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Research Brief: Nurses' Perceptions of Medication Error Reporting

This research brief presents findings from completed research titled; "*Nurse disclosure of medication errors: Towards the development of an intervention*" conducted by Covell, CL & Ritchie, JA (2007).

Background: Seven and half percent of all patients admitted to acute care hospitals in Canada experience one or more adverse events¹. Adverse drug events account for 24% of the total adverse events¹. While underreporting of medication errors (MEs) has been acknowledged²⁻³ it is also recognized that successful error reduction strategies are dependent on ME detection and reporting⁴.

This study examined the perceptions of staff nurses regarding the reporting of MEs. Information collected from this study will be used to develop an intervention designed to encourage the reporting of MEs at the MUHC. The findings and recommendations for the intervention were presented to the MUHC Nursing Quality Committee for follow-up.

What was the purpose of the study?

To determine the perceptions of staff nurses regarding the type of incident they consider to be a reportable ME and why, and the factors that prevent and facilitate nurse reporting of MEs.

How were nurses' perceptions measured in this study?

Nurses participated in an interview and completed a survey.

How was the research conducted?

The study was conducted from June to October 2007 at five sites of the MUHC. Fifty staff nurses, (10 nurses per site) participated. Quantitative data were analyzed using descriptive statistics. Qualitative data were coded and categorized into themes. Recommendations for the intervention were developed after the data were triangulated (merged).

What Were the Findings?

On the survey, nurses indicated that they believe:

- ◆ Less than 60% of all MEs committed on their unit are actually reported.
- ◆ Nurses choose not to report a ME predominately due to fear:
 - Of what their colleagues, physicians, patients/ families will think of them.
 - There will be adverse consequences from reporting.
 - That they will be blamed if something 'bad' happens to the patient.

The nurses reported during the interviews, that:

- ◆ They strive to never make a ME but they believe every nurse has made one.
- ◆ When they make an error they:
 - Are emotionally distressed.
 - Are concerned that harm will come to the patient.
 - Always report the error formally by filling out an incident report if they think the patient's condition is in immediate jeopardy.
 - Disclose the error informally by telling colleagues or a physician if they think the error will not cause immediate harm.



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- ◆ After they report the error they believe:
 - The people involved should be spoken to with respect.
 - The error and the circumstance surrounding it should be communicated with discretion.
- ◆ After they fill out an incident report they don't know :
 - Where the report goes.
 - What is done with the information written on the report.
- ◆ They think receiving timely feedback from the incident reports about the type and reasons for MEs will help nurses improve patient care.
- ◆ They think more nurses will report MEs if:
 - Nurses are aware of the practice or system changes made as a result of reporting.
 - Modifications are made to the incident report form.
- ◆ They do not believe an anonymous reporting system would improve ME reporting at the MUHC.

Based on the findings, the following strategies should be included in the intervention:

- ◆ An organizational policy and procedure for reporting MEs including what is an error and what requires a report.
- ◆ Systems to assure nurses obtain the support required to maintain safe medication administration practices.
- ◆ An “assistance program” for nurses who experience serious MEs.
- ◆ Education for the nursing staff and management about how the information obtained from reporting MEs is used to improve care.
- ◆ A system which provides a meaningful and respectful manner for analyzing, using and communicating information obtained from the incident reports.

Questions for future research

- ◆ What type of factors would influence how managers, physicians and families respond to nurse disclosure of MEs?
- ◆ Does instituting different methods for reporting different types of MEs increase nurse disclosure?

Implications for policy development

- ◆ Develop and implement policies which consider the legal and professional consequences of nurses reporting MEs.

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This research brief was prepared by Christine L. Covell RN, MSN, PhD (c) and Judith A. Ritchie RN, PhD (November, 2007).

¹ Baker, GR et al. (2004). The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. *CMAJ*, 10(11), 1678-85.

² Armitage, G. & Knapman, H. (2003). Adverse events in drug administration: a literature review. *Journal of Nursing Management*, 11, 130-140.

³ Canadian Institute of Health Information (2005). *Medication Incident Reporting and Prevention Systems: Environmental Scan*. Ottawa: Canadian Institute for Health Information, ISBN 1-55392-582-3.

⁴ National Steering Committee on Patient Safety. (2002). *Building a Safer System. A national integrated strategy for improving patient safety in Canadian Health Care*. Ottawa: National Steering Committee on Patient Safety, ISBN 0-9692155-3-3.