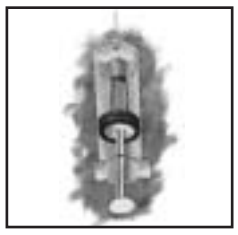

Importance of Patient and/or Family Involvement in Patient Safety

Christine Koczmara

Recalling my many years of nursing experience with listening to patients and families, discussions with health-care colleagues, and most recently working for ISMP Canada has provided me with further insight into the invaluable role that patients and families can play to avert errors, including adverse drug events. Often, the last opportunity to avert harm to a patient occurs at the patient's bedside. Here are a few examples to illustrate this point.

An elderly demented patient was to receive 3 units (0.03 mL) of insulin and the newly graduated nurse drew up 3 mLs of insulin (100 times the ordered dose). Although the patient was very confused, the patient questioned the nurse as to the amount of insulin they were injecting. Unfortunately, the nurse did not pay much attention to the patient and injected the insulin overdose. The patient became comatosed and required admission to the intensive care unit and eventually died.

In another case, which had a fortunate outcome, a nurse intending to flush an intravenous lock with normal saline took a vial of potassium chloride concentrate in error to the patient's bedside. At the bedside, the patient's common practice was to take an active role in their treatments and medications administered and thus questioned the nurse as to why the nurse had a purple vial in hand instead of the usual yellow coloured vial. (Normal saline and potassium chloride concentrate comes in nearly identical looking vials: the normal saline vial is highlighted with a yellow colour and the potassium chloride is highlighted with a purple colour. Normal saline is commonly used for the flushing of intravenous locks whereas potassium chloride concentrate should NEVER be used undiluted and has resulted in a number of accidental fatalities). The nurse was very thankful that the patient had questioned her as it not only saved the patient's life, but also averted a life-threatening error that the nurse, family and others would have agonized with.

Recently, a nursing friend shared with me her own experience, which involved the importance of listening to family members. A diabetic patient, that she was caring for, was on an insulin sliding scale: insulin was administered at preset times according to the patient's blood sugar and physician's corresponding insulin dose. While working an evening shift, a visiting family member questioned whether the patient was having an insulin reaction because of a certain "look" that the patient had that the family was familiar with when the patient's blood sugar was low. The insulin had been administered as ordered and the patient had been stable on this insulin scale for many days. Furthermore, the nurse did not notice any change in the patient's condition or signs that might have indicated the patient was experiencing low blood sugar. The patient exhibited no tremor, fast heart rate, or sweating. The patient, however, was on metoprolol, a beta-blocker commonly used for the treatment of angina that would have masked such clinical signs. Fortunately, the nurse listened to the family member and did a glucometer check and found that the blood sugar was only 1.9 mmol/ L (normal blood sugar being 4 to 6 mmol/ L). The patient was administered intravenous concentrated dextrose to treat the low blood sugar (an adverse event) and prevent harm to the patient. The nurse was very grateful to the family member for bringing the situation to her attention. She could only imagine what the blood sugar might have been and what could have happened to the patient had the blood sugar been taken two hours later, as scheduled.

I know many nurses, including myself, who have had similar opportunities to be thankful to patients and families that have brought forth their wisdom with questions and concerns about medications and treatments that they were receiving. Such valuable examples have served to increase my belief further that patients and family members can contribute greatly to safe medication practices.

Patients and family should always participate in the whole patient care process including the administration of medications. They, or their family, should learn and understand the names of their medications, shape and colour of the medication, as well as the frequency of their administration. In addition, patients should request that health-care providers check their armband against medication administration records prior to being given any medications. Even with outpatients that come in for regular treatments such as chemotherapy, patients should insist on such an identification process before any medications or treatments are received to ensure their own safety and wellbeing.

Health-care workers should embrace the patient and their family into the patient safety and medication safety processes. With the delivery of healthcare becoming increasingly challenging and complex and inevitably adding to the stressors of our work (e.g. shortage of professional staff, increased workloads related to higher patient acuity, ever-increasing new technology, new drugs, more complicated drug protocols), the patient and/or family's involvement can be an invaluable asset. Any questions raised related to patient safety should not be seen as a lack of trust but rather as a necessity in keeping patients safe. We must always remember that in many cases the questions raised by the patient and/or family regarding medications administered can serve as the last and best defense in preventing serious medication errors from occurring.

Christine Koczmara is a Registered Nurse who is on staff at ISMP Canada.

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