



Mental slips and lapses: No one is immune

Everyone in healthcare has made mistakes during the course of their career. No one is immune, regardless of education and experience. Many of these mistakes arise from random and unpredictable mental slips and lapses.

Mental slips and lapses result from a failure to carry out your otherwise correct intentions. They are often controlled by the subconscious, which chooses the wrong automatic action in response to a situation. Slips and lapses occur only *after* you have developed the specific skills involved because you no longer need to proceed slowly and attentively. These types of mistakes are most often caused by distractions, preoccupation, or inattention at critical moments.

processes of receiving and transcribing orders are particularly vulnerable to distractions, as unit secretaries and nurses are often answering telephones and requests for information while carrying out drug order-related tasks.

One example is evident in the transcription of a telephone order below, which was written down and read back! Chances are, this nurse said the correct word 'insulin' instead of 'heparin' when reading back the order. Yet, for many reasons, including distractions and even the fact that both insulin and heparin are dosed in units, the nurse made a mental slip and documented the wrong drug. Fortunately, the patient received insulin, not heparin, because the nurse who accepted the telephone order also

give 10u heparin IVP now
 for BS 324. 1BS in the
 T.O. [redacted] PA-C / [redacted]
 order read back

Whereas prescribing and dispensing medications create a few opportunities for error, drug administration may occur many times a day, leaving nurses especially vulnerable to errors from mental slips and lapses at each instance.

As an example, one evening, a nurse put aside her usual cup of coffee to prepare a patient's dose of chloral hydrate liquid in a cup. On her way to give the dose, she stopped to talk to a coworker. In the middle of the conversation, she drank the chloral hydrate, thinking it was her coffee!

Mental slips and lapses are also responsible for 11% of prescribing errors, 12% of administration errors, and **73% of transcription errors**.¹ The

administered the medication without realizing that she had transcribed the drug name incorrectly. However, another nurse might have given the heparin as transcribed without noticing the second line of the order, which links the drug to a glucose value.

Because we are all prone to mental slips and lapses, it is imperative to plan any error reduction strategies with the assumption that we will all make mistakes, no matter how careful and vigilant. See **check!tout!** for ways to avoid or manage mental slips and lapses.

Reference: (1) Leape LL, Bates DW, Cullen DJ et al. Systems analysis of adverse drug events. *JAMA* 1995; 274:35-43.

check!tout! ✓✓✓✓

Tips to manage mental slips and lapses:

- ✓ **Focus.** Minimize distractions when receiving telephone orders and administering medications:
 - Create quiet workspaces for unit secretaries and nurses during order transcription or receipt of telephone orders
 - Implement policies for **Do Not Disturb** times (during drug administration) and locations (in the medication room)
 - Provide phone and call-bell support for nurses administering medications.
- ✓ **Simplify.** Each step of a process carries about a 1% chance of error. Thus, reducing the number of steps lessens the risk of errors. To cite one instance, use pharmacy-prepared dosing charts for drugs available in standard concentrations (e.g., dopamine) instead of manually calculating the dose.
- ✓ **Checklists.** For critical processes with multiple steps, develop checklists for reference so that a mental lapse does not cause an omission.
- ✓ **Independent double checks.** For selected high-alert drugs, require an independent double check in which calculations and pump settings are performed separately by two nurses and compared for verification; the second nurse then checks the drugs, doses, and routes against the original order.
- ✓ **Slow down.** Pay attention to alerts and prompts on computer screens, reminder labels on medications, and messages printed on medication administration records (MAR). Speed should never come before safety.
- ✓ **Wellness.** Physical and mental stress can contribute to lapses in attention. So be sure to take meal breaks each shift and "time outs" after stressful events to improve your mental focus.

Readers confirm that NurseAdvise-ERR™ is making an impact on safety

Thank you to the nearly 1,300 readers who completed our survey regarding the impact that *Nurse Advise-ERR™* has made to improve medication safety! Nearly all said the newsletter increased their understanding of the causes and prevention of errors and that our recommendations were practical and helpful. You also let us know we could do more to help you stimulate discussion about medication safety among your colleagues. Nevertheless, more than half (55%) of the respondents said they had worked collaboratively with another unit or department to implement medication error prevention strategies suggested in the newsletter. Likewise, almost two-thirds (65%) had made workplace system changes, and more than half (59%) told us they had changed their individual practices to enhance patient safety as recommended in the newsletter.

Most respondents provided specific examples of both system and individual practice changes that have been prompted by the newsletter. Examples include:

- Separated drugs with look-alike/sound-alike names
- Placed markers and labels at the bedside for easier labeling of lines
- Stocked oral syringes for use with liquid medications
- Created new processes for reporting near misses and hazardous situations
- Eliminated the use of certain abbreviations in nursing documentation
- Improved systematic and consistent read back of telephone orders
- Experienced less hesitancy when asking a coworker to double check their work.

Many also provided examples of how the newsletter had enhanced their critical thinking and sensitivity to medication safety issues.

Newsletter topics that were most useful to respondents included insulin, patient-controlled analgesia, human factors, abbreviations/handwriting, and look-alike/sound-alike drugs. Overwhelmingly, readers found the real “stories” about errors most useful in driving changes. While no topics in particular were found least useful, nurses in specialty areas (neonatal, labor/delivery, long-term care, home health, etc.) wished there were more “stories” related to their practice sites.

Remember, we can only write about errors and near misses if we hear “stories” from YOU! Please send them to us at www.ismp.org/pages/ismperRpt.asp. Your name is optional, and no reporter or location will be divulged. We also respect the wishes of the reporter regarding the level of detail published in ISMP newsletters.

Full survey results are available at: www.ismp.org/s/nursesurvey200508R.asp. Visit www.ismp.org/NursingArticles/list.htm for back issues of the newsletter.

► Special Announcements

ISMP Teleconference. An exciting new accountability model has been winning widespread praise from healthcare organizations for helping to maximize safety and balance *system and individual* responsibility for errors. On **October 27, 2005**, from 1:30 to 3:00 p.m. EST, ISMP will hold a teleconference "**Just Culture—An Emerging Safety-Centered Accountability Model**" to help practitioners learn more about this groundbreaking way to promote an open and fair healthcare environment. **David Marx, JD**, developer of the "Just Culture" model and a safety innovator with more than a decade of experience, will be the guest speaker. "For successful error reporting, we need to encourage cultures where employees are willing to come forward in the interest of system safety. However, no one can offer a completely blame-free system where any kind of behavior can be tolerated without penalty," he says. His recent work with several statewide safety culture initiatives in healthcare has been extremely well received, even by "skeptics." For details and to register, visit www.ismp.org/T/200510/.

Message in our mailbox



In response to our July 2005 article, "**Safe-guarding automated dispensing cabinets,**"

a reader wrote: "I am a

nursing instructor and at one of the hospitals in which my students rotate, they have [automated dispensing cabinets] ADCs, but what they do not have is a 'nurse-friendly' process. Nurses stand in line in the mornings waiting for their turn at the ADC. They pull their meds and place them in a plastic bag which is carried in their pockets for the rest of the day. They hand my students their meds which [are] then put in the student's pockets. ... I think these ADCs are put into place without planning the actual process the nurses have to follow to get the correct meds to the client."

Pre-selection and pocketing of medications negates the safety features of ADCs. Yet, despite the risk, this is a common practice, especially if drug administration processes have not been altered upon installation of ADCs. If fear of administering medications late contributes to this risky practice, consider extending the *allowable* time-span for scheduled drug administration. Or, establish *priority* times for time-sensitive drugs (e.g., hypoglycemics with meals) to help avoid crowds at the ADC. Also alert nursing students to the risks involved with this unsafe practice.

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Report medication errors to ISMP at 1-800-FAIL-SAF(E).