Using simulation to teach nurse residents about healthy work environments ID#94230

REBEKAH POWERS DNP, RN-BC, CMSRN, CSPHA, CHTS-CP

LYNDA SANCHEZ DNP, RN-BC

Objective

- Incorporate medical error and coping skills training into simulation scenarios
- Nothing to disclose

Second Victim

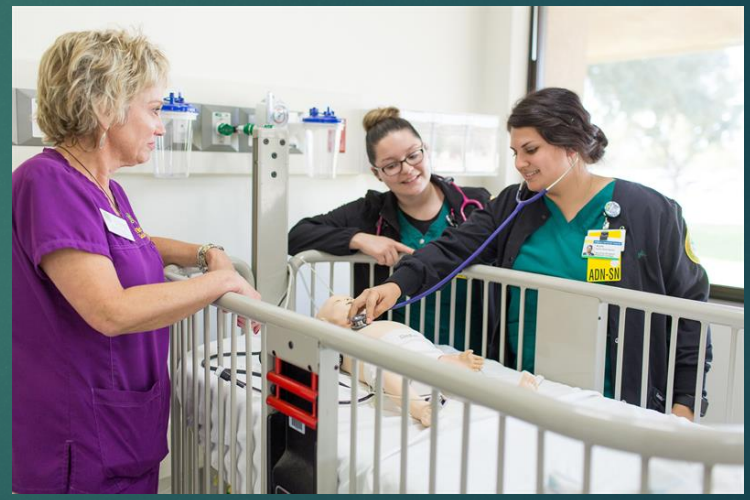
- Although there are many reports that cite medication errors and the resulting patient harm and death, many do not speak to the second victim, the health care worker who was involved the medical error.
- Grissinger (2014) stated that health care workers who have performed a medical error often suffer with "medical emergency equivalent to post-traumatic stress disorder (PTSD)" (p.1).
- These second victims suffer a myriad of anxiety, shame, loss of confidence, and months later may exhibit continual signs of PTSD, and ultimately some commit suicide (Grissinger, 2014).

Second victim

- The Institute for Healthcare Improvement has issued a white paper on the treatment and support of those that have experienced a medical error, and encourages the establishment of a formal support system for second victims.
- To address this pressing issue, new nurse residents are exposed to the medication error and second victim simulation in which they are placed in a simulation scenario in which they have the potential for a medical error to be made. After the scenario, the participants engage in a forum where the process after a medication errors is discussed as well as the effects on the second victim.

Simulation

- Scenarios based on the International Nursing Association for Clinical Simulation and Learning (INACSL)
  - Simulation Design
  - Objectives
  - Debriefing
  - Participant Evaluation
- QSEN competencies
- Fidelity
  - Intermediate simulation manikins
  - Name bands, Physician orders
  - Medication administration records
  - Based on actual medication errors



Simulation Design

- Simulation scenario
  - Participants are given report as change of shift via SBAR (Situation, Background, Assessment, Recommendation)

PO Medication Administration

- Situation
  - Betty June 65 year old female of Dr. S's, Admitted 5 days ago with pneumonia, and Right hemiplegia
- Background
  - History of atrial fibrillation, Hypertension, High cholesterol, Smoked 2 ppks/day x 30 years, quit 10 years ago
- Assessment
  - Heart rate is elevated between 110-120, No distress. Morning medications have been administered
- Recommendation
  - Called physician re elevate heart rate, waiting on call back

Simulation

- Designed with potential errors, but if adhere to 5 rights of medication administration can be avoided
  - Wrong medication
    - Look alike, sound alike medications in medication administration cabinet- placed beside each other
      - Metoprolol succinate
      - Metoprolol tartrate

Simulation Debrief

- Best practice for debriefing
- Immediately after scenario
  - Set the scene
  - Reaction phase
  - Description phase
  - Analysis phase
    - Delta method
- One week after scenario
  - Peer review
  - Second victim

Incident Based Nurse Peer Review

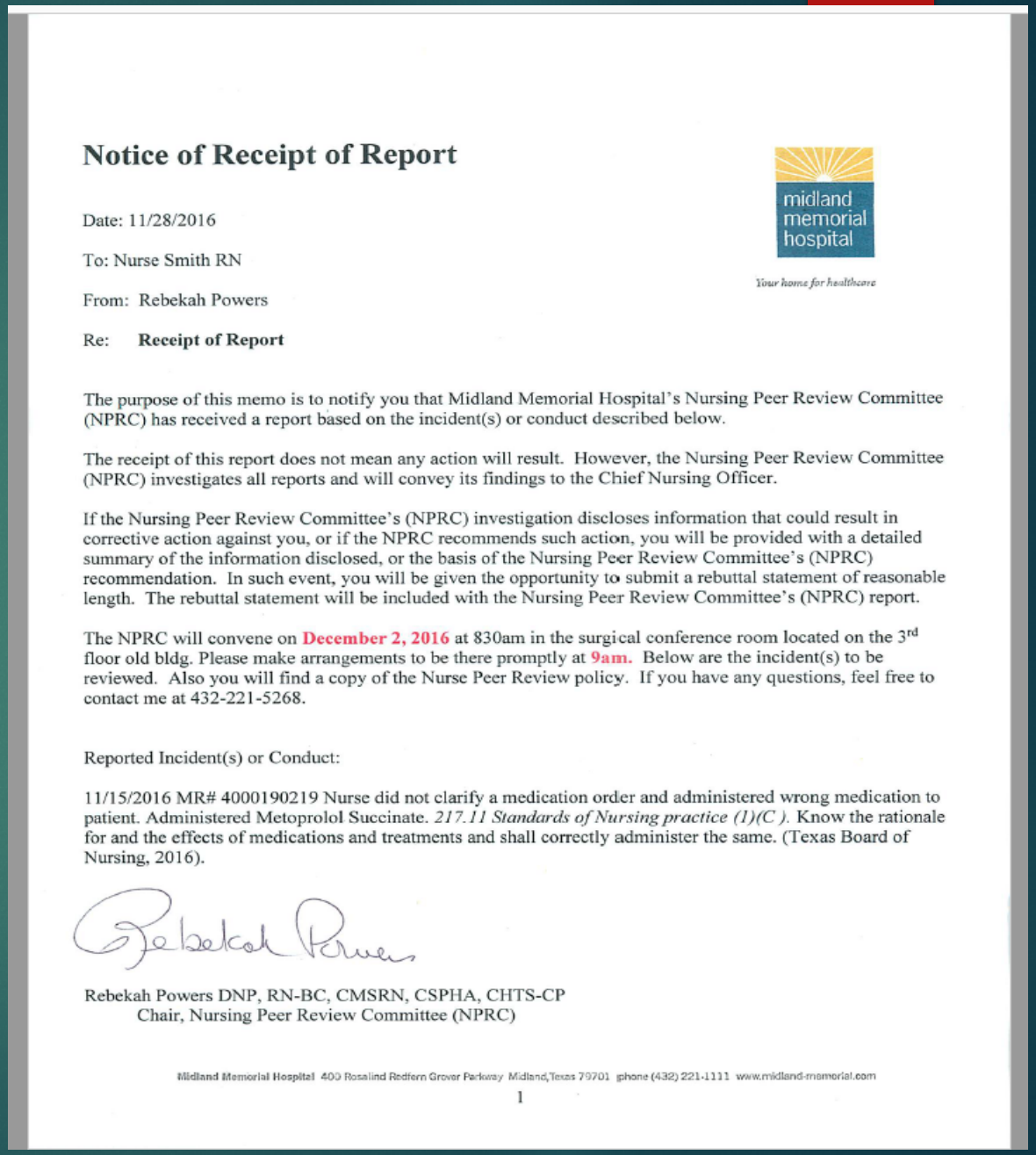
- Peer review is the evaluation of nursing services, the qualifications of a nurse, the quality of patient care rendered by nurses, the merits of a complaint concerning a nurse or nursing care, and a determination or recommendation regarding a complaint (Texas Board of Nursing, 2016).
- A "minor incident" is defined by Texas Occupations Code (Nursing Practice Act) §301.419(a) as "conduct that does not indicate that the continuing practice of nursing by an affected nurse poses a risk of harm to the client or other person."

Brief Training on Nurse Peer Review

- PowerPoint that reviews Nurse Practice Act Rules
  - Peer Review
  - Minor Incidents
  - Confidentiality
  - Make up of Committee

Delivery of Notice to Appear

- Letter
- Copy of Board Rules and Texas Occupations Code



Notice of Receipt of Report

midland memorial hospital
Your home for healthcare

Date: 11/28/2016

To: Nurse Smith RN

From: Rebekah Powers

Re: **Receipt of Report**

The purpose of this memo is to notify you that Midland Memorial Hospital's Nursing Peer Review Committee (NPRC) has received a report based on the incident(s) or conduct described below.

The receipt of this report does not mean any action will result. However, the Nursing Peer Review Committee (NPRC) investigates all reports and will convey its findings to the Chief Nursing Officer.

If the Nursing Peer Review Committee's (NPRC) investigation discloses information that could result in corrective action against you, or if the NPRC recommends such action, you will be provided with a detailed summary of the information disclosed, or the basis of the Nursing Peer Review Committee's (NPRC) recommendation. In such event, you will be given the opportunity to submit a rebuttal statement of reasonable length. The rebuttal statement will be included with the Nursing Peer Review Committee's (NPRC) report.

The NPRC will convene on **December 2, 2016** at 830am in the surgical conference room located on the 3rd floor old bldg. Please make arrangements to be there promptly at **9am.** Below are the incident(s) to be reviewed. Also you will find a copy of the Nurse Peer Review policy. If you have any questions, feel free to contact me at 432-221-5268.

Reported Incident(s) or Conduct:

11/15/2016 MR# 4000190219 Nurse did not clarify a medication order and administered wrong medication to patient. Administered Metoprolol Succinate. *217.11 Standards of Nursing practice (1)(C).* Know the rationale for and the effects of medications and treatments and shall correctly administer the same. (Texas Board of Nursing, 2016).

Rebekah Powers

Rebekah Powers DNP, RN-BC, CMSRN, CSPHA, CHTS-CP
Chair, Nursing Peer Review Committee (NPRC)

Midland Memorial Hospital 400 Rosalind Redfern Grover Parkway Midland,Texas 79701 phone (432) 221-1111 www.midland-memorial.com

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Question Ideas

- Tell us your process for administering medications
- What resources do you have to look up unfamiliar medications
- What was going on at the time you were giving medication
- When did you notice the error
- Do you have a mentor or someone you can ask questions
- Have you changed your practice since the error

Determination/Remediation

- Committee finding
- What would you have the nurse do to improve their practice

Second Victim

- Empathy towards someone who has made an error
- Influencing how others respond when someone makes an error
- Resources available
  - EAP
  - Mentors

Evaluation questions

- Describe how you felt during the mock peer review?
- Describe how the mock peer review affected you?
- How will the mock peer review influence your future practice?

Reactions

1. Describe how you felt during the mock peer review?
    1. Nervous/scared/afraid of making an error or making a mistake
    2. Felt bad (guilt, empathy, made someone else make a mistake)
    3. Awareness of how easy medication errors are to make
2. Describe how the mock peer review affected you?
    1. Errors are easy to make
    2. Change in practice
    3. Informational
3. How will the mock peer review influence or affect your future practice?
    1. Double check
    2. Slow down
    3. Ask questions

Questions