

If To Err Is Human - To Distract Is Inhuman

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- **Problem:** What practice problem did you address and why is change needed?

Many efforts to decrease them had been tried and failed. Distractions and interruptions continue to be major factors in medication errors. Few people realize how inhuman it is to distract or interrupt nurses, thus contributing to the medication errors that occur. The nursing unit is susceptible to all sorts of interruptions and distractions. Nurses use their working memory to focus during medication administration, but distractions reduce this ability.

- **Evidence:** What evidence did you use to address the problem and how was it gathered and appraised?

The innovation was based on original dissertation research, and modified to fit these Hospitals. Medication errors were tracked by the Quality Department and relayed to the clinical services directors. Compliance with the protocol, rate of medication errors, and number of distractions were measured. These quality improvement studies were conducted in 2006, and 2007 at two different facilities. Results continue to be promising as the innovation has spread.

- **Strategy:** What strategy was used to link the innovation to the evidence?

The use of a special vest or sash was used as a strategy to reduce nurses' interruptions, distractions during medication administration, and decrease medication errors.

- **Practice Change:** What specific practice change was made (for quality improvement studies) or procedure evaluated (for research studies)?

A special vest or sash was used during medication administration. Nurses and staff members were educated about the procedure, and medication errors began to decrease.

- **Evaluation:** What outcomes were measured and how?

The number of distractions and medication errors was measured. Observations were conducted by 5 different individuals. They remained within 5-20 feet of the individual.

- **Results:** What did you find?

When compared to the first 6 months in 2006, there was a 47% decrease in medication errors during the second 6 months. In 2007, during the 3rd quarter, the only nurses interrupted or distracted were the nurses who failed to wear the vest or sash. Of those nurses (N=7), interruptions and distractions occurred 43% of the time.

• **Recommendations:** What recommendations do you have for practice? What lessons did you learn?

All hospitals should use this simple process to decrease interruptions and distractions, and thus reduce medication errors. The lessons learned are that simple inexpensive tools can be used to reduce medication errors and that through persistence organizational culture can be changed. Initially, the nurse did not know they were being monitored, but now they do know. Safety has become a personal issue for all staff and clinicians. One of these hospitals has been nominated for a Joint Commission Best Practice award.