Exploring hierarchy deferral in medication administration through simulation

ANDERTON, Leisa <http://orcid.org/0000-0003-3801-7708>

Available from Sheffield Hallam University Research Archive (SHURA) at:

https://shura.shu.ac.uk/31384/

EXPLORING HIERARCHY DEFERRAL IN MEDICATION ADMINISTRATION THROUGH SIMULATION

Leisa Anderton

BACKGROUND

Nurses are often at the front line of the medication administration process and therefore have the potential to be the last measure against drug errors being committed. Conversely they are also in the prime position for committing medication errors themselves.

Work carried out by Wolf, Hicks and Serembus (2006) & Wolf, Hicks, Altimer & Bicknell (2009) suggest that medication errors committed by students are far more prevalent than originally thought. Schneidereith (2014) in a longitudinal study purported that students error checking processes deteriorated throughout their nurse education despite robust teaching and numeracy proficiency within the curriculum.

AIM

The aim of the project was to explore potential human factors that may contribute to this phenomenon, such as hierarchy deferral, through observation of student behaviour in response to an embedded medication error within a simulated environment

METHOD

A group of second year student nurses were presented with a scenario which included medication error checking and administration amongst other clinical activities.

The simulation contained an embedded error that if unchecked would result in an overdose of a controlled drug by a factor of 10.

The simulation was recorded and a facilitated debrief was utilised to support and continue the learning at the end of the simulation.

RESULTS & CONCLUSIONS

The embedded error was missed and there was no evidence of an error check used during the simulation and students concurred this during the facilitated debrief. Students recognised their own assumptions and how this could lead to near miss or potential fatality in practice.

The session resulted in pivotal learning for the group focused on the implications of accountability and deferral of responsibility. The experience helped contextualise theoretical seminars with learners being able to articulate and explore their own responses and behaviours to the situation and the implications this may have on their practice.

STUDENT RESPONSES

"It was eye opening that errors happen so quickly"

"I was a bit shocked actually, I never thought to check, it all appeared right"

"You asked me to give that (the injection) I would have been liable"

"I would have administered the medication if that had been my placement, I never thought anything of it"

"you just presume that because the nursing staff are qualified, they get everything right"

"It's made me realise that I need to be fully aware of the situation and equally active in checking and not assume that it is going to be right"

"If in doubt, you need to check again, or ask for more time"

"It made me realise that you need to speak up"

REFERENCES

Schneidereith T(2014),Using Simulations to Identify Nursing Student Behaviors: A Longitudinal Study of Medication Administration, Journal of Nursing Education • Vol. 53, No. 2, Wolf, Z., Hicks, R., Altmiller, G., & Bicknell, P. (2009). Nursing student medication errors involving tubing and catheters: A descriptive study. Nurse Education Today, 29(6), 681-688. Wolf, Z., Hicks, R., & Serembus, J. (2006). Characteristics of medication errors made by students during the administration phase: A descriptive study. Journal of Professional Nursing, 22(1), 39-51.

CONTACT   l.anderton@shu.ac.uk