Avoid Blame

Coronavirus disease 2019 (COVID-19) has taken a significant toll on healthcare professionals around the world. Stretched to their limits, nurses are working long hours with heavy patient loads and are often reassigned to areas outside of their clinical expertise. Under these circumstances, mistakes are bound to happen, and it's natural to ascribe blame. However, due to a shortage of time and a fear of chastisement, very few errors related to COVID-19 patients have been reported. There are several factors that contribute to medication mistakes in the critical care setting:

- Disorganization and frenzied pace
- Under-staffing
- High patient-to-nurse ratios
- Burden of continuous donning of Personal Protective Equipment (PPE)
- Stockpiling medication infusions in isolation rooms
- Multiple concentrations of drugs made available for fluid-restricted patients
- Difficulty in responding to smart pump alarms
- Requiring any available nurse to manage critical infusions resulting in programming errors, titration errors and mix-ups

One example of a serious medication error involves fentanyl infusions. The typical dilution is 10 mcg/mL however it can be concentrated to 50 mcg/mL for fluid-restricted patients. Errors have occurred when the wrong fentanyl infusion bag was left in a drawer or closet in a patient's isolation room, when the wrong concentration was selected during smart pump programming, or when the infusion was programmed in mg/hour instead of mcg/kg/hour. Another fatal error occurred when a nurse thought she was titrating a norepinephrine infusion to treat her patient's hypotension but instead was titrating a fentanyl infusion. The fentanyl had been administered through a smart pump programmed for norepinephrine, and the norepinephrine was infusing via a smart pump programmed for fentanyl.

When mistakes happen, staff talk about the event and who may have been involved since many different nurses enter a patient's room to respond to an alarm, hang an infusion or reprogram a smart pump. Administrators may blame their staff causing nurses to feel targeted, isolated, frustrated and fear of being fired. Nurses do not feel supported and are concerned about the frequency of medication errors. Nurses in turn blame managers for their inability to prevent medication errors. It is important that all healthcare providers strive to avoid blaming others when medication errors occur.

Recommendations include:

- **Identify errors and establish a safe and easy way for clinicians to report errors**
  - Leaders and managers should establish trust with staff.
  - Reporting system must be confidential, clear, uncomplicated, effective, and streamlined.
  - Informal reporting pathways are designed to foster communication and feedback (i.e. daily "safety huddles").
- **Prevent errors**

Reference

1. Institute for Safe Medication Practices. (2020). *Nurse Advise-ERR.* Retrieved from Institute for Safe Medication Practices: https://www.ismp.org/nursing/medication-safety-alert-september-2020

- Standardize to a single concentration of intravenous (IV) high-alert medication infusions when possible.
- Standardize the dose-rate (mcg/kg/hour versus mg/hour) for specific IV infusions and make these standard dose-rates the only available choices in smart pump drug libraries.
- Require the use of standardized order sets that use standardized dose-rates.
- Utilize premixed solutions that look different from others when possible.
- Attach bold auxiliary labels to critical care infusions when dispensing a nonstandard. concentration or a neuromuscular blocking agent (i.e. Warning: Paralyzing Agent, Patient Must Be Ventilated).
- Label all IV lines between the pump and container, and near the access to the patient's body; be sure to always trace the line from the source container to the smart pump, to the patient prior to hanging a new container or programming a pump.
- Institute independent double checks before administration of critical care infusions.
- Conduct "safety huddles" with providers, pharmacists, and nurses.
- If feasible, schedule a "resource" nurse in the ICU with a light patient assignment to increase the nurse-to-patient ratio and help with other clinical activities.
- Implement bedside barcode scanning in the ICU and create a procedure to use in isolation rooms.
- Monitor compliance with use of the smart pump drug library.
- Create interoperability between smart pumps and the electronic health record (EHR).
- If feasible, place smart pumps in hallways to allow for timely management of pump alarms, infusion bag changes, and prevent stockpiles of medications in COVID-19 patient rooms.

- **Avoid blame:** There has been a great deal of "finger-pointing" during the pandemic
  - Blaming and shaming do not help to decrease errors.
  - Leaders should set an example and support their staff through:
    - Effective listening and communicating
    - Fostering collective decision-making
    - Demonstrating trust, respect, and appreciation
    - Disapproving shame and blame

Reference

1. Institute for Safe Medication Practices. (2020). *Nurse Advise-ERR.* Retrieved from Institute for Safe Medication Practices: https://www.ismp.org/nursing/medication-safety-alert-september-2020