July 11, 2024 | Volume 29 ■ Issue 14

ISMP
An ECRI Affiliate

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

Cultivate discussions in a psychologically safe workplace—Part I

Problem: In the workplace, psychological safety is the belief that your leaders and colleagues will not punish or humiliate you for speaking up with ideas, questions, concerns, or mistakes that are exposed. Sharing and learning is crucial for continuous improvement of healthcare quality and patient safety. However, if a healthcare organization does not provide a psychologically safe environment, practitioners are less likely to question practices, share ideas, or report and learn from incidents.[1] Understandably, practitioners may be reluctant to report errors or safety concerns due to fear of liability and repercussions, including losing their license or job, limiting their career development opportunities, being blamed or perceived as careless or incompetent, or being estranged from peers.[2]

In our August 26, 2021 newsletter article, *Pump up the volume: Tips for increasing error reporting and decreasing patient harm* (www.ismp.org/node/27067), we discussed how a nurse was reluctant to report a dosing error to the charge nurse fearing harsh consequences. A summary of the event is also provided below:

A nurse misunderstood an order for a bolus dose of intravenous (IV) verapamil 5 mg, followed by a continuous infusion to run at a rate of 5 mg/hour, for a step-down unit patient who suddenly developed atrial fibrillation and tachycardia. For the bolus dose, the nurse removed two vials of verapamil from an automated dispensing cabinet (ADC) that clearly noted the strength on each vial as "5 mg per 2 mL." She confused the "2" in "2 mL" on the package labeling to mean that she should administer "2 vials" to equal the prescribed 5 mg dose. She administered both vials of verapamil—10 mg or double the prescribed bolus dose—and immediately recognized the error.

When the patient's physician suddenly appeared on the unit, the nurse was comfortable telling the physician about the error, but she spoke in a hushed tone. The nurse then added that she would have to tell him the rest of the details after the charge nurse moved out of earshot. The pharmacy prepared the verapamil continuous infusion and the nurse started it 15 minutes later. Luckily, the patient, who was already on telemetry, showed no signs of verapamil toxicity over the next several hours.

Despite encouragement from the physician, the nurse never reported the error within the facility. Thus, other practitioners lost the opportunity to learn from this mistake because something—perhaps fear of reprisal—prevented this nurse from reporting the error or involving her charge nurse. This event reinforces that sharing safety concerns or reporting errors is highly dependent on the degree of psychological safety felt by healthcare workers. This raises concern about other hazards, close calls (i.e., good catches), or errors that reach patients that practitioners are fearful to speak up about, thus hindering learning, system changes, and the potential to prevent patient harm.

Safe Practice Recommendations: Organizations that foster a positive safety culture are characterized by open communication founded on mutual trust, where practitioners have shared perceptions of the importance of safety and learning, and willingly share safety concerns and events that have occurred or nearly occurred.[3] To support leaders and staff involved in medication safety discussions, and to encourage open reporting, active questioning, and frequent sharing of insights and concerns, organizations should consider the following recommendations:

continued on page 2 — Psychologically safe workplace >

NANALERT

Warning! Manufacturer's dexmedeTOMIDine premixed IV bags may be packaged within an overwrap labeled as acetaminophen!

A prescriber ordered an acetaminophen 1,000 mg/100 mL infusion for a patient. The nurse removed what she thought was an acetaminophen infusion bag from the automated dispensing cabinet (ADC), scanned the barcode on the overwrap, and administered the infusion to the patient. Approximately 15 minutes later, the patient experienced bradycardia and bradypnea. The nurse looked at the empty bag hanging on the intravenous (IV) pole and discovered that it was labeled "dexmede**TOM**idine hydrochloride injection, 400 mcg/100 mL" (lot number 24070461, expiration date 03/2026). The infusion bag label had a different font from the typical product and contained statements in French with ISMP Canada's tall man lettering (i.e., dexmede**TOM**idine) (www.ismp.org/ext/1394) which differs from the tall man lettering (i.e., dexmede**TOMID**ine) on ISMP ***List of Look-Alike Drug Names with Recommended Tall Man (Mixed Case) Letters*** (www.ismp.org/node/136) (**Figure 1**). The nurse notified the prescriber and provided supplemental oxygen to the patient. Fortunately, the patient recovered.

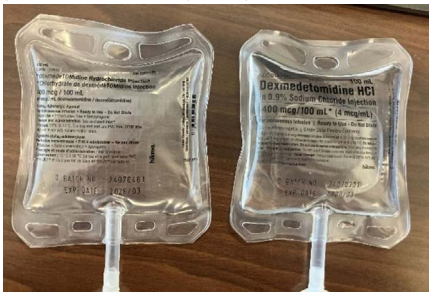

Figure 1. An infusion bag (left) found inside the acetaminophen injection overwrap by Hikma, was labeled dexmede**TOM**idine 400 mcg/100 mL with Canadian labeling and a different font compared to the US product labeling (right).

continued on page 2 — NANALERT >

> Psychologically safe workplace — continued from page 1

Create a psychologically safe environment[3-6]

- ☐ Promote and implement a fair and Just Culture (www.justculture.com) where safety is a primary value in the organization, and staff continually look for risks that pose a threat.
- ☐ Develop and disseminate nonpunitive policies about event reporting.
- ☐ Show concern for a practitioner's emotional distress and provide support (e.g., employee assistance programs) when they have been involved in an error or close call.
- ☐ Be curious, regularly ask about safety issues, and exhibit appreciative listening.
- ☐ Highlight situations where harm was prevented when practitioners raised concerns and reported close calls.
- ☐ Use staff feedback to initiate improvements and provide staff with recognition of their critical role in system or process changes.
- ☐ Establish a code of conduct that declares the organization's intolerance of disrespectful behaviors, so staff feels safe speaking up about disrespectful behaviors without fear of reprisal (www.ismp.org/node/30311).

Promote a culture of safety and learning[3]

- ☐ Communicate and prioritize the safety of both patients and staff.
- ☐ Create a sense of urgency to learn and change.
- ☐ Encourage practitioners to notice details and assume the system is fallible; investigate close calls as a sign of system vulnerability and look for multiple explanations for failures.
- ☐ Reward those who report risk (e.g., good catch program) and adverse events.
- ☐ Maintain confidentiality of those involved in events.
- ☐ Make appropriate changes to enhance safety.
- ☐ Inform staff that the changes were a result of reporting to foster ongoing reporting.
- ☐ Gather feedback and reevaluate after changes are made.

Conduct Patient Safety Leadership Walk Arounds

Instead of waiting for an error to occur, engage in proactive staff interviews to identify safety risks. To do this, leaders can engage frontline staff by being visible in work areas, encouraging them to speak up about barriers leading to workarounds, and establishing cross-departmental feedback systems.[3] For example, the Institute for Healthcare Improvement describes what they have dubbed *Patient Safety Leadership WalkRounds*[7] as a systematic approach to patient safety where leaders informally talk with frontline staff about safety issues to demonstrate their support of an organizational culture that promotes nonpunitive reporting of errors, adverse events, close calls, and unsafe conditions. The structure may include hallway conversations, individual conversations, and/or conversations with practitioners in specific roles.[7-9] Inform staff about the purpose of safety walk arounds by describing the process and encouraging them to raise quality and safety issues. Flatten hierarchies by addressing staff by their first name to prompt familiarity and comfort. Communicate interest, including nonverbal cues such as eye contact.

Questions to cultivate discussions during WalkRounds[3,10]

- ☐ Were you able to care for your patients this week as safely as possible? If not, why not?
- ☐ Can you describe the unit's ability to work as a team?
- ☐ Have there been incidents that almost caused patient harm?

continued on page 3 — Psychologically safe workplace >

NANALERT continued from page 1

After the event, the hospital reported that the nurse retrieved the overwrap from the top of the trash bin that she had scanned prior to administration, which was labeled acetaminophen 1,000 mg/100 mL (Hikma, NDC 0143-9386-01, lot number 24070381, expiration date 09/2025) (**Figure 2**). The hospital quarantined the overwrap and infusion bag and notified Hikma. The hospital did not find additional infusion bags with this issue.

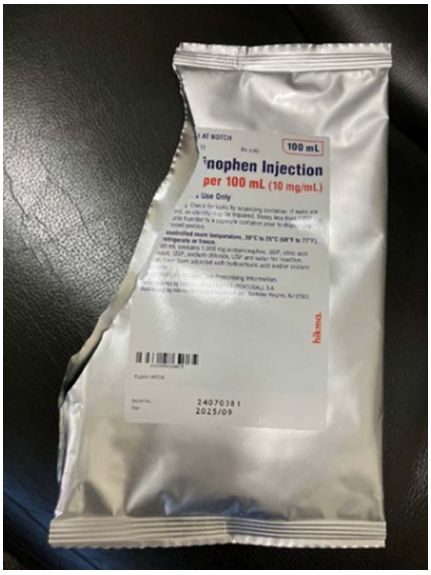

Figure 2. A hospital reported that Hikma's overwrap labeled acetaminophen injection 1,000 mg/100 mL contained an infusion bag labeled dexmede**TOM**idine 400 mcg/100 mL.

We have reached out to the US Food and Drug Administration (FDA) and Hikma to notify them of this concern. Hikma told us they are completing an immediate and ongoing investigation. They have notified the impacted wholesalers who have placed Hikma's acetaminophen 1,000 mg/100 mL injection with the lot number 24070381 in quarantine, and a formal recall is planned. If your organization has purchased this product, check your inventory, and if an infusion bag overwrap labeled as acetaminophen with lot number 24070381 is found, sequester the product until further instructions are provided by the FDA/wholesaler. While this is an unusual situation, the best practice is to scan the barcode directly on an infusion bag (not the overwrap) prior to administration. Educate staff to read the infusion bag labels prior

continued on page 3 — NANALERT >

> **Psychologically safe workplace** — continued from page 2

- ☐ What could the unit staff do on a regular basis to improve safety?
- ☐ Do you know how to report a safety event?
- ☐ If you prevent or intercept an error, do you always report it?
- ☐ Do you know what happens to the information once you report it?
- ☐ What intervention would make your work safer for patients?
- ☐ Are there technology issues (e.g., problems with computers, ADCs, smart infusion pumps)?
- ☐ Do you have any drug diversion concerns?

After WalkRounds, leaders should[2,6,8]

- ☐ Debrief with staff to reflect on what was learned and identify opportunities for improvement.
- ☐ Ensure two-way, open communication by asking for input and clarification before discussing the next steps.
- ☐ Record safety concerns, analyze and classify issues by contributing factors, prioritize and create a summary report for the most important issues, and address high-priority issues.
- ☐ Follow up with staff to provide feedback about actions that are planned or have been implemented based on their input during WalkRounds.

Conclusion

Promoting a culture of safety and learning by conducting regular walk arounds with purposeful questions that leaders ask in a manner that intentionally supports psychological safety can proactively help identify the staff's medication safety concerns (e.g., "What keeps you up at night?"). It is also important to learn about and address safety issues after an event occurs by conducting a root cause analysis (RCA). We plan to publish a follow-up article, **Part II**, describing how to apply this framework when conducting RCA interviews to improve the quality of learning from events.

References

1) ISMP Canada. Safe spaces: psychological safety for patients. *ISMP Canada Safety Bulletin.* 2024;24(3):1-4. www.ismp.org/ext/1391
2) Castel ES, Ginsburg LR, Zaheer S, Tamim H. Understanding nurses' and physicians' fear of repercussions for reporting errors: clinician characteristics, organization demographics, or leadership factors? *BMC Health Serv Res.* 2015;15:326.
3) Smetzer JL. Managing medication risks through a culture of safety. In: Cohen MR, ed. *Medication Errors.* 2nd ed. American Pharmacists Association; 2007:605-54.
4) Alingh CW, van Wijngaarden JDH, van de Voorde K, Paauwe J, Huijsman R. Speaking up about patient safety concerns: the influence of safety management approaches and climate on nurses' willingness to speak up. *BMJ Qual Saf.* 2019;28(1):39–48.
5) Okuyama A, Wagner C, Bijnen B. Speaking up for patient safety by hospital-based health care professionals: a literature review. *BMC Health Serv Res.* 2014;14:61.
6) Ortega A, Van den Bossche P, Sánchez-Manzanares M, Rico R, Gil F. The influence of change-oriented leadership and psychological safety on team learning in healthcare teams. *J Bus Psychol.* 2014;29(2):311–21.
7) Patient safety leadership WalkRounds. Institute for Healthcare Improvement. Accessed March 1, 2024. www.ismp.org/ext/1392
8) Singer SJ, Tucker AL. The evolving literature on safety WalkRounds: emerging themes and practical messages. *BMJ Qual Saf.* 2014;23(10):789–800.
9) Frankel A, Graydon-Baker E, Neppl C, Simmonds T, Gustafson M, Ghandi TK. Patient safety leadership WalkRounds. *Jt Comm J Qual Saf.* 2003;29(1):16–26.
10) Alsowaida YS, Kovacevic MP, Belisle C, et al. Implementation of pharmacy executive quality and safety WalkRounds at a tertiary academic medical center. *Hosp Pharm.* 2022;57(2):211-16.

NANALERT continued from page 2

to barcode scanning and administration, and to be vigilant when checking the actual infusion bag for Hikma's acetaminophen injection, regardless of the lot. Report issues to ISMP (www.ismp.org/report-medication-error), FDA (www.ismp.org/ext/544), and Hikma, the manufacturer, at: +1-877-845-0689 or 1-800-962-8364, or online at: www.ismp.org/ext/1395.

Special Announcements

Virtual MSI workshop

Join us for our next ***ISMP Medication Safety Intensive (MSI)*** workshop on **August 8 and 9, 2024**. For more information and to register, please visit: www.ismp.org/node/127.

CHEERS AWARDS nominations open

Each year, ISMP honors various healthcare disciplines that have demonstrated an exemplary commitment to medication safety through innovative projects with an ISMP **CHEERS AWARD**. Nominations for this year's **CHEERS AWARDS** are now open and will be accepted through **August 2, 2024**. Please refer to the information provided on our website when submitting a nomination. For details, visit: www.ismp.org/node/123.

To subscribe: www.ismp.org/ext/1367

ISMP Medication *Safety Alert!* Acute Care (ISSN 1550-6312)

Report medication and vaccine errors to ISMP: Please call 1-800-FAIL-SAF(E), or visit www.ismp.org/report-medication-error. ISMP guarantees the confidentiality of information received and respects the reporters' wishes regarding the level of detail included in publications.

Editors: Shannon Bertagnoli, PharmD; Ann Shastay, MSN, RN, AOCN; Rita K. Jew, PharmD, MBA, BCPPS, FASHP; Editor Emeritus, Michael R. Cohen, RPh, MS, ScD (hon), DPS (hon), FASHP. ISMP, 5200 Butler Pike, Plymouth Meeting, PA 19462. Email: ismpinfo@ismp.org; Tel: 215-947-7797.