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.


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