Discussion: Workarounds and Their Implications for Patient Safety

A. What is a workaround? Identify a workaround (specific to technology used in a hospital setting) that you have used or perhaps seen someone else use, and analyze why you feel this risk-taking behavior was chosen over behavior that conforms to a safety culture. What are the risks? Are there benefits? Why or why not?

B. Discuss the current patient safety characteristics used by your current workplace or clinical site. Identify at least three aspects of your workplace or clinical environment that need to be changed with regard to patient safety (including confidentiality), and then suggest strategies for change.

Week 4: Workarounds and Their Implications for Patient Safety

Hi Everyone,

A workaround is a bypass of a recognized problem or limitation in a system. A workaround is typically a temporary fix that implies that a genuine solution to the problem is needed. Or it can be defined as shortcuts or ways to bypass troublesome technology. Placing pressure on a workaround may result in later system failures (McGonigle & Mastrain, 2015).

One of the technologies used in the hospital setting for Workaround is computerized providers order entry (CPOE). This is a process whereby medical professionals enter medication orders or other physician instructions electronically instead of a paper chart. A primary benefit of CPOE is that it can help reduce errors related to poor handwriting or transcription of medication orders. But in some cases, nurses work around by beginning medication work based on the notes they took during medical rounds from other health workers. The nurse's intention for this risk-taking behavior is to save time, but such behavior can cause more harm than good. It is not appropriate to use the information we got from a previous shift or during rounds to administer medication to a patient. For example, due to patient familiarity, some healthcare workers administer medication without looking at the patient chat which is wrong. We need to check every patient's chat before giving any medication and call for clarification if needed. We need to check the patient vitals prior to administering a blood pressure medication. We need to assess or recheck our patient as needed and at the beginning of every shift. If nurses are chatting what they did not do, this can impact the computerized provider's order entry (CPOE) negatively. It can affect patient outcome and harm patient or even cause death. However, if computerized provider order entry (CPOE) is used properly it can help reduce errors related to poor handwriting or transcription of medication orders (Debono et al, 2013).

The term patient safety is defined as a discipline that emphasizes safety in healthcare through the prevention, reduction, reporting, and analysis of medical error that often leads to adverse effects. The patient safety roles used in my current workplace or clinical site are as follows: Paper shredder to protect personal information. Proper disposal of needles in the sharps container to avoid sticking other people. Proper use of PPE to prevent the spread of disease. The use of the isolation protocol to prevent the spreading of disease. There are various aspects of the workplace or clinical environment that need to change regarding patient safety. Healthcare management should review policies and agency regulation with caregivers at least once every month to ensure the safety of the patient. Proper in-service should be conducted at least once a month or after an error has been noted in the workplace environment. To decrease medication error, it will beneficial to review policy for the administration of medication when the patient's armband is not effective. In addition, cultural safety is very important in all healthcare environment. It very vital that healthcare providers be culturally competent when caring for patients, for this will greatly increase the patient outcome and nurse relationship. Finally, patient safety and confidentiality must be made a priority in the clinical setting. Healthcare workers need to acknowledge patient's right when providing care because this will help eliminate most common error in the workplace.

References

Debono, Greenfield, Travaglia., Long, Black, Johnson., & Braithwaite. (2013). Nurses' workarounds in acute healthcare settings: a scoping review. *BMC Health Services Research*, *13*, 175. http://doi.org/10.1186/1472-6963-13-175Links to an external site. (Links to an external site.)Links to an external site.

McGonigle, D., & Mastrian, K. (2015). *Nursing informatics and the foundation of knowledge* (3rd ed.). Burlington, MA: Jones & Bartlett.

Unit 4: Workarounds and Their Implications for Patient Safety

1. **What is a workaround? Identify a workaround (specific to technology used in a hospital setting) that you have used or perhaps seen someone else use, and analyze why you feel this risk-taking behavior was chosen over behavior that conforms to a safety culture. What are the risks? Are there benefits? Why or why not?**
2. **Discuss the current patient safety characteristics used by your current workplace or clinical site. Identify at least three aspects of your workplace or clinical environment that need to be changed with regard to patient safety (including confidentiality), and then suggest strategies for change.**

- Collapse Subdiscussion
- Marissa Dopp
  - **Marissa Dopp**
    Jun 16, 2019
  - Local: Jun 16 at 7:52pm
Course: Jun 16 at 6:52pm
  - Manage Discussion Entry
- Hello Class,
  I look forward to this weeks discussion focused on workarounds and their implications for patient safety. Please be sure to address all aspects of the question in your initial post.
  As a reminder:
  You are required to post a minimum of two substantive posts in each graded discussion.
  These two posts must be on 2 separate days.
  The first post in each graded discussion must be completed by Wednesday, 11:59 p.m. Mountain Time (MT).
  Week 1-7 discussions must be completed by end of week, Sunday, 11:59 p.m. Mountain Time (MT).
  For credit, you can start posting on Sunday of each week.