Nurses Are Critical to Patient Safety

Many people believe that doctors oversee a patient’s care, but it’s the nurse that does so, continually assessing a patient’s condition and interacting with all members of the patient’s health care team. Of all the members on this team, “nurses play a critically important role in ensuring patient safety by monitoring patients for clinical deterioration, detecting errors and near misses, understanding care processes and weaknesses inherent in some systems, and performing countless other tasks to ensure patients receive high-quality care” (Patient Safety Network, 2016, para. 1). Nurses are the key to maintaining and improving patient safety.

Factors Affecting Patient Care and Safety

There are many factors influencing how nurses care for their patients, and a nurse’s work environment plays a large part in how a patient is cared for and how safely it is done. Consider these points:

• Too large a number of patients to care for eventually compromises the nurse’s ability to provide safe and effective care. Since careful monitoring of each patient is required to ensure patient safety, having too many patients can lead to errors.

• A nurse’s educational level, their skill mix, and the quality of their on-the-job training may also affect patient outcomes (Patient Safety Network, 2016).

• Fatigued nurses working longer shifts and overtime have an increased chance of error; exhaustion can cause distraction and poor decision making which can adversely affect patient safety.

• Patient care is by nature “high-intensity” and because of this, nurses are at risk of committing errors while providing routine care. Interruptions are a part of a nurse’s job and have been tied to an increased risk of errors, particularly medication administration errors (Patient Safety Network, 2016).

• Some errors result from flawed systems that do not allow for adequate checks, and many come from a culture that can leave nurses powerless to intervene when doctors or others commit errors (“Nurses are key,” 2011).

These points illustrate how a nurse’s day-to-day patient load, skills, training, effectiveness, and work culture can impact patient care and safety.

Failures and Errors Affecting Patient Safety

“The kinds of errors that both involve nurses in some way and endanger patients cover broad territory. This territory spans “wrong site, wrong patient, wrong procedure” errors, medication mistakes, failures to follow procedures that prevent central line bloodstream and other infections, errors that allow unsupervised patients to fall and more” (“Nurses are key,” 2011, para. 4).

Some failures and errors which adversely affect patient safety include:

• Medication errors are "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer. Such events may be related to professional practice, healthcare products, procedures and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use” (Mckay, n.d.).

• Communication failures between healthcare providers are one of the most significant contributing factors in medical errors. They are more likely to occur during transition periods, such as change of
shift report. Additionally, poor communication between healthcare providers, patients, and caregivers can lead to safety issues, and previous negative interactions experienced by a nurse may cause them to be unwilling to clarify discrepancies. Language barriers between healthcare providers and patients can also contribute to communication issues and errors (Mckay, n.d.).

- Care provider workarounds (measures that bypass safety processes) increase errors; a workaround should signal the need for workflow process analysis. Nursing leadership is essential in creating workflow processes and environments that prevent and reduce errors. Lack of leadership in the area of safety may limit an organization’s effort to identify risk and implement effective preventative strategies (Mckay, n.d.).

- Healthcare providers who work longer than 12.5 hours have decreased productivity, are three times more likely to commit a patient care error, and suffer higher rates of occupational injury (Mckay, n.d.).

- Organizational cultures should not punish error reporting, investigation, and mitigation. The need for proactive, non-punishing approaches to patient safety is critical to establish and maintain a culture of safety within healthcare organizations (Mckay, n.d.).

- Unsafe physical environments can cause safety issues for both patients and nurses. Water or fluids on the floor can cause falls and injury, and poor lighting can affect nurse effectiveness while performing critical tasks.

**What Can Nurses Do?**

To help ensure their patients’ safety, nurses need to stay focused on the patient in front of them and the task at hand, especially when administering medications; follow hand washing hygiene guidelines; check at least two patient identifiers when providing care, treatment, and services; develop good communication skills and the ability to listen; and use translators when speaking with patients who don’t understand English well. Nurses also need to support and advocate for a culture of safety in their workplace. By doing these things, nurses can positively affect their patients’ safety and ensure the quality of care the patients deserve.

According to McKay (n.d.), some strategies to decrease medication errors include: adhering to the eight rights of medication administration (right patient, right drug, right dose, right route, right time, right documentation, right reason and right to refuse); minimizing distractions when preparing and administering medications; integrating technology at specific steps in the medication administration process to decrease medication errors; avoiding established do not use abbreviations; using specific protocols for high-risk drugs; and encouraging healthcare providers to document indication for drug use on prescriptions.

**The Bottom Line**

Nurses play a critical role in patient safety. They must see it as a core value and their primary mission, they need to recognize situations where they may be vulnerable to unsafe practices, and they need to stay focused on the patient in front of them and the task at hand. Nurses must support and advocate for a culture of safety in their workplace and collaborate with other healthcare providers in a culture where they are provided with opportunities to question inconsistencies, report errors, and participate in safety improvement strategies.

Patients deserve the safest care possible, and nurses want to provide them with it.

**References**

