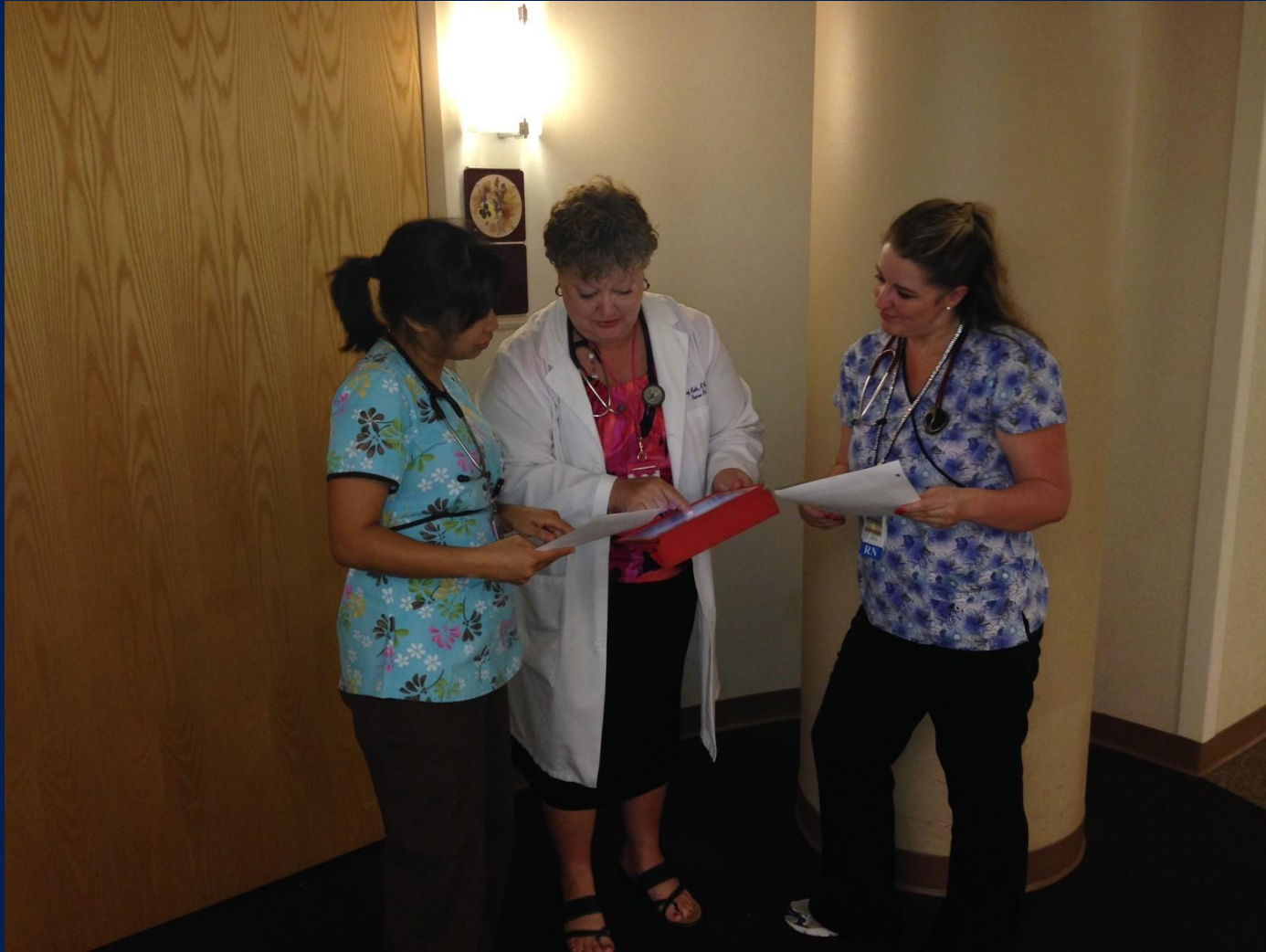


Why Do Nurses Make Errors? Everyone's Human!

Cheryl Roth, PhD, WHNP-BC, RNC-OB, RNFA

HONORHEALTH™



The Journey...

It all started with a YouTube video.



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WHY did that nurse /physician make that mistake?

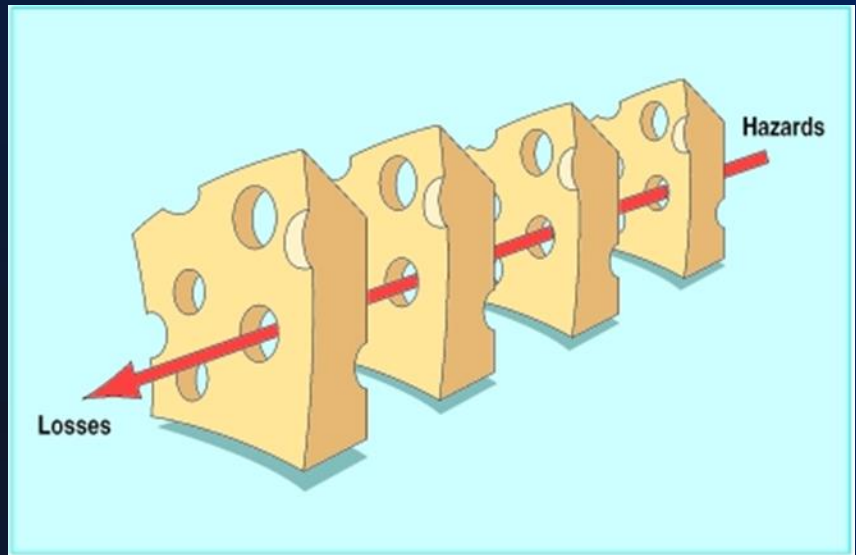
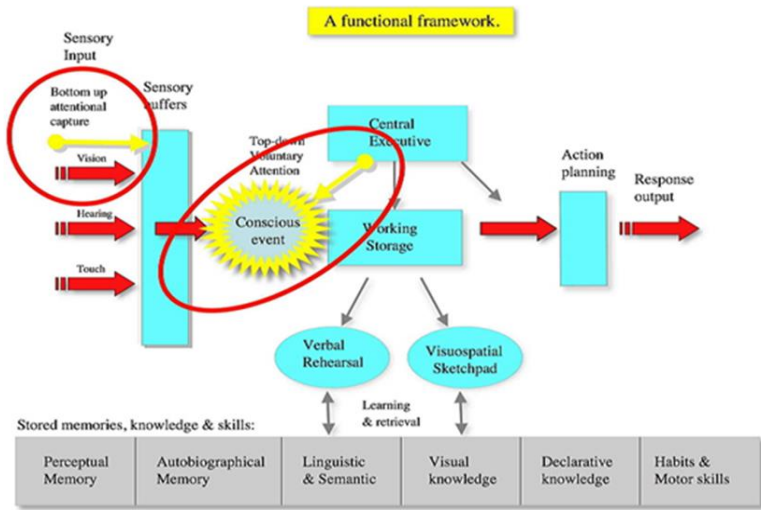
What are Human Factors?

- The International Ergonomics Association (as cited in Human Ergonomics Society, 2000) defines human factors (which is also termed ergonomics) as the “scientific discipline concerned with the understanding of interactions among humans and other elements of a system, and the profession that applies theory, principles, data, and other methods to design in order to optimize human well-being and overall system performance” (para. 5).
- What are the things we cannot control because we are human?
 - Fatigue
 - Environmental Issues
 - Miscommunication
 - Shock
 - Focus issues
 - Emotions
 - Time

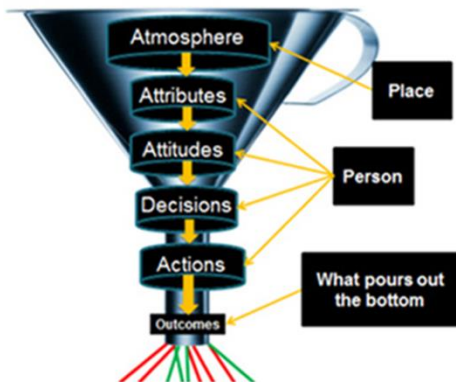
Human Factors Examples

Brain Games

Conceptual Framework



Human Factors Funnel Model



???

Delphi Surveys

- ❖ Delphi Survey with two iterations
- ❖ *Using Delphi Technique to Identify Human Factors Contributing to Nursing Errors*
 - ❖ What are the human factors that contribute to nursing errors?
- ❖ *Hospital Nurses' Perceptions of Human Factors Contributing to Nursing Errors*

MISCONCEPTIONS

When you are under pressure due to dwindling time or resources, your brain releases adrenaline and noradrenaline to pump you up to attend to the task at hand.

This is helpful in truly life-threatening circumstances but when it comes to a cognitive task, these chemicals cause your pre-frontal cortex, responsible for cognitive function, performance and emotion, to function less effectively.

Sample

- ❖ Hospital-Based Nursing Survey
 - ❖ 1808 Registered Nurses employed
 - ❖ Survey sent out from Quality Director through Managers and Directors
 - ❖ n=393

Instrument Survey 3

	How likely is this item to cause a nursing error?	How much ability does the nurse have to intervene is this item?	How important is this item to the chance of an error?	How common is this item in nursing errors?
Fatigue from lack of sleep	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10
Fatigue from too many hours worked	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10
Swamping too heavy work load	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10
Work too fast paced	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10
Non-clinical demands	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10
Lack of nursing competency or knowledge	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10	1-2-3-4-5-6-7-8-9-10

Top Five Likely, Intervenable, Important, and Common Reasons

• Likely

1. Nurse impaired by substance
2. **Swamping**
3. Problem with communication
4. Lack of Critical Thinking
5. **Errors made by others that nurses are expected to fix**

• Intervenable

1. Nurse impaired by a substance
2. Nurse acting outside the scope of practice
3. **Problem with communication**
4. Problem with teamwork
5. **Errors made by others that nurses are expected to fix**

• Important

1. **Swamping**
2. Nurse impaired by substance
3. **Errors made by others that nurses are expected to fix**
4. Problem with communication
5. Lack of critical thinking

• Common

1. **Swamping**
2. Work is too fast-paced
3. **Problem with communication**
4. Fatigue from too many hours worked
5. **Errors made by others that nurses are expected to fix**

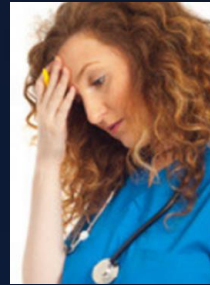
Swamping



This patient is complaining of tightness in the chest



This patient needs pain meds now



This patient is waiting on you for discharge



The bed alarm is going off on this patient

Attentional Divot

Why did I walk in this room?



Recommendations

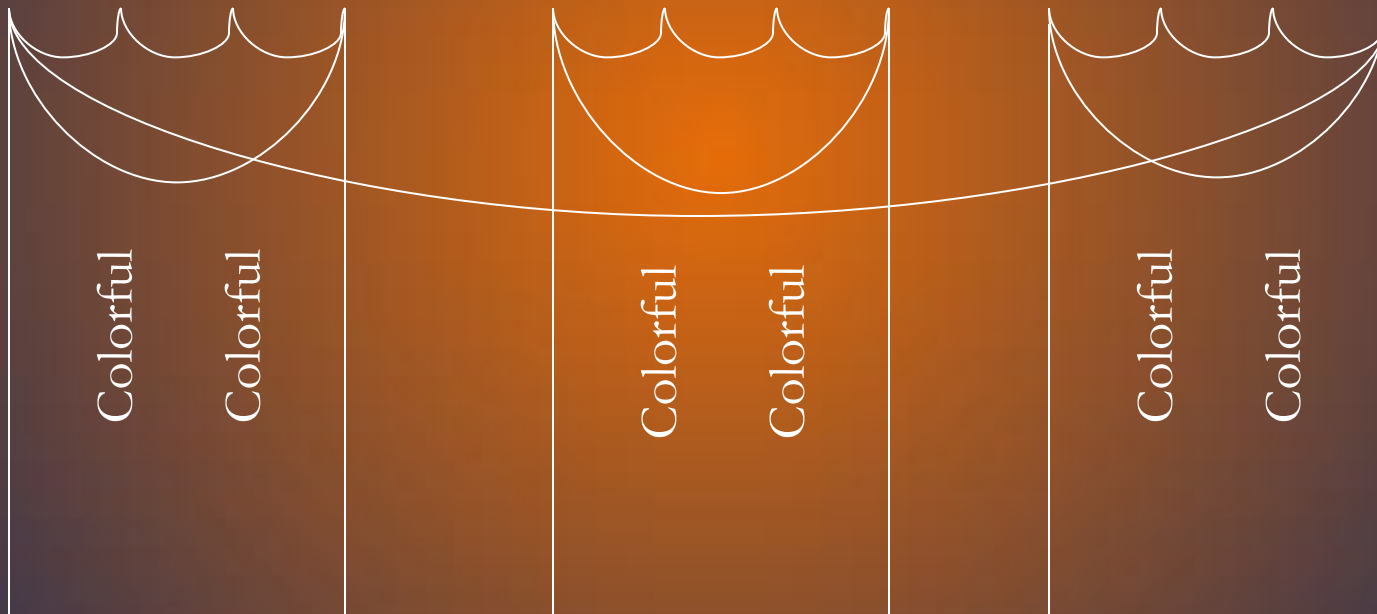
- ❖ Education for nurses on signs of substance impairment
- ❖ Focused education for nurses on the impact of fatigue and swamping
- ❖ New tools to identify swamping and work that is too fast-paced and methods to intervene
- ❖ Research expanding on the identified factors and themes: swamping, attentional divot, inattention blindness

Recommendations

- ❖ New technology to facilitate communication
- ❖ All team members held accountable for errors by others that nurses are expected to recognize and fix
- ❖ Development of nursing model that identifies common reasons for loss of focus
- ❖ Work with nurses to develop a healthy work environment

The Von Restorff Effect

3 Hour Module



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References

- American Nurse Credentialing Center (ANCC). (2013). *Forces of Magnetism*. American Nurses Association. Retrieved from <http://www.nursecredentialing.org/Magnet/ProgramOverview/HistoryoftheMagnetProgram/ForcesofMagnetism>
- Anthony, K., Wienczek, C., Bauer, C., Daly, B., & Anthony, M. K. (2010). No interruptions please: impact of a no interruption zone on medication safety in intensive care units. *Critical Care Nurse, 30*(3), 21-29. doi:10.4037/ccn2010473
- Arndt, M. (1994). Nurses' medication errors. *Journal of Advanced Nursing, 19*(3), 519-526.
- Baars, B. J. (1988). *A cognitive theory of consciousness*. New York, NY: Cambridge Univ. Press.
- Baron, R. (2011). *The human factors funnel model (HFFM): Another window on error causation*. Unpublished manuscript. The Aviation Consulting Group. Retrieved from <http://www.universalweather.com/blog/2012/12/the-human-factors-funnel-model-another-window-on-error-causation/#ixzz2gCtRkky2>
- Bellebaum, K. L. (2008). *The relationship between nurses' work hours, fatigue, and occurrence of medication administration errors*. Ohio State University, Dissertation.
- Bennett, J., Dawoud, D., & Maben, J. (2010). Effects of interruptions to nurses during medication administration. *Nursing Management - UK, 16*(9), 22-23
- Biron, A. D., Loiselle, C. G., & Lavoie-Tremblay, M. (2009). Work interruptions and their contribution to medication administration errors: An evidence review. *Worldviews on Evidence-Based Nursing, 6*(2), 70-86. doi:10.1111/j.1741-6787.2009.00151.x
- Brady, A.M., Malone, A.M., & Fleming, S. (2009). A literature review of the individual and systems factors that contribute to medication errors in nursing practice. *Journal of Nursing Management, 17*(16), 679-697. doi: 10.1111/j.1365-2834.2009.00995.x
- Brake, E.J. & Bates, G.P. (2001). Fatigue in industrial workers under thermal stress on extended shift lengths. *Occupational Medicine, 51*(7), 456-463. Retrieved from <http://ocmed.oxfordjournals.org/content/51/7/456.full.pdf>
- Brous, E. (2008). The criminalization of unintentional error: Implications for TAANA. *Journal of Nursing Law, 12*(1), 5-12.
- Bureau of Health Professions. (2013). *The U.S. nursing workforce: Trends in Supply and Education*. Washington DC: Health Resources and Services Administration. Accessed at <http://bhpr.hrsa.gov/healthworkforce/reports/nursingworkforce/nursingworkforcefullreport.pdf>
- Carlton, G. (2007). Nurses' perceptions of factors leading to the discovery of potential medication administration errors. *University of Colorado Health Sciences Center*.
- Chiggs, E., Wills, C., E., Tanda, R., Patterson, E., S., Elfrink, V., Brodник, M., . . . Ryan-Wenger, N. (2011). Registered nurses' judgments of the classification and risk level of patient care errors. *Journal of Nursing Care Quality, 26*(4), 302-310. doi: 10.1097/NCQ.0b013e31820f4c57
- Coli, R., P., dos Anjos, M., & Pereira, L. L. (2010). The attitudes of nurses from an intensive care unit in the face of errors: An approach in light of bioethics [Portuguese]. *Revista Latino-Americana De Enfermagem, 18*(3), 324-330. doi: S0104-11692010000300005
- Common. (2014) In *Merriam-Webster's online dictionary*. Retrieved from <http://www.merriam-webster.com/dictionary/common>

References

- Conrad, C., Fields, W., McNamara, T., Cone, M., & Atkins, P. (2010). Medication room madness: Calming the chaos. *Journal of Nursing Care Quality, 25*(2), 137-144. doi:10.1097/NCQ.0b013e3181c3695d
- Crawford, W. (2004). Losing What Counts: The Swamping Phenomenon. *Econtent, 27*(6), 42-43. Frame, K. (2004). Intervention, intervene, interfere... what are we doing? *Nursing Forum, 39*(1), 23-27. doi:10.1111/j.0029-6473.2004.00023.x
- Elbardissi, A. W., & Sundt, T. M. (2012). Human factors and operating room safety. *Surgical Clinics of North America, 92*(1), 21-35.
- Elganzouri, E. S., Standish, C. A., & Androwich, I. (2009). Medication administration time study (MATS): Nursing staff performance of medication administration. *Journal of Nursing Administration, 39*(5), 204-210. doi:10.1097/NNA.0b013e3181a23d6d
- Fry, M. M., & Dacey, C. (2007). Factors contributing to incidents in medicine administration. Part 2. *British Journal of Nursing, 16*(11), 676-681.
- Gary, J., C. (2013). Exploring the concept and use of positive deviance in nursing. *American Journal of Nursing, 113*(8), 26-35. doi:10.1097/01.NAJ.0000432960.95762.5f
- Gibson, T. (2001). Nurses and medication error: A discursive reading of the literature. *Nursing Inquiry, 8*(2), 108-117. doi:10.1046/j.1440-1800.2001.00098.x
- Hartnell, N., MacKinnon, N., Sketris, I., & Fleming, M. (2012). Identifying, understanding and overcoming barriers to medication error reporting in hospitals: A focus group study. *British Medical Journal of Quality & Safety, 21*(5), 361-368.
- Henneman, E. A., Gawlinski, A., Blank, F. S., Henneman, P. L., Jordan, D., & McKenzie, J. B. (2010). Strategies used by critical care nurses to identify, interrupt, and correct medical errors. *American Journal of Critical Care, 19*(6), 500-509. doi: 10.4037/ajcc2010167
- Hicks, R. W., Sikirica, V., Nelson, W., Schein, J. R., & Cousins, D. D. (2008). Medication errors involving patient-controlled analgesia. *American Journal of Health-System Pharmacy, 65*(5), 429-440. doi:10.2146/ajhp070194
- Holden, R., J., Scanlon, M., C., Patel, N., R., Kaushal, R., Escoto, K., Hamilton, Brown, R., L., . . . Karsh, B. (2011). A human factors framework and study of the effect of nursing workload on patient safety and employee quality of working life. *British Medical Journal of Quality & Safety, 20*(1), 15-24. doi: 10.1136/bmjqs.2008.028381
- Hopkinson, S. G., & Mowinski-Jennings, B. M. (2013). Interruptions during nurses' work: A state-of-the-science review. *Research in Nursing & Health, 36*(1), 38-53. doi:10.1002/nur.21515
- Hughes, R. G., & Blegen, M. A. (2008). Medication administration safety. In R. G. Hughes (Ed.), *Patient Safety and Quality: An Evidence-Based Handbook for Nurses* (Chapter 37). Rockville, MD: Agency for Healthcare Research and Quality (US). <http://www.ncbi.nlm.nih.gov/books/NBK2656/>
- Important. (2013). In *Merriam-Webster*. Retrieved from <http://www.merriam-webster.com/dictionary/important>
- Institute of Medicine. (2006). *Preventing Medication Errors*. Retrieved from <http://www.iom.edu/~media/Files/Report%20Files/2006/Preventing-Medication-Errors-Quality-Chasm-Series/medicationerrorsnew.ashx>
- Institute for Safe Medication Practices (ISMP). (2009). *Inattentive blindness: What captures your attention?* Retrieved from <http://www.ismp.org/newsletters/acutecare/articles/20090226.asp>

References

- Institute of Medicine (IOM), (2006). Report Brief: Preventing Medication Errors. Retrieved from <http://www.iom.edu/~media/Files/Report%20Files/2006/Preventing-Medication-Errors-Quality-Chasm-Series/medicationerrorsnew.ashx>
- International Ergonomics Association (2000). Definition of ergonomics. *What is Ergonomics?* Retrieved from <http://www.iea.cc/whats/index.html>
- Johnson, M., Tran, D., Thuy, & Young, H. (2011). Developing risk management behaviours for nurses through medication incident analysis. *International Journal of Nursing Practice*, 17(6), 548-555. doi: 10.1111/j.1440-172X.2011.01977.x
- King, C. (2010). Patient safety first. To err is human, to drift is normalization of deviance. *Association of PeriOperative Room Nursing Journal*, 91(2), 284-286. doi:10.1016/j.aorn.2009.10.020
- Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (2000). *To err is human: Building a safer health system*. Washington, D.C.: Institute of Medicine.
- Leape, L. L., Bates, D. W., Cullen, D. J., Cooper, J., Demonaco, H. J., Gollivan, T., & Hallisey, R. (1995). Systems analysis of adverse drug events. ADE prevention study group. *Journal of the American Medical Association*, 274(1):35-43.
- Likelihood. (2014). In *Dictionary.com*. Retrieved from <http://www.dictionary.reference.com/likelihood>
- Lum, T., Fairbanks, R., Pennington, E., & Zwemer, F. (2005). Profiles in patient safety: Misplaced femoral line guidewire and multiple failures to detect the foreign body on chest radiography. *Academic Emergency Medicine*, 12, 258-262.
- Niu, S. F., Chu, H., Chen, C. H., Chung, M. H., Chang, Y. S., Liao, Y. M., & Chou, K. R. (2012). A comparison of the effects of fixed- and rotating-shift schedules on nursing staff attention levels A randomized trial. *Biological Research for Nursing*, 5. doi: 10.1177/1099800412445907
- Pagano-Therrien, J. (2013). Exploring research fatigue in HIV-infected youth. *Journal of the Association of Nurses in AIDS Care*, 24(1), 11-16.
- Palese, A., Sartor, A., Costaperaria, G., & Bresadola, V. (2009). Interruptions during nurses' drug rounds in surgical wards: Observational study. *Journal of Nursing Management*, 17(2), 185-192. doi:10.1111/j.1365-2834.2007.00835.x
- Parker, S. H., Schnell, J., & White, A. (2009). Smart management. basics of human factors and patient safety. *Operating Room Nurse*, 3(3), 6.
- Pennathur, P., R., Thompson, D., H., Martinez, E., A., Pronovost, P., J., Kim, G., R., . . . Gurses, A., P. (2013). Technologies in the wild (TiW): Human factors implications for patient safety in the cardiovascular operating room. *Ergonomics*, 56(2), 205-219. doi:10.1080/00140139.2012.757655

References

Qualtrics [Computer software]. Provo, UT: Qualtrics Company.

Raymond, J.E., Shapiro, K.L., & Arnell, K.M. (1992). Temporary suppression of visual processing in an RSVP task: an attentional blink? *Journal of Experimental Psychology, Human Perception and Performance* 18(3): 849–60.

Reason, J. (2000). Human error: Models and management. *British Medical Journal*, 320(7237), 768-770.

Rock, I., Linnett, C. M., Grant, P., & Mack, A. (1992). Perception without attention: Results of a new method. *Cognitive Psychology*, 24(4), 502-534.

Rogerson, W., J., & Tremethick, M. J. (2004). Turning the tide on medical errors in intensive care units: A human factors approach. *Dimensions of Critical Care Nursing*, 23(4), 169-175.

Santos, J. O., Silva, A., Munari, D. B., & Miasso, A. I. (2010). Conducts adopted by nursing technicians after the occurrence of medication errors [Portuguese]. *Acta Paulista De Enfermagem*, 23(3), 328-333.

Simpson, K. R., & Knox, G. E. (2003). Adverse perinatal outcomes: Recognizing, understanding & preventing common accidents. *AWHONN Lifelines*, 7(3), [224.

Soares, M. M., Jacobs, K., Gurses, A. P., Martinez, E. A., Bauer, L., Kim, G., & ... Thompson, D. (2012). Using human factors engineering to improve patient safety in the cardiovascular operating room. *Work*, 4:1801-1804.

The Joint Commission. (2013). *Facts About the National Patient Safety Goals*. Retrieved from http://www.jointcommission.org/standards_information/npsgs.aspx

The Joint Commission. (2012). Section III: Standards relating to sentinel events. *2013 Comprehensive Accreditation Manual for Hospitals*. Oakbrook Terrace, IL; The Joint Commission.

Unver, V., Tastan, S., & Akbayrak, N. (2012). Medication errors: Perspectives of newly graduated and experienced nurses. *International Journal of Nursing Practice*, 18(4), 317-324. doi:10.1111/j.1440-172X.2012.02052.x

Wadsworth, E.J.K., Allen, P.H., Wellens, B.T., McNamara, R.M., & Smith, A.P. (2006). Patterns of fatigue among seafarers during a tour of duty. *American Journal of Industrial Medicine*, 49: 836 – 844.

Westbrook, J. I., Woods, A., Rob, M. I., Dunsmuir, W. M., & Day, R. O. (2010). Association of interruptions with an increased risk and severity of medication administration errors. *Archives of Internal Medicine*, 170(8), 683-690. doi:10.1001/archinternmed.2010.65