THE LIVED EXPERIENCE OF MAKING A MEDICATION ADMINISTRATION ERROR IN NURSING PRACTICE

PRESENTER (AUTHOR)
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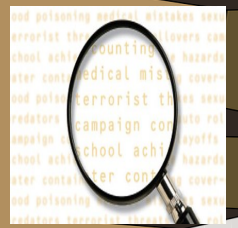
DISCLOSURE
SEEMA LALL



Financial Relationships

- Assistant Professor of Nursing at Harriet Rothkopf Heilbrunn School of Nursing, Long Island University, Brooklyn NY.
- Travel reimbursement expected through Long Island University

Non Financial Relationships

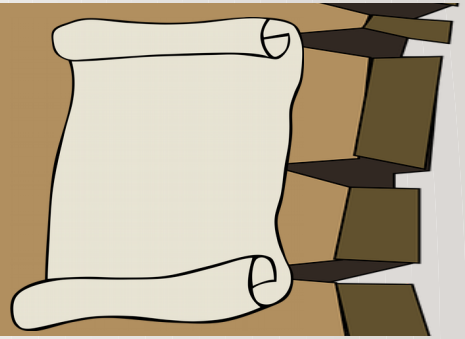
- Member of the National League for Nursing
- Member of the Eastern Nursing Research Society

OBJECTIVES

The learner will (Nurses/Nurse Leaders/Nurse Educators):

- Acknowledge the importance of nurses' responsibility of medication administration process
- Value the accountability towards client and self with respect to medication error occurrences
- Be encouraged to create a culture of support for nurses
- Educate nursing students in error prevention strategies

BACKGROUND



- Safety of patients continues to be concern for nurse leaders & organizational leaders.
- IOM first recognized this in the year 2000 & released a report ***'To err is human, building a safer healthcare system'*** which called attention to medication errors (MEs) being the leading, most common & predictable cause of adverse events in healthcare facilities.
- Other research studies reported administration errors (AdEs) to be the highest, most common identifiable errors among all medication errors.

SIGNIFICANCE

RESEARCH SUGGESTS:

- MEs occur frequently in hospitals, may prove to be fatal & very costly.
- AdEs account for 59% of all MEs.
- Most adverse drug events (ADE**s**) are a direct result of medication errors.
- Healthcare Cost
  - 2% clients experience ADE**s (**$2 billion/yr)
  - 2.43% clients experience complications due to ADE**s, >**LOS & cost by $2,262.
- Indirectly loss of productivity, disability & other care related costs.
- Undetected MEs due to underreporting lead to inaccurate documentation.

PURPOSE

- To examine the lived experience of the nurses involved in making one or more medication errors that reached the patient and may have resulted in negative patient outcomes.
- To understand how nurses coped with the aftermath, and the support these nurses may need after the occurrence.

RESEARCH

- ‘What is the lived experience of nurses involved in medication errors?’
- ‘What is the lived experience of these nurses caring for patients after the medication error occurred?’
- ‘What is the lived experience of these nurses working on the unit after the medication error occurred?’

LITERATURE

CINAHL & MEDLINE databases (2000-2013)

- Contributing factors
- Nurses' perceptions
- Safety systems
- Prevalence of errors among nursing students
- Reporting of medication errors by nurses
- Patient safety culture/just culture

LITERATURE

What constitutes a medication error?

"A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use"

(The National Coordinating Council for Medication Error Reporting and Prevention in 1997).

LITERATURE

- Omission*
- Unauthorized drug*
- Wrong dose*
- Wrong route*
- Wrong rate
- Wrong form
- Wrong time
- Wrong preparation
- Incorrect technique

(ASHP, 1982)

- Failure to follow protocol (Scholz, 1990)

METHODOLOGY

- **Design:**
  - Qualitative descriptive phenomenological approach guided by Husserl (1965).
- **Method:**
  - Seven-step methodological guidelines by Colaizzi (1978).
- **Setting/sample:**
  - Eight Registered Nurses (NYS license)
- **Instrument/field notes:**
  - Qualitative interviewing-researcher & field notes

PARTICIPANT DEMOGRAPHICS

Participant	Gender	Age (yrs.)	Experience (yrs.)	Education	Unit worked on Nurse: patient ratio	Shift/Time of day Length/Status
P1	Female	43	10	BSN	Medical-Surgical (NH) / 1:40	Day/8 hr/FT, Float
P2	Female	39	3	BSN	Neuro ICU/ 1:2	Night/12 hr/FT
P3	Female	39	3	BSN	ER/1:12 or 3;24	Night/12 hr/FT
P4	Female	47	12	BSN, MS	Medical-Surgical (NH) / 1:38	Day/8 hr /Per Diem
P5	Female	55	22	BSN, MPH	Medical-Surgical (NH) / 1:20	Day/Night/8 hr FT
P6	Female	36	9	BSN	Telemetry/1:8 (home care)	Day/12 hr/FT
P7	Female	43	12	BSN	Medical-Surgical /1:10	Night/12 hr/FT
P8	Male	51	10	ADN	Telemetry/1:6	Day/8 hr/FT

METHODOLOGY

- **Methodological Rigor**
  - Trustworthiness: participant engagement/thick descriptions/member checking/audit trail.
  - Bracketing & phenomenological reduction.
- **Ethical considerations**
  - Adelphi University IRB approval obtained.
  - Confidentiality & right to withdraw from study.
  - Anonymity & methods to eliminate coercion.
  - Informed consent, permission to tape record interviews was obtained.

DATA COLLECTION

- Two in depth face-face interviews conducted with each participant.
  - 1st Open ended, 2nd Focused, Duration 50-60 mins,1 week apart.
- Total 16 interviews, conducted in a private area of participant's choice.
- The researcher traveled distances to reach the agreed venue.
- Data collection was completed over a period of about three months.
- Recorded interviews were transcribed verbatim in about two months.

DATA COLLECTION

Interview Protocol I

- Describe the incident when you were involved in a medication error.
- Describe your feelings when you made the medication error.

Interview Protocol II

- What were the reactions of your colleagues/supervisor after the incident?
- How do you think this incident affected your practice?

DATA ANALYSIS

- Extraction of codes
  - Data coded/subjected to intense & thorough analysis.
  - Two hundred thirty formulated meanings (FM) obtained from significant statements.
  - Transcripts reviewed by a nurse researcher for validity of coding system
- Development of theme clusters & theme categories
  - FM were organized into 19 theme clusters under 5 theme categories

DATA ANALYSIS

Category and Description of Error	Error category
Unauthorized drug error * Wrong patient * Drug needed to be held * Patient was allergic to medication	SIX
Wrong route error * Drug administered to wrong area of body	ONE
Wrong dose error * Correct medication /incorrect dose	ONE
Omission error * Medication ordered was missed.	ONE
Wrong documentation error (New) * Medication documented on wrong patient.	ONE

DISCUSSION

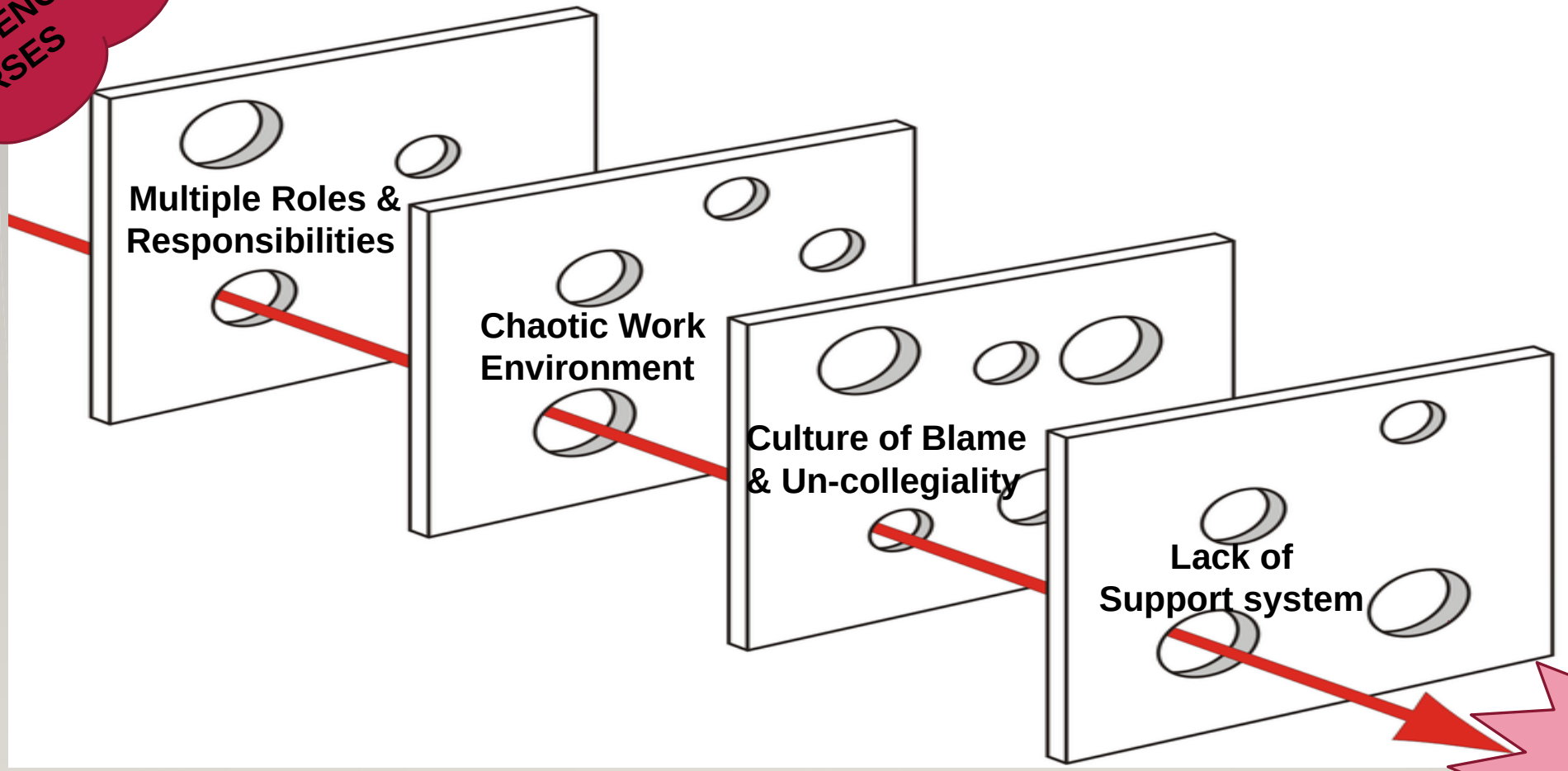
- Fear & Anxiety/Self Degradation
- Feelings of extreme emotional/physical/remorse & self-blame
- Being overwhelmed & coping/Being new & facing practice challenges
- Workplace complexity/constant struggle to complete tasks/balancing RN responsibilities/cope with care challenges/being new & inexperienced
- Workplace culture/Survival and moving on
- General atmosphere of censure/reproach encountered day to day/
- Great concern that interruptions not recognized as significant
- Safe care is not individual responsibility

DISCUSSION

- Communication & teamwork/Voicing concerns without fear
  - Concerns about not being part of discussions related to care issues
  - Lack of communication & teamwork created barriers for safe & effective care
- Governance & collegiality
  - Lack of nurses' input/involvement in patient care decisions resulted in most MEs
  - Concerns about unfair treatment by peers and senior nurses/leadership
- Professional security
  - Fear of losing ones job due to a culture of blame/underreporting of MEs

Nurses' Perception...?

NOVICE & INEXPERIENCED NURSES



STUDY LIMITATIONS

This study was conducted in the state of NY, USA

- Transferability of results globally may be questioned.
- Self-selected sample may be viewed as subject to bias.
- Researchers professional experience as a nurse of several years with multiple roles & responsibilities may be viewed as subject to bias.

RECOMMENDATIONS

NURSING PRACTICE & HEALTHCARE ORGANIZATIONS

- Adequate staffing based on acuity/diversity enabling teamwork for safe care
- Workplace culture to foster collegiality all members of the healthcare team
- Build a blame-free/stress-free culture in workplaces
- Empower nurses to voice concerns fearlessly and be change agents for improved patient outcomes
- Organizational/Nurse leaders to provide learning programs of high caliber & quality for nurses to enhance their management skills for safe & effective patient care

RECOMMENDATIONS

NURSING EDUCATION

Provide students with:

- Varied learning experiences via simulation/clinicals for easy transition to practice.
- Adequate supervision/post conferences/debriefing sessions via meaningful scenarios at simulation/clinicals of future beginner nurses in readiness for practice.
- More & frequent use of simulation of real life patient scenarios for enhancement of cognitive skills enabling critical thinking & clinical judgement to build confidence as they embark on their professional journey.

FUTURE RESEARCH

- Qualitative ME studies of nurses' lived experiences may be conducted in other US states, countries for a varied perspective of MEs in contemporary healthcare systems worldwide.
- Quantitative ME studies to compare & correlate MEs to staff nurse concerns related to patients and nurses.
- Studies to further investigate ME categories to better understand what really constitutes ME in the administration process & staff nurse involvement.
- Studies for in-depth investigation of errors from the perspective of nursing student concerns to understand challenges of transition into practice.


THANK YOU
ANY QUESTIONS?