The Beginning: What Nurses Are Taught to Promote Patient Safety and How It Fails

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Patient Safety Authority

Objectives

- Learners will describe how a robust reporting culture can improve patient safety.
- Learners will explain why the 5 rights are not a safety strategy.
- Learners will identify reportable events within their facilities.
- Learners will recognize their own perception of error
- Learners will recognize when others are judging peers regarding errors.
- Learners will describe how to support staff involved in events.

RaDonda Vaught

Neuromuscular Blocking Agents: Reducing Associated Wrong-Drug Errors

ABSTRACT

Neuromuscular blocking agents (NMBAs) are commonly used to paralyze skeletal muscles during surgery conducted under general anesthesia and for patients requiring intubation for airway management. These medications are used in emergency departments, intensive care units, interventional radiology areas, and even medical and surgical units. NMBAs render patients unable to move or breathe and are considered high-alert drugs because misuse can lead to catastrophic injuries or death, especially when administered to patients who are not properly ventilated. Between June 2004 and March 2009, Pennsylvania healthcare facilities submitted 154 event reports that mentioned medication errors involving the use of NMBAs. Analysis reveals that the most common medication error event types associated with this class of medications were wrong-drug errors (37%) followed by wrong-dose/overdosage errors (16.2%). Further analysis showed that 47.4% of the intended

given to patients who are not properly ventilated. Therefore, this class of medications should only be administered by staff with experience in maintaining an adequate airway and respiratory support in facilities where intubation can readily be performed, oxygen can be administered, and respiratory support can be provided.

Due to the potentially devastating effects from the misadministration of NMBAs, clinical analysts reviewed medication error reports submitted to the Pennsylvania Patient Safety Authority in which an NMBA was listed as the medication prescribed or medication administered, as well as medication error reports in which an NMBA was mentioned in the description of the event.

NMB Errors through the Years

A Look at the Numbers

Pennsylvania healthcare facilities submitted 154 event

Julie Thao

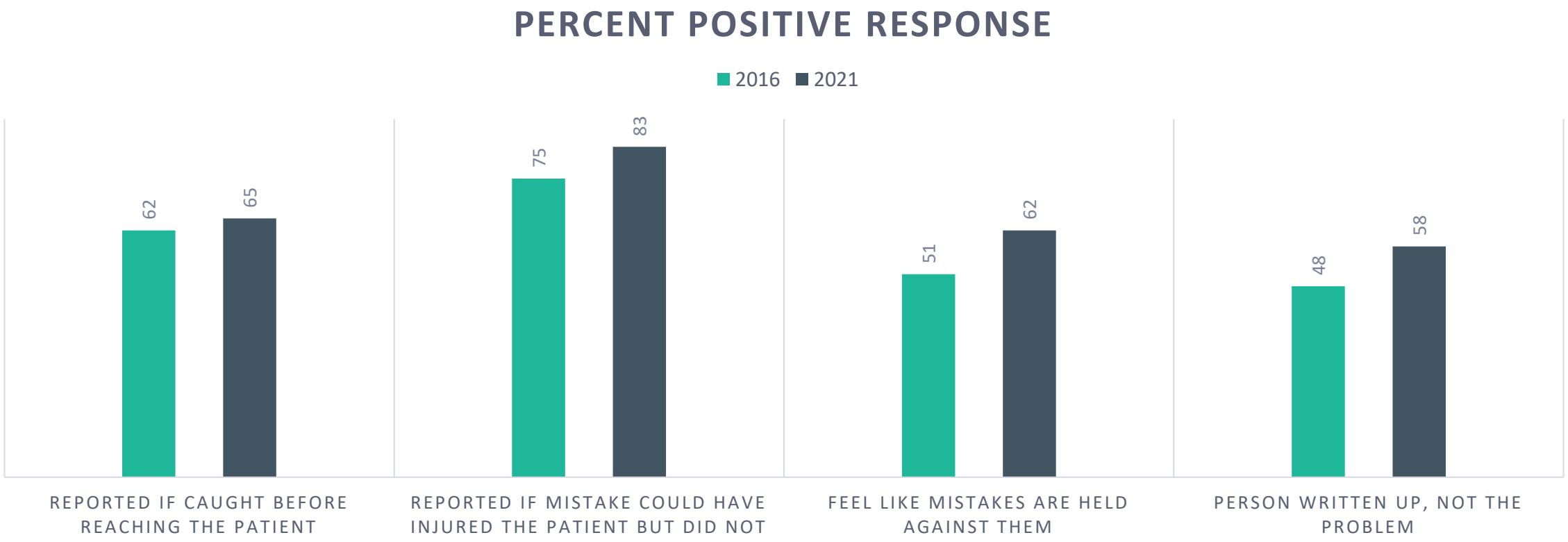

WHAM!

Nurses' Rights

1. The right to a complete and clearly written order
2. The right to have the correct drug route and dose dispensed
3. The right to have access to information
4. The right to have policies on medication administration
5. The right to administer medications safely and to identify problems in the system
6. The right to stop, think, and be vigilant when administering medications


CULTURE

Survey on Patient Safety - AHRQ



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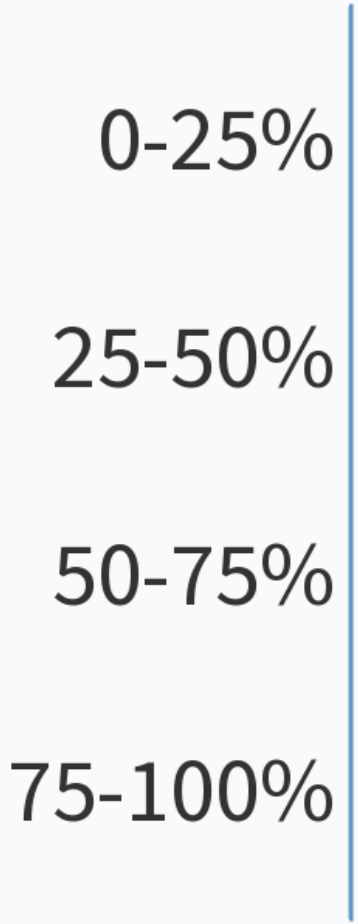
What percent of events do you believe are reported in your facility?

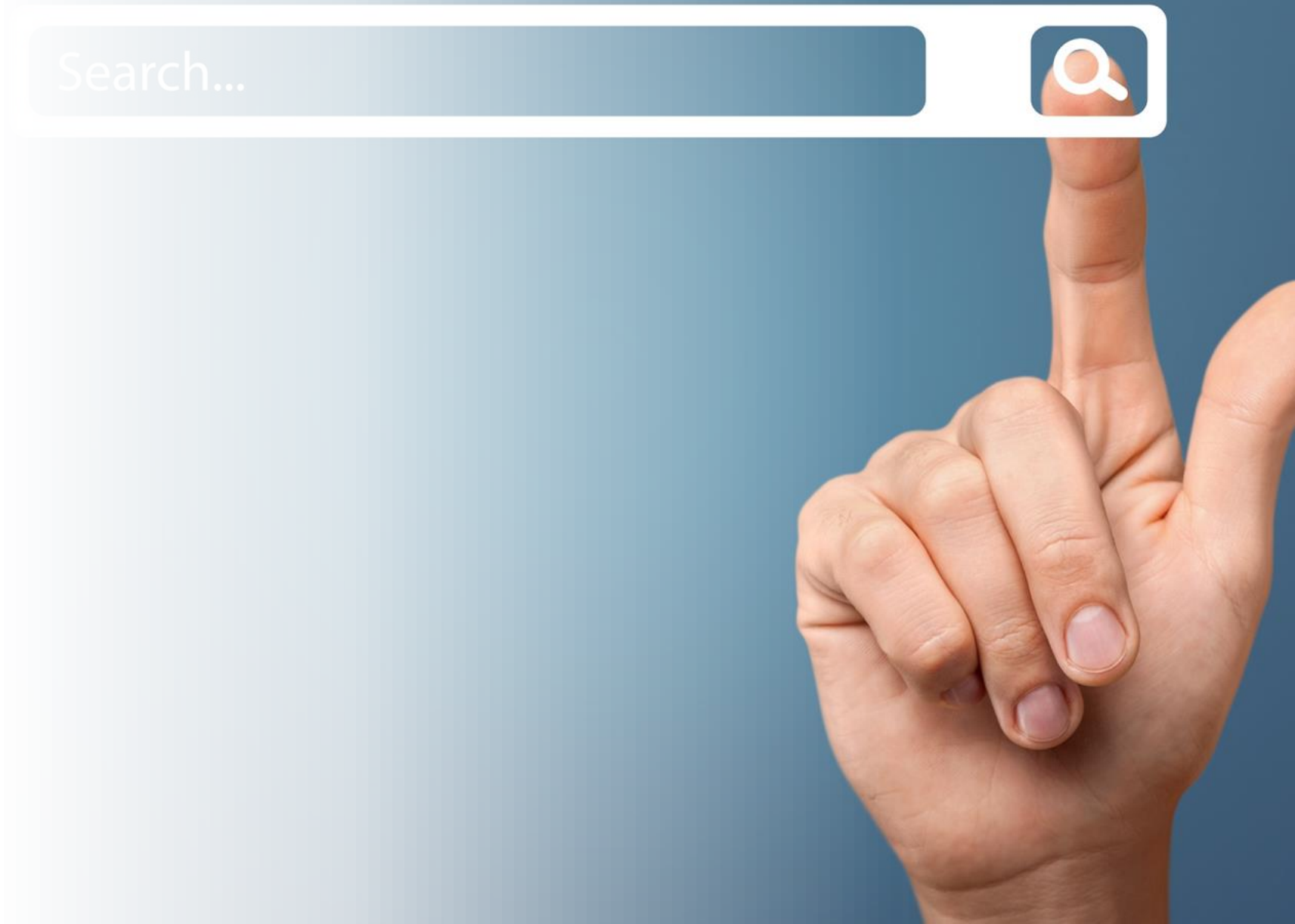


PSA Survey 2021

- Physicians, Nurses, Pharmacists, Respiratory Therapists
- 18,266 responses
- 18 scenarios
  - 6.3% correctly identified all

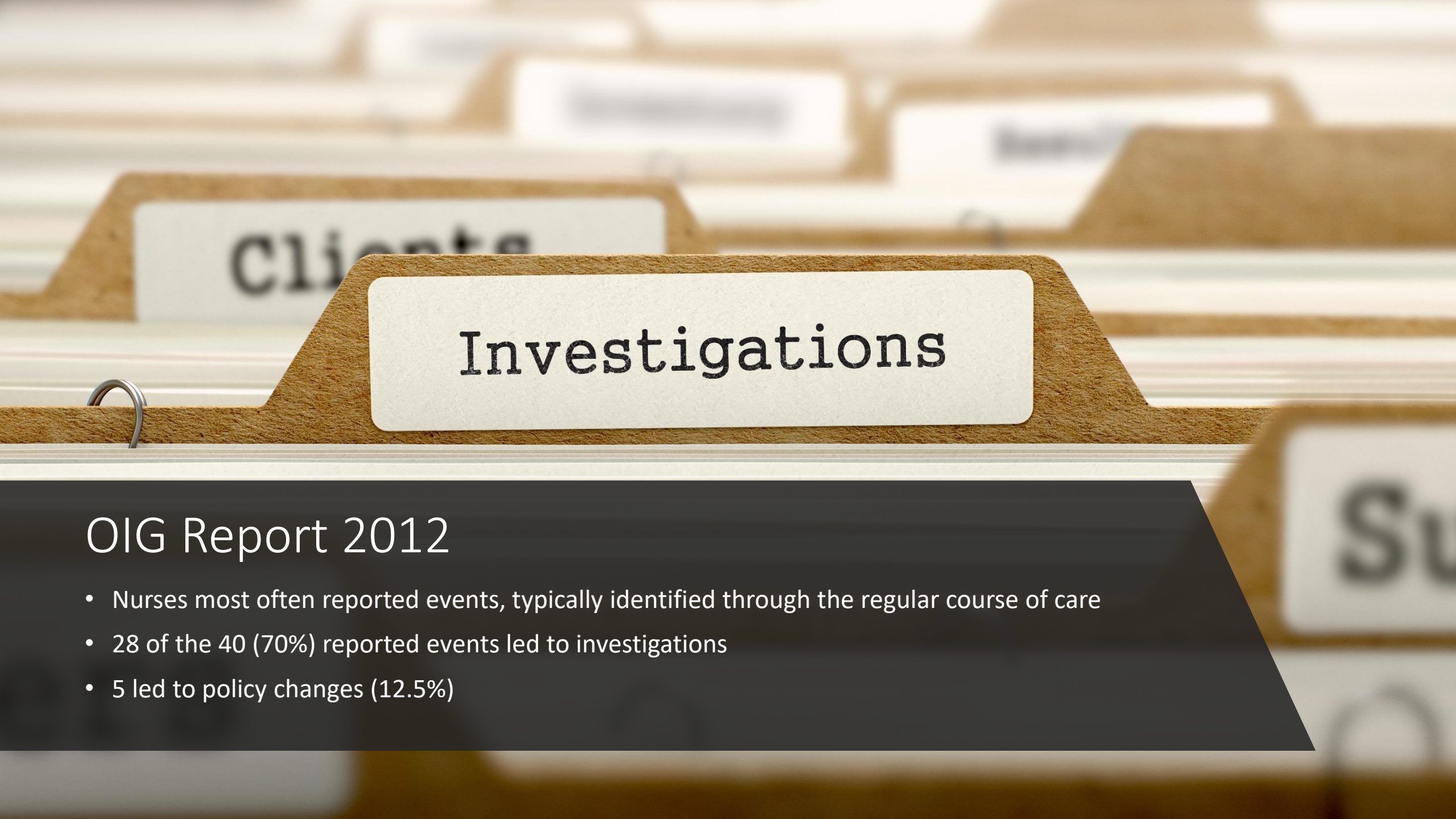
OIG Report 2012

All sampled hospitals had incident reporting systems to capture events, and administrators we interviewed rely heavily on these systems to identify problems



OIG Report 2012

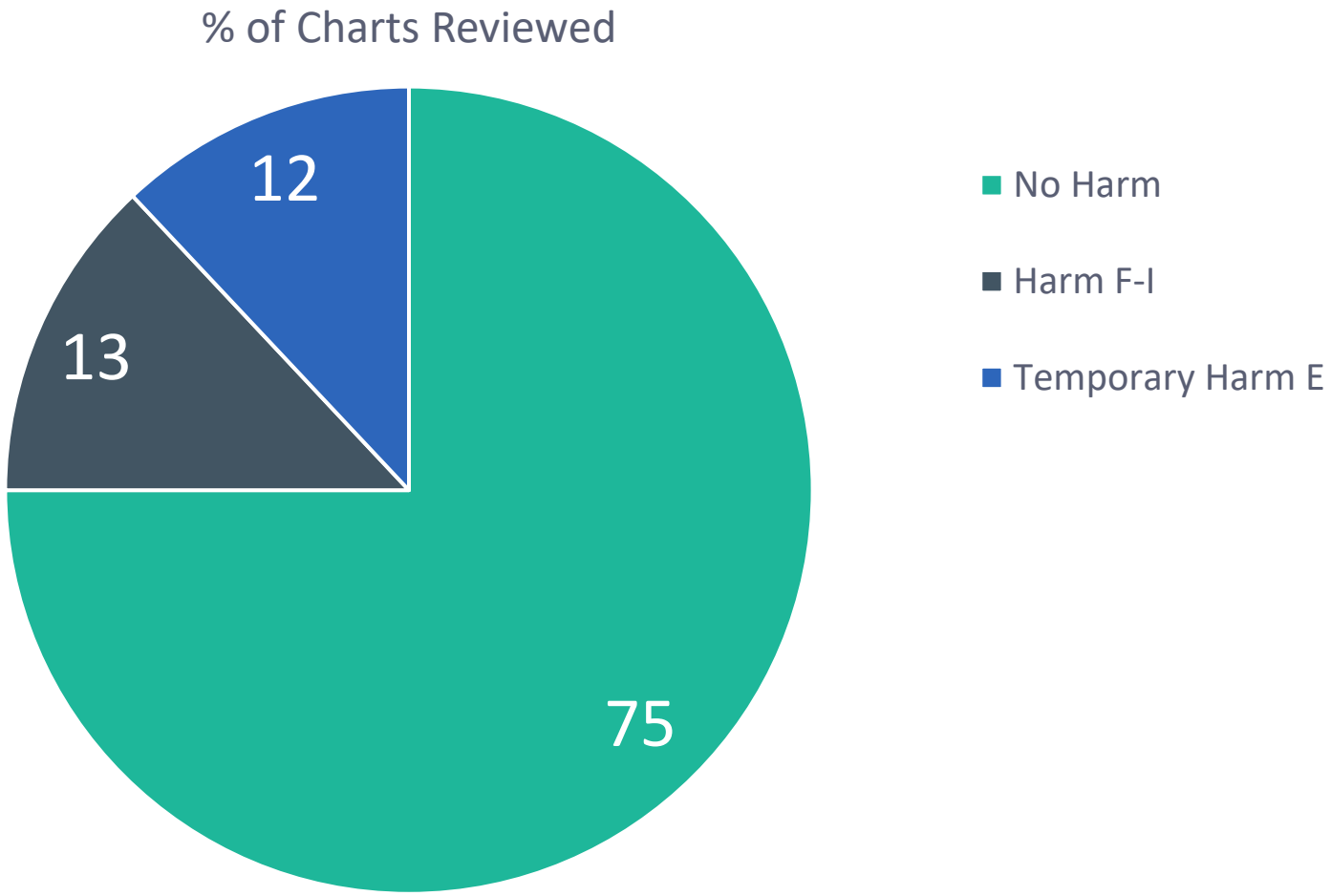
Hospital staff did not report 86 percent of events to incident reporting systems, partly because of staff misperceptions about what constitutes patient harm



OIG Report 2012

- Nurses most often reported events, typically identified through the regular course of care
- 28 of the 40 (70%) reported events led to investigations
- 5 led to policy changes (12.5%)

OIG Report 2022



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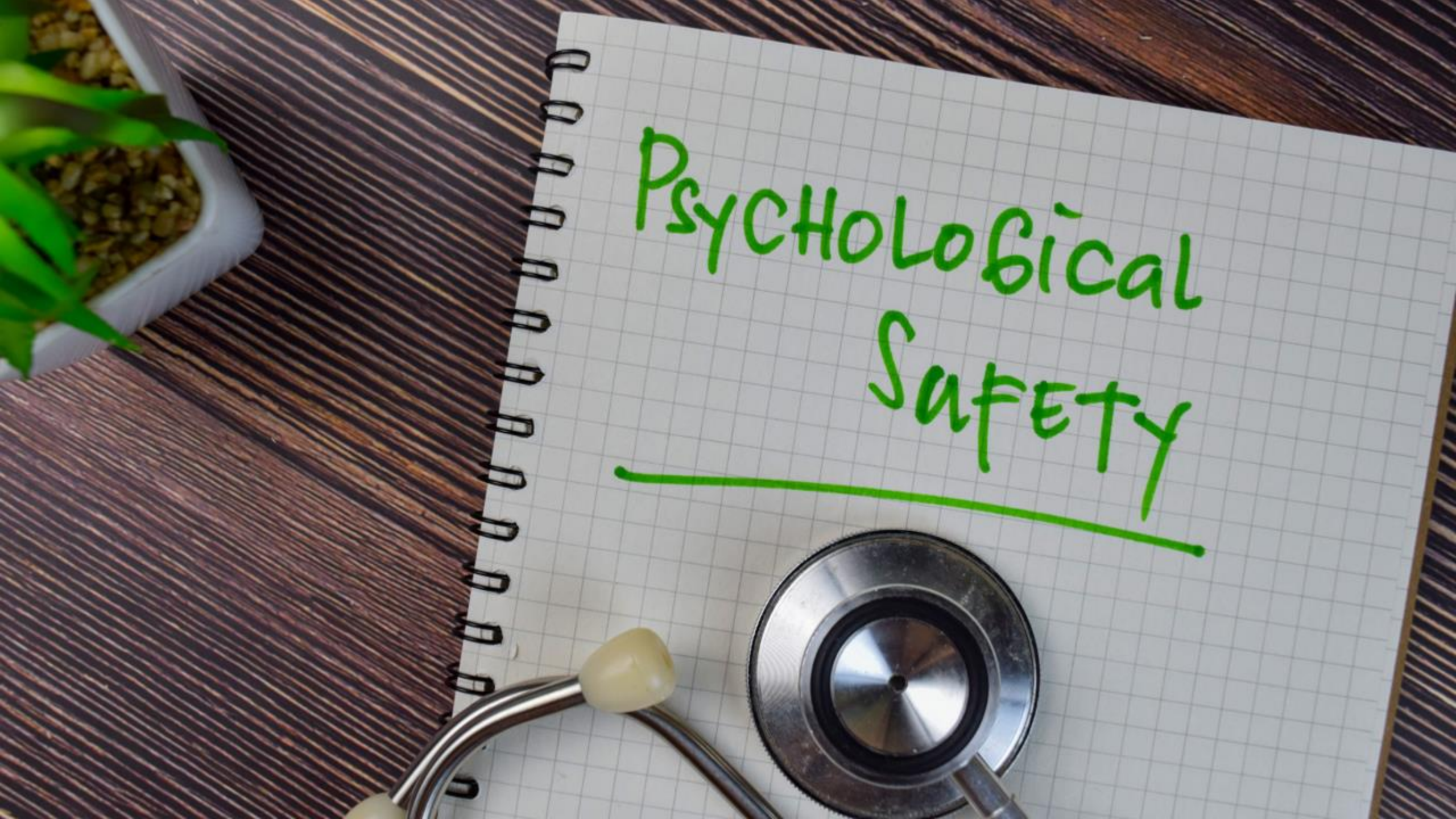
Psychological
Safety

"The single greatest impediment to error prevention in the medical industry is "that we punish people for making mistakes."

Dr. Lucian Leape, Professor, Harvard School of Public Health
Testimony before Congress on Health Care Quality Improvement 2000

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Kimberly Hiatt

What questions do you have?

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References

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- The five rights: A destination without a map. ISMP Medication Safety Alert. January 25, 2007;12(2)

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Thank You!

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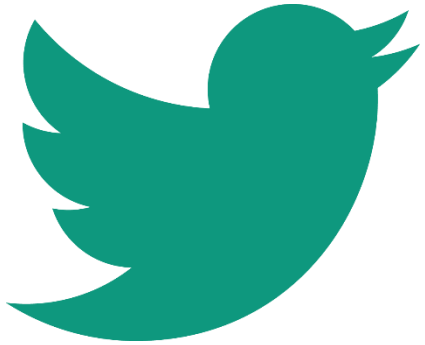

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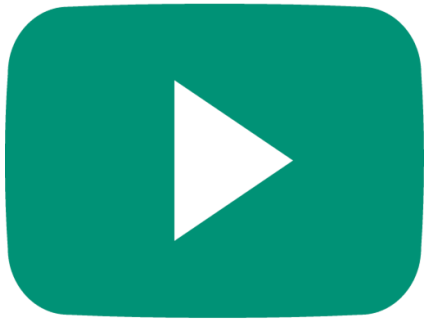

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