

From the October 7, 2004
ISMP Medication Safety Alert!

Institute for Safe Medication Practices
1800 Byberry Road
Huntingdon Valley, PA 19006
215 947 7797
www.ismp.org

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At-risk behaviors

- At-risk behaviors are behaviors that key stakeholders sometimes engage in, knowing on some level that it could risk patient safety.
- Key stakeholders include healthcare providers, the pharmaceutical industry, medical device and technology vendors, insurers, and others who directly or indirectly influence patient care.
- Even the most educated and careful individuals will learn to master dangerous shortcuts and engage in at-risk behaviors because the rewards for risk taking are often more immediate and positive than the potential for patient harm, which is remote and very unlikely.
- These intentional and unsafe practice habits emerge because of system-based problems AND an organizational culture that is tolerant of at-risk behaviors.
- A culture tolerant of at-risk behaviors is evident when there are more positive rewards (e.g., time-saving, high regard of colleagues) than negative rewards (e.g., patient harm) for at-risk behaviors; and/or more negative rewards (e.g., regarded as a slow worker by colleagues) than positive rewards (e.g., high regard of colleagues) for the corresponding safe behavior.
- The most important step when at-risk behaviors are identified is NOT disciplinary measures, but to uncover the conditions under which they occur and any upside-down rewards that spur the behaviors.
- See the September 23, 2004, and the October 7, 2004, issues of the *ISMP Medication Safety Alert!* for additional information on at-risk behaviors, their causes, and how to reduce their occurrence.

Examples of at-risk behaviors for healthcare providers

I. Patient Information

- 1) Preparing more than one patient's medications/more than one medication at one time
- 2) Not checking patient identification using two identifiers (e.g., name, medical record number, birth date)
- 3) Using an estimated patient weight compared to an actual weight
- 4) Prescribing/dispensing/administering medications without checking patients' laboratory values and vital signs
- 5) Not checking a patient's allergies before prescribing/dispensing/administering medications
- 6) Not waking the patient for assessments/medications
- 7) Not viewing/checking the patient's complete medication profile (or medication administration record [MAR]) prior to prescribing/dispensing/administering medications

II. Drug Information

- 8) Prescribing/dispensing/administering medications without complete knowledge of the medication
- 9) Unnecessary use of manual calculations
- 10) Not taking the MAR to the patient's bedside when administering medications
- 11) Administering medications before pharmacy review of the medication order
- 12) Excessive prescribing of non-formulary medications/refusal of therapeutic substitution
- 13) Not questioning unusually large doses of medications
- 14) Writing incomplete discharge instructions
- 15) Failing to validate/reconcile the medications and doses that the patient states are taken at home

III. Communication

- 16) Rushed communication with next shift/covering colleague
- 17) Intimidation/not speaking up when there is a question or concern about a medication
- 18) Use of error-prone abbreviations/apothecary designations/dangerous dose designations
- 19) Unnecessary use of verbal orders
- 20) Not reading back verbal orders
- 21) Overuse of stat orders or stat process as a workaround for slow pharmacy service
- 22) Providing incomplete orders (e.g., lack of full drug name, route, strength, frequency)
- 23) Not questioning incomplete orders
- 24) Not communicating important patient information to the pharmacy (e.g., allergies, height, weight, chronic and acute diagnoses)
- 25) Documenting medication administration/monitoring parameters at end of the shift
- 26) Not sending all orders to pharmacy (i.e., if they contain no medication orders, or if medication is available as unit-based floor stock)
- 27) Illegible handwriting

- 28) Writing for multiple prescriptions on one prescription blank

IV. Labeling, Packaging, Nomenclature

- 29) Removing medications from packages prior to reaching the patient's bedside
- 30) Not labeling or poor labeling of syringes/solutions/other medication packages
- 31) Grab and go without fully reading the label of a medication before dispensing/administering/restocking medications
- 32) Storing medications with look-alike labels and packaging beside one another
- 33) Placing hospital-prepared or auxiliary labels over important information on the manufacturer's label

V. Drug Stock, Storage, Distribution

- 34) Leaving medications at bedside
- 35) Leaving medications in an unlocked storage area
- 36) Preparing IV admixtures outside of the pharmacy
- 37) Not notifying physicians, nurses, and other personnel who order and administer drugs of impending and actual drug shortages
- 38) Keeping unused medications from discharged patients in patient care areas for potential administration to other patients
- 39) Borrowing medications from one patient to administer to another patient
- 40) Carrying medications in a uniform or coat pocket
- 41) Placing more importance upon financial criteria than upon safety when procuring medications (e.g., multiple-dose vials vs. single-use vials or prefilled syringes)
- 42) Failure to dispense medications in unit doses or patient-specific doses
- 43) Non-pharmacist access to the pharmacy when closed

VI. Environment/Staffing Patterns

- 44) Managing multiple priorities while carrying out complex processes (e.g., order entry, transcription, drug administration, IV admixture)
- 45) Holding/admitting overflow patients in inappropriate units/areas
- 46) Not notifying management if staffing is inadequate
- 47) Failure to adequately supervise/orient staff
- 48) Inadequate staffing based on patient acuity

VII. Patient Education

- 49) Prescribing/Administering/Dispensing medications without educating patient
- 50) Disregarding patient's/caregivers concerns about a medication's appearance, reactions, effects, or other expressed worry
- 51) Discharging patients without proper education about the medications to take at home

VIII. Staff Education

- 52) Inadequate orientation of new/agency staff
- 53) No organizational incentives to achieve certification or attend continuing education
- 54) Lack of a structured and ongoing staff competency program related to medication use

IX. Quality/Culture

- 55) Sacrificing safety for timeliness
- 56) Failure to report and share error information
- 57) Organizational culture of secrecy rather than openness about medication errors
- 58) Organizational culture of finger pointing rather than system change

X. Double Checks

- 59) Overconfidence in colleague's work (failure to independently double check thoroughly)
- 60) Filling/checking medications using the label, not the order/prescription
- 61) Failure to ask a colleague to double check manual calculations before proceeding
- 62) Failure to ask a colleague to double check high alert medications before dispensing/administration
- 63) Failure to ask a colleague to double check high risk processes (e.g., patient controlled analgesia) before proceeding

XI. Teamwork

- 64) Reluctance to consult others or ask for help when indicated
- 65) Lack of responsiveness to colleague/patient requests

XII. Technology

- 66) Technology work-arounds
- 67) Overriding computer alerts without due consideration
- 68) Over reliance on technology as a safety tool
- 69) Using outdated/poorly maintained technology
- 70) Failure to fully engage available technology
- 71) Failure to provide education/training for new/updated technology
- 72) Inadequate ongoing participation of frontline clinical staff in technology user/planning meetings