Patient safety – our burden to cherish

A Nurses Day Message by Yolanda Walsh, Mediclinic Southern Africa

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I'm here today in celebration of our profession and our ability to keep patients safe despite the many risks.

I am a keen scholar in the science of patient safety and used to oversee the hospital events management system for Mediclinic Southern Africa. The HEM system is a database where all adverse events and near misses are captured, so that there is a record of them, but more importantly, patient safety incidents are captured, so that we can learn how and why they happened in the first place.

The self-chosen title of this message is *Patient Safety – Our Burden to Cherish*. It seems like a contradiction – how can you possibly cherish a heavy load? But isn't this something that you do every day? You protect and care for a multitude of patients – lovingly and with the knowledge that the treatment plan may carry risks and that at any moment something can go wrong. I appreciate this now more than ever, especially because I miss being a comforting presence and interface at a patient's bedside.

If my husband wants to ruffle my feathers, he just needs to jokingly refer to me as an "admin nurse" – as opposed to a "real nurse" – the one who worked the long shifts, experienced the phenomenal highs and lows of patient care, and felt a family's joy and sorrow as if part of it.

The "admin nurse" jibe really hits home when I make a mistake or an error. In my position at Mediclinic's corporate office, a mistake or slip results in an email being sent to the wrong recipient, or omitting a person from an invitation to a regional workshop. How does this compare with similar errors, slips or lapses that I made as a nurse while working with patients? I have a list of errors that I can remember as clear as daylight and these include:

- As a second year student nurse administering a digoxin dose 5 times the prescribed dose
- As a third year student nurse working in a community healthcare clinic manning the sexually transmitted diseases clinic unsupervised and prescribing the wrong antibiotic to a pregnant patient
- As a newly qualified RN working her first month in ICU preparing to turn and wash a critically ill patient with ARDS by increasing the oxygen flow on the ventilator to 100 instead of turning the oxygen concentration to 100
- As a hurried and distracted shift leader who doubled the dose of dobutamine in a 200 ml saline IV (checked with a second RN), but then forgot to halve the rate

Why do I have a list and why can I remember them so clearly? Each one of them is associated with the same sinking feeling, the same intense guilt. I berated myself over my 'stupidity' and suffered countless sleepless nights. I also remember (as if yesterday) the courage it took to inform my supervisor and the treating doctor.

It is important to acknowledge that we are human and we make mistakes. Yes, nurses are human, despite being angels in comfortable shoes! Acknowledging our fallibility upfront is critical to improving patient safety and truly committing to designing work environments which limit the likelihood of error.

We all make mistakes – the types of mistakes just differ. When we are inexperienced, we tend to make knowledge-based mistakes and as experienced practitioners, we are more likely to have attention slips or lapses of memory.

I'd like to come back to the difference between my recent errors and the errors I made in the past as a clinical nurse.

Email being sent to the wrong recipient – how is this different to a drug being given to the wrong patient? Omitting a person from an invitation to a workshop – how is this different to omitting a patient on a medication round?

I see the difference as two-fold – when I make an error in my current position, it does not reach a patient directly. Unfortunately, when you make an error, the person affected is often a patient – and the result is often harm – whether transient or with lasting effect. Nurses also remain accountable to patients – especially for our acts and omissions. And this is why patient safety is a burden – but a burden to cherish because very few professionals have the privilege to serve as you do – your everyday interactions make a difference in countless people's lives.

There are some individual factors which predispose healthcare workers to errors; these include fatigue, stress, hunger and illness. It is important to monitor yourself – pay attention to whether you are **H**ungry, **A**ngry, **L**ate or **T**ired (the mnemonic **HALT**) – you are more likely to make an error under these conditions. Remember that self-care is critical in being able to care for others safely. This quotation comes from a little book titled *When I loved myself enough* – "When I loved myself enough I learnt to meet my own needs and not call it selfish" – this includes having a tea break; taking time to have your lunch; not working more than what you are able to cope with and making sure that you do have 'me' time.

I'd like to finish off with three additional suggestions for improving patient safety from our chief clinical officer – Dr Stefan Smuts:

1. Always be on the lookout for anything that might indicate that something is going wrong....and when it does...react quickly and with the necessary urgency .
2. When things do go wrong, or you have identified an error, call for help early on (it is always better to deal with a false alarm as a team than with a total disaster on your own).
3. Always report your errors and be prepared to learn from them and to share these lessons with others.

And with the last point in mind, I'd like to share the following sweet poem entitled

So You Made a Mistake (by Louise Hernan)

I realise you're feeling badly
And would like to turn back time
To undo something I know
Has been staying on your mind

So you made a mistake – you're human!
No more – no less than that
Nobody here is perfect
And you need to give yourself slack
To live and to learn isn't easy
But that's what we all have to do
There really is no way around it

Not even for nice people – like you!

Today celebrates your work ethic, your kindness, thoughtfulness and amazing commitment despite the days or nights being long. Take time to reflect the work that you do and the impact that you have. Patient safety may be a burden – but it is a burden to cherish.

I hope you have a wonderful day of celebration.