Quality and Safety Matters

TCNJ Nursing's Quality and Safety Newsletter

Volume 4, Issue 2 **November 2018**

5 Common Errors Made by New Nurses

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Class of 2020

Nursing, as rewarding as it is, can be one of the more stressful occupations because of the pressure associated with caring for human lives. Right out of nursing school, new graduates study and prepare to pass the NCLEX, but we don't prepare for the nerves of having a new job in a new environment with new people. Unfortunately, this additional stress can lead to mistakes in patient care. A recent article in *Nurse Journal*[1] has identified five of the most common errors made by new nurses.

The first is errors involving medications. Medication errors can range from minor, like administering outside of the 30-minute window, to being fatal for patients. In order to help prevent medication errors, it is suggested that the nurse use patient identifiers to ensure that the right patient is receiving the right medication. Verbal confirmation of his/her name and date of birth as well as referencing the patient's hospital bracelet are good methods for patient identification. Verifying patient allergies and identifying critical conditions or diagnosis prior to medication administration can also be used to avoid medication errors.

Second, while people are admitted to hospitals for care of infections and injuries (among other conditions), patients are not immune from additional infections acquired in the hospital. It is important for all healthcare professionals to observe proper hygiene techniques. The Centers for Disease Control estimates that 1.7 million Healthcare-Associated infections occur in U.S. hospitals every year, leading to 99,000 deaths and costing approximately 20 billion dollars[2]. Thorough hand washing, aseptic techniques, and cleaning and disinfection are necessary to prevent hospital-acquired infections.

Third, charting to provide documentation is one of the most important, yet time-consuming, tasks that a nurse completes. Charting is required for every interaction with the patient. It protects not only the patient, but also the nurse. Accurate and thorough documentation can help to make nurses less vulnerable to lawsuits, so when in doubt, it is best to chart.

Fourth, it is important to always be mindful to prevent fall accidents. It is important to ensure that patients know they have a nurse's support and that they are not afraid to ask for help to move about their rooms. In order to do this, introduce yourself in a friendly and welcoming tone. Ask the patient if you can help him/her with anything else when you are in the room. Remind patients that you are there to care for them. Again, this strategy protects both the patient and the nurse.

Fifth, being prepared by having enough, appropriate information available on hand is important when calling for help. ***Continued on page 2***

A Step Ahead: Strategies to Prevent Med Errors

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It is no secret that mistakes happen in healthcare. When a business is managed by people, human error is likely to occur. Prescribing patients the wrong medication, the wrong dose or dosage, or wrong instructions for consumption can lead to serious injury. In fact, approximately 7,000 people die due to preventable medication errors each year[1]. While death is the most serious complication, preventable medication errors are not few and far between. Financial burden on hospitals and pharmaceutical companies, adverse health effects, and mistrust in the healthcare system are some of the most prevalent consequences. Although mistakes are inevitable, there are precautions we can take to avoid these major medical mishaps from repeating.

Patient safety is an integral part of nursing practice. When caring for patients, today's modern world often relies on medication as the catalyst of the healing process. In many cases medication is helpful but it becomes harmful for both the patient and provider if not administered correctly. Since nurses tend to be the last person in the chain of events leading up to medication administration, it is up to them to ensure that errors do not occur.

There are several important strategies to consider to steer clear from being a part of the problem. Many health professionals suggest double-checking those drugs classified as "high alert" (heparin, insulin, potassium, narcotics…)by the Institute of Safe Medication Practices[2]. Additionally, taking a step back to let time pass between checks allows for greater mental clarity and better outcomes. Asking a colleague to aid in securing the proper medications has been proven to be helpful in error prevention as well. Keeping the patient's list of current medications up to date and reiterating the importance of how and when your patient should ingest their medication could also be a pivotal point in medication administration safety[3]. As a student not currently in a hospital or primary care setting, completing the Institute for Healthcare Improvement modules with attention to detail can improve knowledge of the system and processes through which care is delivered. These practices may aid in the decline of medication errors in the near future.

It is important to be open and honest with our mistakes as health care professionals. It is when we talk freely about our errors that we allow serious discussion about improvement to ensue. As Florence Nightingale stated in her book *Notes on Hospitals*, "the very first requirement in a hospital [is] that it should do the sick no harm."[4] If we as nurses are to abide by this simple teaching, we must never cease to practice proper communication and take accountability for our own mistakes. Though there is a slim chance that the world of medicine will ever fully emulate utopian ideals, careful practice and proper communication can help it come closer.

1. Walsh, M. H. (2015). *Automated medication dispensing cabinet and medication errors.* Retrieved from https://scholarworks.waldenu.edu/dissertations/305/
2. *Independent double checks: Undervalued and misused: Selective use of this strategy can play an important role in medication safety.* (2013, June 13). Retrieved from https://www.ismp.org/resources/independent-double-checks-undervalued-and-misused-selective-use-strategy-can-play
3. *Twenty tips to help prevent medical errors: Patient fact sheet*. (2017, May 12). Retrieved from https://www.ahrq.gov/patients-consumers/care-planning/errors/20tips/index.html
4. Nightingale, F. (1863). *Notes on Hospitals*. London: Longman, Green, Longman

Prevention of Health Care Errors

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Jerry, a nurse working overtime due to a surge of patients on his floor, is on the fourteenth hour of his shift. He is already exhausted, but feels the need to stay because of the large number of patients and few nurses available. He is administering a PO medication which he crushes because his patient is intubated and has an NG tube. Because he is tired, Jerry's decreased mental concentration causes him to miss an important piece of information about his patient's medication that reads, "Do not crush." He instills the crushed medication into the patient's NG tube. Not too long after, the patient's oxygen saturation drops drastically causing an emergency.

Medical errors such as these occur far too often. As many as 40,000 to 80,000 deaths from medical errors occur every year[1]. Some of the most common causes of these errors are not due to negligence or lack of education or training, which is easy to assume, but to poor system design and organizational factors. As shown in Jerry's case, the expectation of some healthcare workers to work for an extensive number of hours can cause overwork, fatigue, and decreased mental concentration. All of which increase the possibility of error and patient harm. This is just one example of the many poor system designs that cause avoidable errors in health care. Others examples include a lack of communication between healthcare providers as patients transfer between different facilities and medication errors due to delivery system design flaws.

The lack of communication between healthcare providers can result in misinformation or lack of information about a patient resulting in inappropriate care. This can be solved with the creation of a better system that ensures safe patient hand-off. Medication errors can be caused by improper prescribing, label confusion, name similarities, or order miscommunication. Similar named medications such as the arthritis drug Celebrex, the anticonvulsant drug Cerebyx, and the antidepressant drug Celexa, create an increased likelihood of confusing medications and can result in administering the incorrect one.

Many hospitals have computer programs and ID scanners that ensure patients are receiving the correct medication, however, some hospitals still do not. The care of children and the elderly have a higher incidence of medication errors. Errors in children are due to the additional calculation of the dose amount by weight which allows more room for error. Elderly patients have more complex lists of medication and care which can also increase the potential for error. Additionally, committing the error of providing too little information to the patient about a medication, can result in a lack of adherence to taking it.

Steps have been taken to prevent these errors such as implementing computer systems to double-check one's work and the use of ID scanners throughout the hospital. Even with systems such as these, medical errors are still present. National Patient Safety Goals provide direction for error prevention. The following goals demonstrate ways to ensure patient safety:

1. Identify patients correctly-Use at least two ways to identify your patient
2. Use medicines safely-Educate your patient about the medications he is taking and be extra cautious when dealing with medications.
3. Prevent Infection-Always practice good hand hygiene.
4. Prevent mistakes in surgery-Make certain that the surgery is being performed on the right place on the patient's body.
5. Prevent patient safety risks-Prevent falls and other potential hazards to the patient.
6. Office-based surgery care-Educate about surgical site care and infection prevention

Nurses and other healthcare providers must follow these steps to aid in the prevention of unnecessary health care errors. They must not be afraid to report medical errors. Patients who are able to advocate for themselves must have a role in their own care. Patients can protect themselves by being educated about the correct questions to ask so that their care is provided accurately. Medical errors are unfortunately occurring far too frequently. Nurses supporting system changes that prevent errors is an important step in keeping patients safe.

1. Warren, D. & Hudson, S. Prevention of Medical Errors. (2018). Retrieved from: https://www.nursece.com/courses/107-prevention-of-medical-errors

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continued from page 1.

If a nurse were to call a provider without the proper information, the call could waste of time in a potentially urgent situation. Additionally, calling for help without sufficient information puts the nurse at risk for looking ill-prepared in front of his/her colleagues and patients. Using a common communication method known as SBAR—situation, background, assessment, recommendation—can be helpful to avoid lacking information.

Nursing is a complicated art. There are many things that could go wrong. However, there are many strategies to prevent errors. Charting, preventing falls and medication errors, infection control and collecting sufficient information are all aspects of nursing that are taught in school. It is important to be confident in the knowledge one possesses. Remembering the strategies we are taught in school can prevent error and patient harm.

1. The 5 most common mistakes made by new nurses. (2018). *Nurse Journal*. Retrieved from: https://nursejournal.org/articles/the-5-most-common-mistakes-made-by-new-nurses/

2. Preventing healthcare associated infections. (2018). *Centers for Disease Control*. Retrieved from: https://www.cdc.gov/washington/~cdcatWork/pdf/infections.pdf

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