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# Medical Errors: A Nurses Role

Nurses have a genuine impact on patient safety. Studies have found a link between patient safety and RN staffing and an increase rate of error when the hospital nursing staff with a smaller proportion of RNs (Ramsey 2005). Other studies have shown that increasing the nurse to patient ratio by 1 can significantly impact the 30-day mortality in surgical patients (Aiken et al. 2002). Errors have also been linked to long work hours for nurses. In 2003 the Institute of Medicine (IOM) claimed that nurses' long working hours posed one of the most serious threats to patient safety, as fatigue slows reaction time, saps energy and diminishes attention to detail (IOM report "Keeping Patients Safe: Transforming the Work Environment for Nurses").

While the provision of care involves multidisciplinary teams, there are clear examples where error is clearly associated with nurses. Medication errors are one example where more often than not directly involve a nurse interacting with the patient. These errors have been studied by many researchers and generally are preventable errors such as inappropriate dosage, errors of omission, the wrong medication, or the wrong route of administration. Such errors are felt to stem from a confluence of factors including environmental distractions, miscommunications, drug labelling errors, and deviations from policy and procedures.

The relationship between quality nursing care and patient outcomes has been recognised. On the list of Hospital Acquired Conditions (HAC) are several that nursing has a direct impact on, including the development of pressure ulcers; hospital acquired injuries including fractures related to falls; and catheter associated urinary tract infections. Nurse staff-to-patient ratios and staffing mix does have a potential to impact these complications directly. In an American Nurses Association (ANA) study, five adverse outcome measures including hospital-acquired pneumonia, postoperative infections and decubiti (pressure ulcers), significantly decreased with higher levels of RN involvement in the care.

It is clear that there is a need to enhance patient safety through improving nursing care. There is a need for a firm and shared commitment on the part of the multidisciplinary team. Working side by side to care for the critically ill and injured, critical care staff understand that teamwork is necessary to prevent error and harm. To this end, the adoption of protocols and checklists has become a part of the work in many critical care units. Standardisation of care to reduce the reliance on human memory is an important characteristic of a well functioning critical care team. The use of checklists for insertion of a central line is a key example to the role of the nurse in preventing harm. The nurse gets to "call a time out" if the checklist is not followed by the physician inserting the line. The procedure will stop until all safety aspects are followed. This is a powerful way to protect the patients from a central line infection.

Daily rounding by the team and incorporation of nurses, therapists and the medical staff on the team with daily goal setting can facilitate patient care and help to move the patient out of the critical care unit in a more timely way. The team not only plans the care for the day but monitors through the bedside nurse that the goals have been achieved.

#### Conclusion

The environments in which nurses work are complex systems that are prone to error. The team approach to care is important to error prevention. Recognition of the interdependence of the team members is key to optimising care – everyone brings something to the care team. This comes from the lesson learned from aviation where team training is required to foster trust and mutual commitment.

As errors are underreported in healthcare, it is important to encourage efforts that promote the recognition and reporting of errors. Creating the environment that is blame free but with accountability for care is the most important step to having staff report error. This is where the learning environment can be so helpful. It will also help to support the development of systems to prevent error.

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