INTIMIDATION AND MEDICATION ERRORS: STRATEGIES TO ASSIST UNDERGRADUATE NURSING STUDENTS

Kailee Burdick, DNP, RN, CNE

Donna Crawford, PhD, MSN, RN, CNE

INTIMIDATION & MEDICATION ERRORS

- Medical errors are a leading concern in healthcare today
- Adverse drug event (ADE) - harm to a patient resulting from a medication[1]
- Intimidation does not always have to be overt but rather can be more subtle such as with tone of voice or impatience[2]

SIMULATION

- N218 Pharmacotherapeutics students participate in a medication simulation that involves an unsafe dosage

- Sudden, acute pain
- Order given for 30 mg morphine IM STAT
- Requires rescue with naloxone

COURSE EVALUATION

- Survey used for program improvement to determine students perceptions regarding the medication order and feelings surrounding intimidation in the scenario
- About 65% of participating students (n=39) felt that something was wrong with the order for 30 mg morphine IM
- 90% administered the morphine
- 100% would like to repeat the simulation

HOW DO YOU ADDRESS INTIMIDATION?

- Simulation[3]/interprofessional work[4]
- Conflict resolution
- SBAR[5]

- Move concerns to a higher level[6]

FUTURE RESEARCH

- Survey future N218 Pharmacotherapeutics students
- Gather understanding of student perceptions regarding the simulated medication error and feelings of intimidation
- Work towards repeating the simulation in the future
- Provide students with intervention on how to approach intimidation in the clinical setting

REFERENCES

1. Agency for Healthcare Research and Quality. (2019). Medication errors and adverse drug events. Retrieved from https://psnet.ahrq.gov/primers/primer/23/medication-errors-and-adverse-drug-events
2. Institute for Safe Medication Practices. (2004). Intimidation: Practitioners speak up about this unresolved problem (part I). Retrieved from https://www.ismp.org/resources/intimidation-practitioners-speak-about-unresolved-problem-part-i
3. Bowling, A. (2015). The Effect of Simulation on Skill Performance: A Need for Change in Pediatric Nursing Education. *Journal of Pediatric Nursing*, 30, p. 439-446.
4. Latimer, S., Hewitt, J., Stanbrough, R., & McAndrew, R. (2017). Reducing medication errors: Teaching strategies that increase nursing students' awareness of medication errors and their prevention. *Nurse Education Today*, *52*, 7-9. doi: https://doi.org/10.1016/j.nedt.2017.02.004
5. Grissinger, M. (2011). Intimidation by superiors affects the safety of medical orders. *Pharmacy & Therapeutics*, *36*(9), 544-563.
6. Institute for Safe Medication Practices. (2008). Resolving human conflicts when questions when questions about the safety of medical orders arise. Retrieved from https://www.ismp.org/resources/resolving-human-conflicts-when-questions-about-safety-medical-orders-arise