



Preventing Medical Errors

for Certified Nursing Assistants

Developed by

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In-service Self-Study Packet & Test

Meets the Preventing Medical Errors 2.0 In-service Hour required by the Florida Department of Health/Board of Nursing for Certified Nursing Assistants



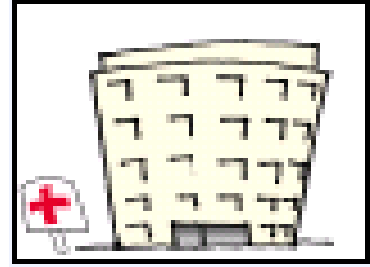
Baptist Health

Preventing Medical Errors

Objectives

At the end of this self study, you will be able to:

1. Name some of the common medical errors and why they occur.
2. List the kinds of patients that are at risk for medical errors.
3. Describe ways that you can prevent mistakes and errors.
4. Discuss what you can do to prevent patient identification errors.



Introduction

It is a known fact that we make a lot of errors and mistakes every day as we take care of patients. No health care worker wants to make a mistake, but they still do happen a lot. No one is happy when they do something wrong or when they forget to do something that they should have done. The worst part of errors, however, is not how they make us or other people feel. The patients, the people that we take care of can be very seriously hurt and harmed with an error. Our errors can even cause a person to die.

Some of our mistakes are made because we do not do the right thing. These mistakes are called *omissions*. An example is when a nursing assistant forgets to measure urine for a patient's I&O at the end of their work day. Other mistakes are made because someone does the wrong thing. These mistakes are called errors of *commission*. An example of this is when the nursing assistant takes the wrong patient to the operating room for surgery.

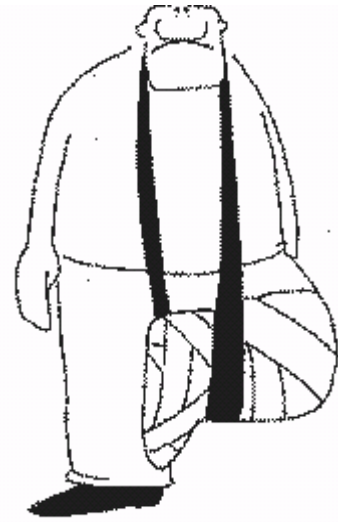
In 1999, The National Institute of Medicine reported that medical errors kill 98,000 people a year in hospitals. Healthcare is at high risk for errors; fortunately, there are many things that all of us can do to stop them from happening. This self-study will help you to avoid them and it will also help you to work with your hospital to find ways that you can keep your patients safe and free from harm.

Patient Safety: How Mistakes Happen

Some people may think that patient injury or mistakes happen because of some "technical" aspect of care. The reality is that they occur due to human error – communication is a key element of patient safety.

Many mistakes can happen when you are:

- Tired and fatigued.
- Faced with a new situation or problem.
- Have equipment or materials that are mislabeled.
- In poor working conditions.
- Distracted, interrupted, and not paying attention.
- Under a lot of stress, or in a hurry.
- So familiar with an environment that you can't even see what's unsafe.
- Have to work with poorly designed equipment.



High Risk Areas for Mistakes

Broken and Faulty Medical Equipment

Do NOT use any patient care equipment that is broken or not working correctly. Report all broken and faulty equipment to the supervisor. Get taught how to use a piece of equipment before you use it. If you are not sure how to use a piece of equipment, tell the nurse in charge. Do NOT use something unless you are sure you know how to use it correctly.

Patients Prone to Falls

Falls kill and injure many patients every year. Frequently observe and monitor your patients who are at high risk for falls. Report and communicate unsafe behaviors to your supervisor. *Restraints:* You must constantly observe patients who are restrained to protect their own safety and the safety of others. Be sure that you are competent and able to apply restraints if you are asked to do so. If you need help or more training, report this need to the nurse.

Confused and Disoriented Patients

Some patients and residents are at risk for harm and injury because they are confused. They may wander off to unsafe places and even leave the hospital or nursing home (elopement). Respond immediately to calls for help, bed alarms and exit door alarms.

Patients at Risk for Suicide

Many patients commit suicide in our hospitals. If you are asked to monitor a patient at risk for suicide, do NOT take your eyes off them. Follow the instructions of the nurse and never leave the person unattended.

What You Can Do To Help Your Patients

Taken from the school.discovery.com Website

Listen to Patients and Families

We are sometimes overly sure and confident of knowing our jobs and what we are doing. Never be too sure; always double check. If a patient questions what you are doing, (or not doing!), look into it. Never just ignore patients and families because you think they don't know what they're talking about.

Work In A Safe Place: Stay Away From Distractions & Noise

It is important to pay attention to what you are doing and nothing else when you are providing care to your patients. Try to see and hear nothing other than your patient. Noise, interruptions, distractions, and poor lighting can make people make mistakes. Some mistakes happen because we:



- ❑ Treat everyone the same. We are sometimes used to doing the same things for all of our patients all of the time without thinking carefully. For example, a nursing assistant who works on a maternity unit usually gives cake or cookies to the patients for their evening snack. When the nursing assistant gives cookies to a diabetic patient on the unit because they were not paying attention to the diabetic patient and the fact that they can not have regular cookies or cake, a mistake has been made. This kind of mistake would probably not occur as often on a unit with older patients where many of them have diabetes. Another example is when a nursing assistant gives a person their usual breakfast without checking to see that they are NPO that morning for lab work.
- ❑ Have a new situation. A nursing assistant who forgets to give an enema to a patient the night before surgery may have not done the right thing because it was a new order. Because it was a new, one-time order and something that is done only occasionally on the unit, it may have been overlooked.

Get Enough Rest and Manage Your Time

You can protect your patients by getting enough rest. Try to get at least 8 hours of sleep a night. This is sometimes a hard thing to do, especially when you have many things to do at work and at home. Try to manage your time in a better way so that you can get enough rest and sleep.

Take Your Time: Do Not Skip Important Rules Like Patient Identification

We may forget to do something new for our patient. For example, a nursing assistant who gives an enema to the wrong patient has not double-checked to make sure she had the right patient.

Here are some ways that you can properly identify your patients:

- ❑ Patients must always have a secure identification (ID) band on. Do NOT provide any care to any person unless their ID band is on.
- ❑ Refer to this patient identification band before you do anything for the patient. Check and double-check the first and last names.
- ❑ Ask the patient to state their name before you do anything. This double check will work for most patients. It will not, however, help identification if the person is confused or sleepy. It will also not help with young children, infants and those with a severe psychiatric illness.
- ❑ Asking a patient, "Is your name Mr. Smith?" can sometimes help with those unable to speak. However, those poor hearing may very well shake their head "yes" without ever having heard what you have asked.
- ❑ Check all treatment records against the patient's identification band.
- ❑ Educate the patient. Tell them what you are doing before you do it. If the patient questions what you are doing, STOP! Re-check the orders so that you are certain that you have identified the correct patient.
- ❑ Know your patients and their needs. If a treatment or other intervention does not make sense or does not seem to be the right thing for the patient, double-check the order and the identity of the patient.
- ❑ Do not call patients by room number or diagnosis. Do NOT refer to patients as the "CVA in room 234".
- ❑ Do not rely on room or bed numbers. For any number of reasons, including confusion and dementia, a patient can go from one room to another or from one bed to another. Do NOT use room numbers or bed numbers to identify your patients.
- ❑ Carefully check the patient's first and last names against the order. Be very careful when two or more patients have the same or like last or first names. For example, when Alex Smith and Alan Smith are in the same unit of the hospital, the wrong Mr. Smith may go to the operating room!
- ❑ Label all specimens and patient care equipment or supplies, such as bedpans and urinals, with the patient name while referring to the patient's ID band.
- ❑ Avoid distractions and interruptions during the course of patient care.
- ❑ Be a part of the solution. If you think that there are problems in your hospital or nursing home regarding poor procedures, tell the nurse.

Basic Rules to Prevent Mistakes

Be competent.

- ❑ Do NOT do anything when you are not sure how to do it. Get the training you need to do things right. Tell the nurse if you do not know how to do something that you have been asked to do.

Communicate with your supervisor and other members of the healthcare team.

- ❑ Communication, including documentation, helps to prevent mistakes.

Report, report and report.

- ❑ Report everything that seems unusual. Report all changes in the patient or resident. Report things that do not seem right. Report all dangers. Report all safety problems. Report all mistakes and near misses.

Respond to your patients and residents.

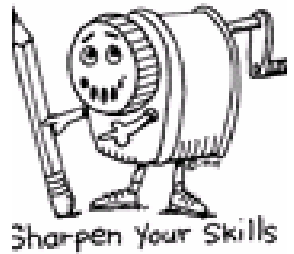
- ❑ Listen and respond to your patients and residents. If they question a treatment, stop and check the order. Immediately respond to all alarms and calls for help.

Identify your patients and residents.

- ❑ Accurate identification is critical to patient safety. Do NOT skip this important part of patient care.

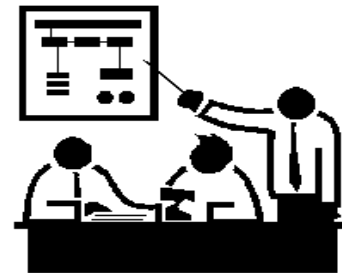
Pay attention to what you are doing.

- ❑ Do NOT get distracted. Pay attention to what you are doing.



Reporting Errors: The Road to Preventing Other Mistakes

One of the best ways to protect our patients and maintain their safety is to report all errors that are made. You can prevent future errors when you immediately report errors. Reporting gives us a chance to look at things that led to the mistake. It also gives us a chance to fix the things that are not good. You should report actual errors and also when you almost made an error. Reporting should never be used to blame the person or to punish the person for making a mistake. Reporting errors and near misses helps us to make things better. The goal of reporting is to help us all find ways to prevent future mistakes. It is up to the entire team to make a safe and error free place to care for our patient.



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