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ISMP Institute for Safe Medication Practices
An ECRI Company

Acute Care
ISMP Medication Safety Alert!®
Educating the Healthcare Community About Safe Medication Practices

Time-saving bias—Time to rethink the need for speed

Problem: When humans are under pressure, they tend to steer towards biases or cognitive shortcuts to justify their reasoning. Speeding while driving as an attempt to save time is common, although the average driver only saves about 26 seconds per day by speeding. The faster you drive, the less time you save. For example, increasing your speed from 40 mph to 50 mph saves an average of 3 minutes, but going from 80 mph to 90 mph saves less than 1 minute.[1] When applying this concept to healthcare, shortcuts are sometimes welcomed if it means staff are able to complete a task quickly. Have you ever heard a colleague praise a practitioner for being "the best at their job" because they have completed a task faster compared to their peers? This leads to the acceptance of time-saving bias, which is the tendency to overestimate time saved by doing tasks faster, even if the job is not done as effectively.[1] While time efficiency is important, focusing on it without considering how it might affect patient safety and the potential risk of a bad outcome can result in poor quality care, counterproductive work, and unnecessary costs.

When Time-Saving Tactics Backfire

Time-saving bias could potentially lead to rushed decision-making or skipping critical steps in the medication-use process, either of which can result in a medication error. Consider the following examples, paying special attention to the potential risk to the patient.

- A prescriber gives a nurse a verbal order to administer a high-alert medication to a patient instead of entering the order in the electronic health record (EHR)
- A prescriber types instructions in the "free text" medication order field rather than taking the time to select the appropriate options from the drop-down menus
- A prescriber enters orders for multiple acetaminophen formulations (e.g., oral tablets, intravenous [IV] injection, rectal suppository, oral combination product [acetaminophen with **HYDRO**codone]) to avoid a call later if the patient cannot tolerate a particular route or needs a stronger formulation
- A pharmacist verifies an order for a pediatric patient, or approves the dose of a weight-based drug for an adult, neither of whom have a current weight documented
- A pharmacist processes a prescription without having patient allergy information, then selects "no known drug allergies" without confirming the patient's allergies in order to clear out the queue
- A pharmacist chooses not to counsel a patient about a new medication
- A pharmacist who is preparing multiple medications during a code, does not label the patient's doses
- A pharmacy technician preparing a dose of medication that requires several vials, scans the barcode on one vial multiple times instead of scanning the barcode on each individual vial

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Your Reports at Work

Sandoz ceFAZolin recall. Our July 3, 2025 article, *Is it ce**FAZ**olin or penicillin G potassium?*, discussed how a hospital found 4 vials labeled as 20,000,000 units of buffered penicillin G potassium injection (a product that they had not purchased) mixed in with their supply of 1 g ce**FAZ**olin injection vials with the same lot number (PG4360) and expiration date (11/2027). The pharmacist reported this to us with concerns about product authenticity and the potential that this was mislabeled, with uncertainty about what was in the vial. Based on this report, Sandoz recalled this lot number (PG4360) of ce**FAZ**olin due to vials being mislabeled as penicillin G potassium (ECRI alert).

On July 11, 2025, Sandoz expanded the recall to include one additional lot number

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IMPORTANT! Read and utilize the Acute Care Action Agenda

One of the most important ways to prevent medication errors is to learn about problems that have occurred in other organizations and to use that information to prevent similar problems at your practice site. To promote such a process, selected items from the **April – June 2025** issues of the ***ISMP Medication Safety Alert! Acute Care*** newsletters have been prepared for use by an interdisciplinary committee or with frontline staff to stimulate discussion and action to reduce the risk of medication errors. Each item includes a brief description of the medication safety problem, a few recommendations to reduce the risk of errors, and the issue number to locate additional information. The **Action Agenda** is available for download as an Excel file.

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- A nurse overrides a non-emergent medication in the automated dispensing cabinet (ADC) because the pharmacist has not yet verified the order
- A nurse does not check any patient identifiers prior to medication administration because they "know" the patient
- A respiratory therapist removes a respule from the ADC, initiates the nebulizer treatment, and after administration scans the patient's identification and medication barcodes to document the dose on the medication administration record (MAR)
- The cardiac catheterization laboratory team skips a step in the time-out before a procedure
- The director of the emergency department decides not to attend the morning safety huddle

At-Risk Behavior

These time-saving actions (time-saving bias) may also be considered at-risk behaviors, decisions made in good faith without appreciation that these choices represent a substantial and unjustifiable risk. Depending on the organization, skipping critical steps or engaging in workarounds may become normalized if leadership values productivity-focused metrics, which may compromise staff and patient safety. Unfortunately, leaders may rarely investigate contributing factors that lead to these at-risk behaviors and workarounds where staff cut corners, breach policies, or do not follow procedures. In a Just Culture, staff engage in at-risk behavior when they do not appreciate the safety risk of the action they are taking or may mistakenly believe the risk is insignificant or justified. Their behavior is often the norm within their working groups (others do the same). Their "risk monitor" does not alarm and they mistakenly believe the choice they made is safe.

Safe Practice Recommendations: Organizations should consider the following recommendations to help avoid having time-saving bias induce risky behavior:

Evaluate at-risk behavior. Proactively uncover incentives that encourage risky behaviors, reasons behind the decreased perception of risk associated with such behaviors, and identify potential unintended consequences that can erode patient safety. Each at-risk behavior should always be investigated further to determine its causes, which most often reside in the organization's culture or design of systems.

Support safe, effective workflows. Evaluate workflow to identify steps that are vulnerable to being rushed or skipped and implement mitigation strategies that decrease the likelihood of at-risk behaviors and prioritize quality and safety. Select and configure appropriate tools and technologies so they support efficient, safe workflows and standardize processes to avoid rushed decision-making. Design workspaces that minimize unnecessary steps and streamline access to essential supplies and equipment.

Enhance communication. Establish and maintain open lines of communication in which staff can freely share concerns about workflow inefficiencies without fear of retribution. Department leaders should conduct safety walk arounds[2] to gather feedback from frontline staff about what steps in a workflow are vulnerable to time-saving bias. Engage staff by encouraging them to speak up about barriers leading to workarounds. Provide an opportunity to address identified unsafe practices.

Implement lean methodology. Incorporate lean methodology to standardize tasks, remove unnecessary steps, and improve efficiency, thus reducing waste. This includes waste related to defect (correction of a medication error), overproduction (drugs returned to pharmacy), and motion

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Your Reports at Work

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(PG4362) of ce**FAZ**olin. ECRI has released an alert with this updated information. If your organization purchases Sandoz's 1 g ce**FAZ**olin vials, review all inventory (e.g., automated dispensing cabinets, pharmacy storage locations, ambulatory clinics, surgical centers) to ensure you do not have impacted product. If potentially impacted product is found, sequester the vials and report this to the manufacturer, the US Food and Drug Administration (FDA), and ISMP. We sincerely appreciate organizations continuing to report these important concerns to us so that we can work together to prevent medication errors and patient harm.

SAFETY briefs

Review and update parenteral nutrition order forms and order sets. An outpatient infusion center dietitian reported that staff have been receiving outdated parenteral nutrition (PN) order forms from hospitals, which list products that are no longer commercially available. One PN order form had the multiple trace element dose prescribed as 0.2 mL/kg, which was the recommended dosing for a pediatric multiple trace element product that has not been on the market since 2021.

The products that are currently available are **MULTRYS** (trace elements injection 4) and **TRALEMENT** (trace elements injection 4), both manufactured by American Regent. Multrys is indicated for neonatal and pediatric patients weighing less than 10 kg. Each mL of Multrys contains zinc 1,000 mcg, copper 60 mcg, manganese 3 mcg, and selenium 6 mcg. The dosing recommendations for Multrys are weight-based, with a maximum daily dose of 1 mL. When the patient reaches 10 kg, the recommendation is to switch to Tralement, intended for adult and pediatric patients weighing 10 kg or more, which also has weight-based dosing. Each mL of Tralement contains zinc 3 mg, copper 0.3 mg, manganese 55 mcg, and selenium 60 mcg. The dietitian reported that hospitals are also sending orders for Multrys with doses significantly above 1 mL and for patients who are above 10 kg.

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Applications for the **Judy Smetzer Just Culture Champion Scholarships** open **August 1, 2025**. For more information click here.

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(due to the layout of the space). When identifying performance improvements, include outcome metrics that will be monitored to ensure sustainability.[3]

Educate practitioners. Educate practitioners about the risks associated with time-saving shortcuts and reinforce the importance of adhering to established protocols. Emphasize that the organization does not reward staff based on pace, and instead values a culture where safety is prioritized over speed.

Share insights. Collaborate with outside departments (e.g., during safety huddle) to share lessons learned and the actions taken to minimize the need for staff to engage in time-saving behaviors that could lead to patient harm.

References

1) Cavanaugh JE, Thickens JO. Does speeding really save you time? Cavanaugh & Thickens, LLC. October 3, 2023. Accessed March 25, 2025.
2) Patient safety leadership WalkRounds. Institute for Healthcare Improvement. Accessed May 5, 2025.
3) Lean in pharmacy operations to enhance service and safety. Lean Learning Center. February 13, 2024.

Special Announcements

Apply for New Fellowship

Applications are being accepted for the first ***Ochsner Children's & ISMP Safe Medication Management Fellowship***! This unique one-year program for pharmacists offers the opportunity to learn from and work with top experts in medication safety while supporting error prevention strategies in pediatrics at Ochsner Health. **The fellowship requires working onsite at Ochsner Health in New Orleans, LA** and remotely with ISMP. For more information and to apply, please visit: *Safe Medication Management Fellowships*.

Last call for CHEERS nominations

If you have not submitted your nomination for an ISMP **CHEERS AWARD**, please do so now! The completed packet must be emailed to cheers@ismp.org by 11:59 PM ET on **August 1, 2025**. For more details and to submit a nomination, click here.

Podcast and webinar on RTA medications

Join us for one or both of our presentations on the risks associated with manipulating medications at the bedside. The podcast, ***Safe Medicine, Safe Care: What You Need to Know About IV Push Medications***, provides a basic overview of errors that have occurred and the importance of utilizing ready-to-administer (RTA) products. The on-demand webinar, ***Applying Best Practices for Injection Safety: A "How To" Roadmap***, teaches participants how to review their own data to compare the cost and safety of manufacturer-prepared RTA products with traditional products and the next steps needed to successfully optimize RTA products within their organization. These programs were made possible through an educational grant from Fresenius Kabi. Click on the presentation title to access the program.

>SAFETY briefs

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Organizations should build PN order templates with standardized units for defined patient populations (i.e., dose per day for adults, dose/kg/day for pediatric and neonatal patients). Ideally, hospitals should collaborate with local provider offices, clinics, and infusion pharmacies to develop a consensus on these order templates. Evaluate what clinical decision support is available (in the electronic health record and/or automated compounding device) and ensure there are soft warnings and hard stops to warn practitioners when approaching or exceeding limits (e.g., single dose, daily dose). Review order sets and order forms at least annually and when new products are purchased. If your organization uses Multrys and/or Tralement, educate practitioners about the various patient weight categories that will require different dosages as well as differing amounts of individual trace elements. Regularly review alert overrides to determine appropriateness and to improve the safety of PN practices.

Updated guidelines for electronic communication. ISMP has updated the ***Guidelines for Safe Electronic Communication of Medication Information***. The first draft of these guidelines was published in 2003, when implementation of electronic health records (EHRs), electronic prescribing (e-prescribing), and other health information technology (HIT)-related tools began to evolve in both inpatient and outpatient settings. These technologies are now a mainstay in healthcare, and in 2019, we revised these guidelines. In this recent revision, we have continued to streamline the recommendations and have considered all clinical areas where technology is utilized to communicate medication information. If you have any questions or comments about the 2025 version, please feel free to contact us at: ismpinfo@ismp.org.

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