

POPSCI: ID# 96770

Title:

Nurses' Perceptions of High-Alert Medication Safety: A Qualitative Descriptive Study

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ACCEPTED

Session Title:

Research Poster Session 1 (Saturday/Sunday, 16 & 17 November)

Slot:

RSC PST1: Sunday, 17 November 2019: 11:45 AM-12:15 PM

Abstract Describes:

Completed Work/Project

Applicable Category:

Clinical, Academic, Students, Leaders, Researchers

Keywords:

High-Alert Medications, Qualitative Descriptive Research and Safety

References:

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Abstract Summary:

High-alert medication (HAM) error incidence ranges from 14-28%. In this qualitative descriptive study, nurses were interviewed about HAM practices. Three themes contributed to HAM safety: Culture of Safety, Collaboration, and RN Intrinsic Factors. Clear HAM policies, decreased disruptions, enhanced technology, and HAM safety education are recommended to prevent HAM errors.

Content Outline:

1. Introduction
 1. Incidence: Why are we concerned about high-alert medication (HAM) safety?
 2. Current practices: What the literature tells us about HAM safety
2. Methods
 1. Qualitative descriptive research
 1. Content analysis
 2. Participants
 1. Adult acute care registered nurses

2. Urban and suburban hospitals
 3. Waiver of signed consent
 2. Data collection
 1. Semi-structured interviews: How the nurses defined high-alert medications; practices that protected patients during HAM administration; barriers to safety; and information to include when teaching nurses about HAMs.
 3. Data management: HIPAA compliant server
 4. Data analysis
 1. Inductive: Data collection and inductive content analysis occurred concurrently
 2. Deductive: Reason's Swiss Cheeses Model
3. Results
 1. Participants
 1. 83% female
 2. 72% White
 3. 56% BS
 2. Themes:
 1. Culture of Safety
 1. Organizational values
 2. Organizational processes
 2. Collaboration
 1. Intra-professional
 2. Interprofessional
 3. Patient-nurse
 3. RN Intrinsic Factors
 1. RN Engagement
 2. RN Competence
4. Conclusions
 1. Findings corroborate known factors that interfere with safe medication administration (i.e. interruptions, inefficient workflow, fear of retribution for errors, ineffective collaboration, and insufficient nurse knowledge)

2. Safety measures such as bar code scanning and the independent double check are inconsistently and incorrectly applied
3. Participants identified that a lack of clear and consistent HAM policies, disruptions to processes, and ineffective technologies contributed HAM errors
4. Enhancement of nurse education into and accountability for safe HAM practices could lead to improvement in patient safety outcomes
5. Areas for future research: the impact of just culture, nursing judgment, professional engagement, and patient-nurse collaboration on HAM safety

Topic Selection:

Research Poster Session 1 (Saturday/Sunday, 16 & 17 November) (25745)

Abstract Text:

Background: In the United States, 21% of Americans experience a medical error. High-alert medications (HAMs) such as anticoagulants, antidiabetics, and opioids have an increased risk for causing patient harm. HAM error incidence ranges from 14-28% of which 11-29% occurred during the administration process. Factors such as task interruptions due to workflow issues, frequent transfers from one ward to another, failure to implement bar-code scanning appropriately, and insufficient HAM knowledge contribute to errors. Although research on safety practices specific to HAMs have begun to emerge, there is a gap in the current literature regarding nurses' perceptions of factors that contribute to safe practices and errors when caring for patient's receiving HAMs.

Methods: In this qualitative descriptive study, 18 adult, acute care nurses were interviewed about HAM safety to answer the question *What are nurses' perceptions about factors that contribute to safety when caring for patients receiving high-alert medications?* Content analysis was used to identify, describe, and make inferences about the qualitative data captured from the RNs. Processes to assure trustworthiness were incorporated into the preparation, organization and reporting phases of this study. Data from this analysis was used to generate a model for HAM safety, and to identify areas for further research.

Results: Three themes contributed to HAM safety: Culture of Safety, Collaboration, and RN Intrinsic Factors. A culture of safety included organizational values (i.e., just culture, organizational culture) and organizational processes (work flow, information resources, work load). Collaborations were intraprofessional, interprofessional, and patient-nurse. RN intrinsic factors included nurse competence and nurse engagement. Factors contributing to medication error (distractions, patient load, and acuity) also affected HAM safety. Work arounds and incorrect use of independent double check procedures were common.

Conclusions: Current HAM safety strategies are not consistently or correctly utilized. Clear HAM policies, methods to decrease disruptions to processes, enhanced technology, and education on safe HAM practices are recommended to prevent HAM errors.