

SAFETY

ANNOTATED BIBLIOGRAPHY

OCTOBER 2007 – NEW CITATIONS

Ackermann, A. D., Kenny, G., & Walker, C. (2007). Simulator programs for new nurses' orientation: A retention strategy. *Journal for nurses in staff development : JNSD : Official journal of the National Nursing Staff Development Organization*, 23(3), 136-139.

The phenomenon of role transition for new nurses has been a topic of research and concern for practicing nurses, educators, and administrators for many years. This transition has an impact on the job retention of new nurses. Stress, lack of confidence, and unmet expectations have been found to influence patient safety and outcomes. Simulator programs have enhanced the experiences of students and nurses in the clinical setting. Within this safe environment of simulation, nurses find the opportunity to develop critical thinking, decision making, and clinical confidence. A simulator program was developed in Vassar Brothers Medical Center to assist in the transition of new graduate registered nurses to acute care practice. This article describes the process of developing a program and suggestions for instructors who are interested in developing a simulation program. (Source: PubMed)

Beyea, S. C., von Reyn, L. K., & Slattery, M. J. (2007). A nurse residency program for competency development using human patient simulation. *Journal for nurses in staff development : JNSD : Official journal of the National Nursing Staff Development Organization*, 23(2), 77-82.

A new graduate registered nurse residency program integrating human patient simulation was developed at an academic medical center. The program focused on orientation through skill-based learning, critical thinking, human factors engineering, and patient safety using simulated experiences for a wide variety of high-risk, low-frequency, as well as

high-frequency, commonly occurring clinical events and situations. Structured evaluations demonstrated that simulation serves as a highly effective strategy for developing competency, confidence, and readiness for entry-into-practice. It strengthened assessment and clinical skills, and enhanced nurse residents' ability to apply critical thinking to simulated patient scenarios. The time and cost of orientation decreased while recent graduate nurse satisfaction with orientation was high. (Source: PubMed)

Brown, Y., Neudorf, K., Poitras, C., & Rodger, K. (2007). Unsafe student clinical performance calls for a systematic approach. *The Canadian nurse, 103*(3), 29-32.

Patient safety is the responsibility of both the system and the individual practitioner. Unsafe incidents are a very real possibility when nursing students are preparing for their profession. The curriculum committee of the Nursing Education Program of Saskatchewan (NEPS) identified the need for a unified and consistent process related to students who demonstrate unsafe clinical performance. Many clinical teachers experience difficulty in identifying and making decisions related to students' unsafe performance. The authors describe the development of a systematic approach that was adopted by NEPS in June 2005 and is being used across all program years and sites. The approach provides students with a fair and just process and reflects the responsibility of the educational program to prepare graduates who will provide safe, competent care. (Source: PubMed)

Conerly, C. (2007). Strategies to increase reporting of near misses and adverse events. *Journal of nursing care quality, 22*(2), 102-106.

The article provides insights and highlights best practices from the field that can be used globally and has significance in the new accreditation process. In this context, the author focuses on the cultural barriers to reporting adverse events and the need to create a change in culture.

With this, many healthcare organizations realized that a change in culture has been needed to improve patient safety. (Source: CINAHL)

Constantino, R. E. (2007). A transdisciplinary team acting on evidence through analyses of moot malpractice cases. *Dimensions of critical care nursing : DCCN*, 26(4), 150-155.

A transdisciplinary team is crucial for healthcare systems to act based on evidence in responding to the global demand of the business of caring and patient safety. The purpose of this paper is to outline a transdisciplinary team led by nurses that examines linkages between moot malpractice cases filed against a healthcare system and to the quality of the healthcare system's ecology, caregiver, and patient safety outcomes. (Source: PubMed)

Cornish, J., & Jones, A. (2007). Evaluation of moving and handling training for pre-registration nurses and its application to practice. *Nurse education in practice*, 7(3), 128-134.

This paper describes preliminary questionnaire survey work in a research programme exploring M&H training for student nurses (n=106) and its application to practice. The aim of the study was to provide evidence of the students' experiences of M&H in the clinical setting to inform future educational development. The students were able to distinguish between acceptable and unacceptable practice they observed. Good practice comprised planning and coordination within the nursing team and careful reassurance of the patient. Regarding poor practice, the students identified that equipment was unavailable or not used and that staff demonstrated poor posture in this work or used condemned techniques thought to be detrimental to the staff and the patients. Fewer students had observed: risk assessments, equipment safety checks and use of a hoist for lifting fallen patients, than had seen other accepted M&H procedures. Contrary to the Manual Handling Operations Regulations (HSE. 1992; 1998. Manual Handling Operations Regulations. HMSO, London.) and hospital 'no-lifting' policies, 71% of the respondents had

been asked to participate in a manoeuvre that they thought was wrong and a similar number had been asked to physically lift patients without using recommended equipment. Perceived injuries to both staff and patients were also described. (Source: PubMed)

Dennison, R. D. (2007). A medication safety education program to reduce the risk of harm caused by medication errors. *Journal of continuing education in nursing, 38*(4), 176-184.

A medication safety education program was developed and implemented to reduce the harm caused to patients by medication errors, specifically errors related to the intravenous infusion of high-alert medications. Participants were required to complete two 30-minute computer modules focusing on medication safety. Changes in the climate of safety, nurses' knowledge and behavior, and the number of infusion pump alerts and reported medication errors were evaluated both before and after completion of the education program. A statistically significant change in knowledge regarding medication errors occurred, but there was no change in the climate of safety scores, the use of behaviors advocated in the medication safety education program to improve medication infusion safety, the number of infusion pump alerts, or the number of reported errors. It was concluded that there was a need for strong administrative support and follow-up to foster changes in behavior, which can lead to a reduction in harm caused by medication errors. (Source: PubMed)

Johnsson, A. C., Kjellberg, A., & Lagerstrom, M. I. (2006). Evaluation of nursing students' work technique after proficiency training in patient transfer methods during undergraduate education. *Nurse education today, 26*(4), 322-331.

The aim of this study was to investigate if nursing students improved their work technique when assisting a simulated patient from bed to wheelchair after proficiency training, and to investigate whether there was a correlation between the nursing students' work technique and the simulated patients' perceptions of the transfer. METHOD: 71 students

participated in the study, 35 in the intervention group and 36 in the comparison group. The students assisted a simulated patient to move from a bed to a wheelchair. In the intervention group the students made one transfer before and one after training, and in the comparison group they made two transfers before training. Six variables were evaluated: work technique score; nursing students' ratings of comfort, work technique and exertion, and the simulated patients' perceptions of comfort and safety during the transfer. The result showed that nursing students improved their work technique, and that there was a correlation between the work technique and the simulated patients' subjective ratings of the transfer. In conclusion, nursing students improved their work technique after training in patient transfer methods, and the work technique affected the simulated patients' perceptions of the transfer. (Source: PubMed)

Johnstone, M. J., Kanitsaki, O., Currie, T., Smith, E., & McGennissen, C. (2007). Designing and delivering clinical risk management education for graduate nurses: An Australian study. *Nurse education in practice*, 7(4), 247-257.

In order to enhance their capabilities in clinical risk management (CRM) and to be integrated into safe and effective patient safety organisational processes and systems, neophyte graduate nurses need to be provided with pertinent information on CRM at the beginning of their employment. What and how such information should be given to new graduate nurses, however, remains open to question and curiously something that has not been the subject either of critique or systematic investigation in the nursing literature. This article reports the findings of the third and final cycle of a 12 month action research (AR) project that has sought to redress this oversight by developing, implementing and evaluating a CRM education program for neophyte graduate nurses. Conducted in the cultural context of regional Victoria, Australia, the design, implementation and evaluation of the package revealed that it was a

useful resource, served the intended purpose of ensuring that neophyte graduate nurses were provided with pertinent information on CRM upon the commencement and during their graduate nurse year, and enabled graduate nurses to be facilitated to translate that information into their everyday practice. (Source: PubMed)

Kazaoka, T., Ohtsuka, K., Ueno, K., & Mori, M. (2007). Why nurses make medication errors: A simulation study. *Nurse education today*, 27(4), 312-317.

The purpose of this study was to investigate about the communication problems in the team nursing systems, if the requests for medication between nurses happen. For this study, we developed a simulation involving a nurse giving a medication prepared by another nurse. Baseline data was collected from 100 third-year nursing students and 163 nurses of two municipal hospitals further subdivided into three groups by their service years. The responders attributing to the errors in the simulation were compared. As a result, the more service years the fewer nurses there were who attributed medication errors to no explanation and no confirmation between nurses. The nurses whose service years were less than five years had a low level of awareness regarding no explanation of a nurse leader requesting the medications as well as the students. These findings suggested that there is the possibility that some medication errors occur due to preoccupation that nurses feel it is less necessary to explain and confirm everything related to medication administrations as their length of service increase. Nurses have a communication problem that is influenced by the relationship in the workplace in the team nursing system. Therefore, the requests for medication should no be permitted. (Source: PubMed)

Kyrkjebo, J. M., Brattebo, G., & Smith-Strom, H. (2006). Improving patient safety by using interprofessional simulation training in health professional education. *Journal of interprofessional care*, 20(5), 507-516. Modern medicine is complex. Reports and surveys demonstrate that

patient safety is a major problem. Health educators focus on professional knowledge and less on how to improve patient care and safety. The ability to act as part of a team, fostering communication, co-operation and leadership is seldom found in health education. This paper reports the findings from pilot testing a simulated training program in interprofessional student teams. Four teams each comprising one medical, nursing, and intensive nursing student (n = 12), were exposed to two simulation scenarios twice. Focus groups were used to evaluate the program. The findings suggest that the students were satisfied with the program, but some of the videos and simulation exercises could be more realistic and more in accordance with each other. Generally they wanted more interprofessional team training, and had learned a lot about their own team performance, personal reactions and lack of certain competencies. Involving students in interprofessional team training seem to be more likely to enhance their learning process. The students' struggles with roles, competence and team skills underline the need for more focus on combining professional knowledge learning with team training. (Source: PubMed)

Lim, A. G., Honey, M., & Kilpatrick, J. (2007). Framework for teaching pharmacology to prepare graduate nurse for prescribing in New Zealand. *Nurse education in practice*, 7(5), 348-353.

The place of nurse prescribing and the preparation for this role is an educational challenge that has been heavily debated in New Zealand and overseas for the past 10 years. Nurse prescribing is relatively new in New Zealand and is related to the expanding roles and opportunities for nurses in health care. Opposition to nurse prescribing in New Zealand has been marked and often this has been linked to concerns over patient safety with the implication that nurses could not be adequately prepared for safe prescribing. The educational framework used to teach pharmacology to nurses by one university in New Zealand is presented, along with early findings on the effectiveness of this approach. Further

research is required to confirm that nurse prescribers in New Zealand are well prepared and able to utilise effective decision-making processes for safe prescribing. (Source: PubMed)

Lorenz, S. G. (2007). Protection: Clarifying the concept for use in nursing practice. *Holistic nursing practice*, 21(3), 115-123.

The protection of patients is integral in any healthcare setting. Healthcare organizations are increasingly held accountable for preventable medical errors, the attitudes toward safety, and communication among all levels of providers, collaborative practices, and recognition of risks. The concept of protection is inherent in nursing practice. It provides a framework, that further defines healthcare provider's roles in meeting these imperatives. The scope of protection is considered both globally and individually prominent. Nurses protect patients from environmental hazards, themselves, and any perceived threat. In this analysis of the phenomenon, the concept is clarified, and an evidence-based approach to protection is utilized for theory development and concept measurement. (Source: PubMed)

Malloch, K. (2007). The electronic health record: An essential tool for advancing patient safety. *Nursing outlook*, 55(3), 159-161.

While the implementation of the electronic record has resulted in significant improvements in patient safety, it is not a panacea for all medical errors; rather, it is a supporting tool that requires an organizational culture of safety and an awareness of the new generation of errors that are emerging. Screen design, data entry errors, and changes in communication that minimize face time are new and different events that will require analysis and new solutions. (Source: Publisher)

Paparella, S. (2007). Failure mode and effects analysis: A useful tool for risk identification and injury prevention. *Journal of emergency nursing: JEN : Official publication of the Emergency Department Nurses Association*, 33(4), 367-371.

By its very nature, the emergency department uses a multitude of processes that would be considered high risk and eligible for study. It is no longer acceptable to rely solely on the competence of individuals and current ED processes without questioning possible risks because “we have always done it that way.” Being a safety-conscious practitioner includes thinking and working *proactively* (and using FMEA as a tool) before adverse events occur to achieve a safe environment, free from preventable patient harm. (Source: Publisher)

Sheridan-Leos, N. (2007). A model of chemotherapy education for novice oncology nurses that supports a culture of safety. *Clinical journal of oncology nursing*, 11(4), 545-551.

Chemotherapy education at a mid-sized community hospital was redesigned to help novice oncology nurses improve patient safety and their own practice by implementing error prevention techniques during chemotherapy administration. Using a proactive approach with multidisciplinary participation and open communication, a systems analysis was conducted to identify potential chemotherapy errors. Then, chemotherapy processes were devised or strengthened to avoid errors. The project required a philosophical shift from error measurement to safety promotion. (Source: PubMed)