%, and right coronary artery 90%. The unstable angina despite maximal medical management had become progressively worse over a period of 6 months. The patient’s 12 lead electrocardiograph, demonstrated widespread non ST segment elevation myocardial ischemia.

On clinical examination, he was anxious, had a pulse rate of 110 beats per minute; a systemic blood pressure 130/80 mmHg; Shortness of breath with a respiratory rate of 28 breaths per minute; a SpO2 of 92% on room air. Audible crackles on auscultation throughout bilateral lung fields. Chest x-ray confirmed cardiomegaly, and congestive heart failure. The angina pectoris was stated to be a constant ache, sub-sternal in location, with a degree of left arm numbness and “pain” with a numerical value of 8/10 to 10/10 depending on his physical activity or psychosomatic stresses.

 A medical-surgical procedure was recommended to the patient, which was coronary artery bypass grafts as a definitive intervention to circumvent his coronary lesions. On the day of the scheduled surgery, a patient was collected from the cardiology ward and transferred to the operating room. Before commencing the surgery, a final patient verification “TIME OUT”, was performed according to hospital policy and the Joint Commission International’s patient safety goal, “*Ensure right site; right patient; right procedure–surgery*” (Joint Commission International, 2010). This was done in the presence of the cardiac surgeon, who with astonishment stated that this was the wrong patient and that this patient was not for the scheduled surgical procedure of coronary artery bypass grafts. The surgery was subsequently cancelled and the patient was returned to the recovery unit.

## Reflecting on the “*Near Miss*” Event

As a healthcare professional and provider identifying a patient correctly prior to any procedure is an established responsibility, whether a procedure is minor or major. Typically, before any medical procedure, the patient’s full name and medical record number must be confirmed. Correct identification of a patient prior to any procedure is a standard healthcare practice, which preserves patient safety (Joint Commission International, 2010). There are no routine medical procedures in healthcare, every intervention could place the patient at risk and in harms-way. The patient concerned was incorrectly identified and taken to the operating room for open chest surgery, a major procedure. This surgery would involve opening the chest cavity, commencing cardiopulmonary bypass, harvesting the saphenous vein and radial arteries for the coronary artery bypass grafts and include numerous additional invasive interventions. Employing; the Joint Commission International’s patient safety goal number 4; “*Ensure right site; right patient; right procedure–surgery*” (Joint Commission International, 2010) or the equivalent depending on the organization’s policy (Emergency Care Research Institute, 2016). All patients must be afforded a safe systematic organizational process to be identified correctly before any procedure. Correct patient identification is a practice which all healthcare professionals and providers, have been informed and instructed on, with subsequent compliance being validated.

This “*Near miss*” event demonstrates that there is a “*theory-practice-ethics gap*”. When healthcare professionals and providers are non-compliant within their practice, despite being ratified by their profession and prepared by their employing organization to provide ethical care which has been fortified with the relevant evidence-based theory and practice. The case study focuses on two issues which relate to patient care and safety, the first is an ongoing medical dilemma, which involved correct patient identification. The second, an issue which revealed a potential conflict of professional ethics within a new paradigm called the “*theory-practice-ethics gap*”. This paradigm, acknowledges that all healthcare professionals and providers are provided with theoretical knowledge and functional skills to practice competently and safely. Yet, these same healthcare professionals and providers continue to be ethically non-compliant in their clinical practice, which creates an ethical patient safety dilemma.

### Case Study 2

A 3-year-old toddler was brought into emergency department of a tertiary hospital by his parents. The father informed the emergency department nursing staff that the toddler had been unwell with a cough and fever for several days. The emergency department nursing staff recorded the following observations. A fever with a core temperature of 38.5°C, rigor like shivering, rapid, shallow breathing, an SpO2 88% on room air, chest retractions, and fatigue. During the ensuing history undertaking by the emergency department physician, when asked about allergy status, the parents stated that the toddler had developed a severe rash and breathing difficulties following the administration of an oral Penicillin suspension on a previous occasion. The Penicillin allergy status of the toddler was documented and flagged in the physician’s hand-written and electronic medical records. Succeeding investigations included laboratory tests, such as nasopharyngeal bacterial swabs, blood cultures, and a complete blood count which highlighted a high white cell count of 15,000/mm³; neutrophils 70%, bands 15%, lymphocytes 15%. An Anterior-Posterior chest x-ray was also recorded.

The toddler was commenced on oxygen therapy which elevated the SpO2 to 94% and was subsequently transferred to the Paediatric High Dependency Unit for specialist care, close monitoring and the commencement of prophylactic antibiotic therapy. On arrival in the Paediatric High Dependency Unit, the toddler’s physical examination findings by nursing staff revealed that the toddler was drowsy, had a pulse rate of 138 beats per minute; a systemic blood pressure of 104/63 mmHg; a respiratory rate of 55 breaths per minute with associated shortness of breath, and an SpO2 of 92% on oxygen 40% non-rebreather mask. Pulmonary auscultation revealed wheezing and decreased air entry on the right side of the chest. The chest x-ray verified a right sided middle and lower lobe abnormality and probable pneumonia.

Once the toddler was settled, the Paediatric High Dependency Unit physician prescribed intravenous Amoxicillin as antibiotic prophylaxis until the culture and sensitivity report from laboratory was available to prescribe the specific antibiotic regime. Following the medical prescription of the intravenous Amoxicillin for the toddler, it was then transcribed by the Paediatric High Dependency Unit nurse, and subsequently dispensed from the satellite pharmacy to the Paediatric High Dependency Unit. The intravenous Amoxicillin was then prepared for administration by the primary nurse caring for the toddler. The antibiotic was connected to the toddler’s intravenous site and about to be administered intravenously when the parents who were still present at the bedside queried the medication. The father restated to the nurse that their child had a medication allergy to Penicillin. The nurse informed the parents that this medication was not Penicillin, it was Amoxicillin and that they needn’t worry as “*she knew what she was doing*”. Following the commencement of the intravenous Amoxicillin as prescribed, transcribed, dispensed and administered, the toddler had an anaphylactic reaction and subsequently had a cardiopulmonary arrest.

A paediatric Code Blue was announced over the hospital’s public address system, the paediatric Code Blue team arrived within minutes and the toddler was effectively resuscitated. The toddler was then intubated with an oral tracheal tube and was transferred to the paediatric intensive care unit for mechanical ventilation and stabilisation.

## Reflecting on the “*Sentinel*” Event

As a healthcare professional and provider, knowledge about pharmaceuticals is a fundamental requirement for all registered nurses in their daily practice (Nursing and Midwifery Council-UK, 2018; World Health Organization, 2010; Australian Commission on Safety and Quality in Health Care, 2013). Before administering any medication to a patient, the nurse must know about the medication administration rights and establish the “*known allergy status*” of the patient (Powrie, 2018). The nurse must also know the rationale for the prescription of the medication, the generic name of the medication, the related medication “*families*”, the actions, and potential adverse effects of the medication. These are fundamental medication principles which are established as a nursing practice responsibility. This praxis applies to all medications, whether the medication is oral, nasal, enteral, trans-dermal, sub-cutaneous, intra-muscular, intra-venous, epidural, or intra-thecal.

The benchmark in healthcare practice, before the administration of any medication, is to verify the patient’s Full name, Medical Record Number and the documented “*known allergy status*”. This practice ensures patient safety and prevents any potential medical error related harm (Joint Commission International, 2010). Nurses, as healthcare professionals, providers and patient advocates are aware that there are no routine medical procedures in healthcare, every medication prescribed and administered could place the patient at risk and in harms-way. Antibiotics such as Penicillin are often used to treat streptococcus infections, as they damage the bacterial cell, inhibit cell wall synthesis, and stop bacterial growth. Penicillin is also a known medication and is interrelated to a “*family*” of antibiotics known as the Beta-lactams, which includes Amoxicillin. Amoxicillin is therefore termed a “*Penicillin-like-antibiotic*”*.* If you are allergic to Penicillin, you may be allergic to other types of Beta-lactams, such as Amoxicillin.

This case study involved a 3-year old toddler who was admitted to the hospital with presumed pneumonia. During the medical examination by the emergency department physician it was noted and documented that the toddler was allergic to Penicillin. An allergy status alert was applied on to the medical records documentation hardcopy and was immediately flagged electronically to the pharmacy department. The toddler was subsequently transferred and admitted to the Paediatric High Dependency Unit by the nursing staff. This was followed by a review of the emergency department medical records documentation and a targeted physical assessment by the Paediatric High Dependency Unit physician. The antibiotic that was subsequently prescribed by the Paediatric High Dependency Unit physician was intravenous Amoxicillin, this medicament was then transcribed by the primary nurse and relayed electronically to the satellite pharmacy. The intravenous Amoxicillin was dispensed by the pharmacist to the Paediatric High Dependency Unit primary nurse caring for the toddler. The intravenous Amoxicillin was administered which resulted in an anaphylactic reaction and cardiopulmonary arrest.

The process of identification and acknowledgement of the toddler’s “*known allergy status*” in this case study progressed through four stages of safeguards which should have identified the patient’s “*known allergy status*”. These stages included 1. The Paediatric High Dependency Unit physician prescribing the medication, 2. The Paediatric High Dependency Unit nurse transcribing, the medication order, 3. The Pharmacist dispensing the medication, 4. The Paediatric High Dependency Unit nurse administering the medication. However, all of the stages failed to identify the patient’s “*known allergy status*” prior to prescribing, transcribing, dispensing and administering the medication, and resulted in the near fatal cardiopulmonary arrest of a 3-year old toddler.

The practice of correct patient identification with medication administration is a standard practice and complies with the recommended Joint Commission International’s patient safety goal number 1; “*Identify the correct patient*” (Joint Commission International, 2010). All patients must therefore be correctly identified by their Full name, and Medical Record Number in addition to confirming the “*known allergy status*” and medication administration rights for that drug. This is a standard safety practice which is required from all healthcare professionals and providers who are involved with patient medications.

Irrespective of the contributing issues, whether they are attitudinal behaviours, medical errors, faults, slips, non-compliance problems, questions about ethics. The healthcare professionals and providers who instigated this “*Sentinel event*” neglected to follow the standard policies and practices related to “*known allergy status*” which ensures a patient’s safety when receiving a medication. The safeguard failures occurred at multiple levels, which included the Paediatric High Dependency Unit physician; the Paediatric High Dependency Unit nurse, the Pharmacist, and the toddler’s parent’s concerns about their toddler’s allergy status. The failure to acknowledge the “*known allergy status*” could have resulted in fatal consequences associated with the cardiopulmonary arrest for the 3-year old toddler. In a perfect world, healthcare would occur in an exceedingly reliable system where no one is hurt and everyone gets the quality care they need. But, in reality, patients continue to be harmed with the professionals choosing to state that “*we*’*re all human*” and, “*To Err is Human*” ([Hinno, Partanen, & Vehviläinen-Julkunen, 2011](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4954916/#ref29); [James, 2013](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4954916/#ref34); Fowler et al., 2008).

This case study focused on two issues which relate to patient safety, the first was an ongoing medical predicament, which involved the identification of a 3-year old toddler’s “*known allergy status*”. The second, was the issue which exposed a potential conflict of professional ethics within a paradigm called the “*theory-practice-ethics gap*”(Mortell, 2013, 2012). This paradigm, again acknowledges that all healthcare professionals and providers are provided with theoretical knowledge and practical skills to perform competently and safely, yet continue to be ethically non-compliant. Non-compliance to the authorized policy and procedure for clinical practices, such as medication administration creates an ethical dilemma, with potential fatal consequences. It also serves as a cautious and far-sighted reminder that everything we do to or for the patient has potential consequences.

## Conclusion

In this chapter, viewpoints related to patient safety and quality care were presented and discussed in the context of a “*Theory-Practice-Ethics gap*”. [The](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4954916/#ref32) Institute of Medicine’s report ‘*To Err Is Human: Building a Safer Health System*’ stated that patients are frequently placed at risk of morbidity and mortality in the United States of America as a result of medical errors ([Institute of Medicine, 2000](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4954916/#ref32)). European nations also had concerns associated with ongoing medical errors which increase the risk of a patient’s morbidity and mortality (Classen, et al., 2011; [Hinno, Partanen, & Vehviläinen-Julkunen, 2011](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4954916/#ref29)). The Institute of Medicine’s report (2000) generated questions about patient safety and an obligation for healthcare professionals and providers to deliver high quality, safe healthcare ([Institute of Medicine, 2000](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4954916/#ref32), 2012). However, despite the transparency that was revealed by the Institute of Medicine’s report (2000) and the safety strategies recommended by organizations such as The Joint Commission International; patients continue to experience preventable harm and unacceptable care ([Leape, 2015](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4954916/#ref38); Dixon-Woods, et al.,2014*)*. Alarmingly, MakaryandDaniel, (2016), concurred that the healthcare errors remained prevalent and are considered the third leading cause of death in the United States of America, after heart disease and cancer.

There is no refuting that health care dynamics are complex and involve care processes which include sophisticated technologies and therapeutic interventions. However, with an enlarging world-wide population and an extended human life expectancy, the enduring frequent occurrences of healthcare errors, remain as a patient safety issue and concern.

Historically, the role of a patient advocate was perceived as fundamental for the profession of nursing, as it pledged the patient their rights, and their safety when receiving therapeutic treatment and care. Traditionally, the role of an advocate emphasized the provision of a duty of care; which was also embraced by nurses and the international nursing profession. The obligation for a patient-nurse advocate is therefore regarded as an ethical ideal which is grounded on the notion that nurses provide continuity of care with greater intimacy (Mathews, 2012). The modern-day nursing profession also declares that patient advocacy is a fundamental tenet of nursing practice. Nurses, as health care professionals and providers, practicing within the modern era must therefore question and reason logically why “*ethics*” are important and why they must be integrated with “*Theory and Practice*”. Present-day healthcare integrates the latest evidence based education, which we call ‘*theory*’, and combines this with psycho-motor skills, which we call ‘*practice*’, in order to provide high quality care to achieve the best patient outcomes. However, despite being provided with instruction [theory] and competence assessments [practice] the healthcare errors continue to be commonplace in the healthcare setting (Emergency Care Research Institute, 2016).

The “*Theory-Practice gap*” currently remains a significant topic in nursing, given that it confronts the concept of evidence based practice, which is the foundation of nursing as a profession. Although numerous studies have acknowledged a “*Theory-Practice gap*” this chapter reveals patient safety concerns which relate to healthcare ethics, and a “*Theory-Practice-Ethics gap*”. Actions must therefore be taken to promote healthcare ethics and have healthcare professionals and providers reflect on their moral duty, to provide safe, quality patient care. Only by creating a culture of ethical care can we hope to provide safe quality care and decrease the “*theory-practice-ethics gap*”. This “*Theory-Practice-Ethics gap*”must be considered when reviewing some of the unacceptable outcomes in health care practice (Mortell, 2009).

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