

WHAT COULD HAPPEN: The Consequences of “Practice Drift”... Is It Worth the Risk?



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Purpose:

To assist nurses in understanding and identifying practice drift and how to eliminate/mitigate effects.

Objective:

1. Explain “practice drift.”
2. Recognize factors that contribute to the occurrence of “practice drift.”
3. Discuss the impact of “practice drift,”
4. Create a plan to eliminate and decrease “practice drift.”



Have you ever...

1. Deviated from the procedure for safe medication administration?

- administered a medication prior to obtaining an order from a provider because you “knew” what the physician would order;
- borrowed a medication from another patient or used STAT orders to override the system as a workaround to bypass slow pharmacy services;
- administered a pain medication without completing a pain assessment because you were in a hurry;
- prepared medications simultaneously for more than one patient

because you were pressed for time and/or you were trying to save a few steps;

- carried medications in your pocket and wasted them at the end of the shift because there wasn't anyone available at the time to serve as a witness;
- signed as a witness to a narcotic medication waste you did not observe because you trusted your co-worker;
- left a patient's medications on the bedside table because he/she was on the phone;
- failed to check 2 identifiers when administering medication because you were in a rush;

- failed to scan the bar code on a medication because the scanner wasn't working;
- made assumptions when orders were incomplete or were illegible because you didn't want to bother the provider; or,
- hidden away unused medications from discharged patients for administration to other patients if needed in the future to avoid delays.

2. Neglected a patient?

- failed to perform an assessment or treatment because the patient was sleeping;
- silenced a piece of equipment (bed alarm, IV pump, cardiac monitor, etc.) because it kept alarming for



- no apparent reason and you felt it was disturbing the patients; or,
 - failed to complete the “time out” in surgery because the surgeon was upset with how long it took to set up for his/her patient.
3. *Failed to maintain an accurate patient medical record?*
- pre-documented an assessment or care delivered to save time because the information was always the same;
 - pre-documented medication administration because you knew you would not have time later; or,
 - waited until the end of the shift to document all assessments and care rendered because you didn't have time during the shift to get it done.
4. *Breached a patient's confidentiality?*
- out of curiosity, looked up information on a patient you were not assigned to provide care;
 - posted pictures or comments about patients or family members on social media;
 - discussed patient information in a public setting (e.g., elevator or cafeteria) or commented on a patient's condition to another patient or family member.
5. *Exceeded scope of nursing practice?*
- acted outside your scope of practice by writing “verbal orders” without actually speaking with the provider, believing they would be signed off at next rounds; or,
 - performed a procedure that was outside your scope of practice (e.g., rupturing membranes to induce labor) because the provider instructed you to do so.
6. *Inappropriately delegated a task to an unlicensed staff member?*
- directed a nurse aide (not appropriately educated and validated competent) to administer a medication or perform a simple dressing

- change because you were busy with another patient; or,
 - allowed unlicensed personnel to make assignments and delegate patient care tasks to others.
7. *Accepted an assignment when you knew you were not fit for duty?*
- worked while so fatigued that you were nodding off to sleep because you agreed to work an extra shift at the request of your manager; or,
 - worked an early shift while still “hung over” from a party that ended only a few hours before.

Chances are you have done some of these yourself, or if not, you have worked with someone who has! The multiple “at-risk” behaviors listed above all describe “practice drift.” The term “practice drift” is another way of describing a “work-around,” “shortcut,” or “rule-bending” done in order to accomplish an immediate goal, to meet a perceived expectation of another, and/or to promote efficiency (Collins, 2003). All of these incidents are types of practice violations which the NC Board of Nursing has investigated. Thankfully the vast majority of these incidents did not result in serious negative patient outcomes but each incident represents a “drift” from the standard of care and has the potential to jeopardize patient safety.

STOP READING: Make a list of work-arounds, shortcuts, and rule-bending in your practice setting. What variations from standards of practice or policies and procedures have you witnessed? Which variations have you used? How often does “practice drift” occur in your practice and that of your co-workers?

Behavioral research has shown that all humans are mentally programmed to drift into unsafe habits, to lose perception

of the risk attached to everyday behaviors, or to mistakenly believe the risks taken to be justified. Decisions about what is important on a daily list of tasks are based on the immediate desired outcomes and over time, as perceptions of risk fade away, individuals try to do more with less and take shortcuts, drifting away from behaviors they know are safer (ISMP, June 2012).

Articles published by the Just Culture Community, have identified “at-risk” behaviors as the most common of the 3 types of errors (human, at-risk, reckless). Marx of Outcome Engineering (2005) explains,

“We all tend to lose perception of the risk attached to everyday activities, or mistakenly believe in some situations a risk is justified. Often our decisions to circumvent an evident or perceived workflow hindrance are based on immediate outcomes (time saver) in order to meet a goal or to achieve it more readily and do not consider the potential or uncertain consequence (patient harm) which is more remote.”

Studies have shown that once you have bent the rules and had a favorable outcome and/or a positive response from your peers and supervisors, you are likely to be tempted to do it again (Collins, 2003). If left unquestioned, the rule-bending action then tacitly becomes acceptable practice not only by that individual but may be adopted by others in the unit or facility and many times leads to what is referred to as a “cultural norm.” However, work-arounds and rule-bending are often just temporary fixes for bigger problems in the system and do not promote an environment supportive of safe patient outcomes.

STOP READING: Go back to your “practice drift” list. For each variation, list the reason(s) for those variations. Why do you and your co-workers use these work-arounds and shortcuts and bend established rules? What are you trying to achieve? What problems in the system or environment make it seem necessary to use these approaches?

Consider the following scenario:

Megan, a newly-employed Registered Nurse in the Operating Room of a small rural hospital, was assigned to circulate with another experienced nurse on a surgical case for Dr. S, a very impatient surgeon. The set up for the procedure was taking longer than expected because a specific piece of equipment that had been requested the day before could not be located. Dr. S voiced his frustration and threatened that he would cancel the surgery and “start taking his surgeries elsewhere” as they were never ready and always caused him to be behind in his schedule. The nurses rushed to finish the set up and due to the delays the experienced nurse instructed Megan that they would forgo doing the required “time out” to verify the patient, procedure, site, allergies, and antibiotics administered. Megan voiced concerns but was assured this was “common practice” for this surgeon to keep him happy as you never wanted to be on his bad side.

This example demonstrates how “practice drift” became a “cultural norm” for this facility. Based on extensive studies and the patient safety literature, the risk severity potential of omitting the “time out” procedure was high, but the probability of incident was incorrectly perceived by the nurses to be low as there had been no reports of wrong patient or wrong site surgeries in this hospital. The decision drivers

to “work-around” the rule included the intimidation the nurses felt due to the surgeon’s threats, the nurses’ desire to make up for lost time, and the time delay caused by the lack of preparedness in failing to verify the day before that the equipment was available. As described in this example, it is likely that this cultural norm will be perpetuated by the new nurse for whom this was identified as acceptable behavior. In addition, this cultural norm was reinforced again for all the nurses by the lack of untoward outcomes in this case.

STOP READING: Go back to your “practice drift” list. Highlight those variations that have become “cultural norms” in your setting. Is this “practice drift” so common that it is used routinely by all nurses? Is it used only by some of the nurses? If so, why do the other nurses not use these approaches?

Dr. Van Sell (2012), noted that nurses will engage in a reasoned, intentional rule bending behavior to solve an immediate problem and not realize the potential negative consequences. Factors such as staffing levels, patient acuity, workload, time constraints, interruptions/emergencies, lack of access to providers, lack of input in design of workflow and procedures, familiarity and trusting relationships with providers, and lack of proper working equipment/supplies/medications are just some of the challenges nurses face every day when trying to do what needs to be done to provide effective patient care.

Work-arounds develop in response to factors that:

- are perceived to prevent or undermine nurses’ care for their patients;
- are not considered in the best interests of the patient;
- make performance of their job difficult; or

- potentially threaten professional relationships.

Now, can you identify “practice drift” in the following scenario?

Cindy, a Licensed Practical Nurse, has worked on the evening shift in a long term care skilled nursing facility for a number of years. The facility does not have an on-site pharmacy; therefore, all ordered resident medications are obtained from a pharmacy in a neighboring town. On the date of this incident, a new resident was transferred from the hospital to Cindy’s unit. They were understaffed, which was not an uncommon occurrence on that unit. That evening Cindy was falling behind with all the tasks she was assigned to complete. She completed the admission assessment but failed to review the orders. The Unit Secretary transcribed all the medication orders onto the Medication Administration Record (MAR) for Cindy to verify. Cindy was preparing to do her first medication pass for the shift. She took the Medication Administration Record (MAR) without verifying the orders because she had no doubts that it was accurate. She proceeded to pre-pour all scheduled medications for all residents for the entire shift and place them into individual baggies which she labeled with the residents’ room numbers. At the same time, she documented that all medications poured had been administered at the times noted in the MAR. She believed these practices to be safe. She had worked with these residents for a long time and knew who they were as well as what medications they took. Throughout the shift, she completed the medication passes which she had pre-poured and pre-documented.

The new resident had an order for an oral antibiotic which had not been delivered. Cindy knew another resident on the unit was taking this same medication so she “borrowed” one dose because she didn’t have time to wait on the pharmacy. She failed to check the new resident’s allergies, thus failing to see that there was a documented allergy to the antibiotic she had

administered. The resident had an allergic reaction resulting in the resident having to be transferred back to the hospital.

While trying to take care of the transfer arrangements for the above resident, a nursing assistant (who is currently in nursing school) informed her that another resident was requesting her pain medication. Cindy reviewed the MAR and noticed the medication was ES-Tylenol. She poured the medication and handed it to the nursing assistant directing her to take it to the resident. In addition, a nurse arrived at 8:30pm to assist with medication administration but left and went back to her own unit when she reviewed the MAR and saw all medications had already been administered through 10:00pm doses. The relief nurse reported to the supervisor that there was a discrepancy related to medication administration.

The above scenario involved multiple “practice drifts.” How many did you find?

- Insufficient staff on the unit contributed to Cindy’s decisions to “cut corners.” She did not request assistance because she “knew” it would not be available, leaving the supervisor unaware of the unit status.
- She rationalized that she did not have to check the orders and MAR because she trusted the secretary and believed she would not make an error in transcribing.
- She failed to consider that the unit secretary was not educated in clinical nursing and pharmacology and would not likely identify the problem between the resident’s allergies and the medication ordered.
- In her rush to complete the medication pass, she omitted the safety

check of reviewing the allergies as well.

- Instead of waiting on the pharmacy or calling to see why the resident’s medications had not been delivered, Cindy decided to bypass policy and borrow the medication from another resident. Had she called the pharmacy she would have been informed that there was a question regarding the order. This third safety mechanism would have prevented an error.
- Cindy believed that pre-pouring all the medications at once would save her time and be more efficient. Because she knew the patients, she believed that she could label the baggies with room numbers only. She chose to ignore all patient safety policies and procedures.

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- Cindy’s decision to pre-document all the medications that were scheduled to be administered on her shift ultimately resulted in confusion as to what medications had been administered when another nurse came to assist. Notification of the supervisor resulted in an internal investigation into Cindy’s medication administration practices and resulted in a report to the Board. As a result of this action, Cindy’s credibility was called into question causing her employer to question if she falsified patient records routinely.
- Finally, Cindy inappropriately delegated medication administration to an unlicensed nursing assistant. This, too, was a violation reported to the Board.

Ultimately, Cindy’s actions on this shift demonstrated extreme “practice

drift.” Her overall intent was to provide the best care possible with limited resources. However, the time Cindy thought she was saving by using short-cuts, bending rules, and implementing work-arounds, resulted in compromised patient care, damage to her professional reputation and credibility, a potential loss of her job, and a potential sanction of her nursing license.

It is not uncommon for any one of us, when faced with having to do more with less or when pushed for time, to find ways to use work-arounds and take shortcuts. In a busy work environment, particularly one that is understaffed, rule-bending may seem like the only solution. But none of these influence substantive change and they only provide a temporary fix when what is needed is a change in the underlying condition that made work-arounds, short-cuts or rule bending necessary.

“Practice drifts” operate as adaptations to inefficiencies and have the potential to both subvert and augment patient safety. Occasionally, workarounds operate as localized acts of resilience, are at times crucial to the delivery of services, place the patient’s best interests at the forefront, operate as adaptations to inefficiencies, and provide opportunities for improvement. When operating in this manner, they are used as unique, short-term solutions and the opportunities for improvement are immediately addressed. More frequently, however, because rule-bending, work-arounds, and shortcuts circumvent safety blocks, mask environmental and operational deficiencies, and undermine standardization they have the potential to jeopardize patient safety as well as your career. When a patient is injured because you deviated from the standard of care, there is little defense to be found (HPSO, 2016).

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Rules: we can't live without them, but there is probably not a day goes by when we don't break or bend one. Rule-bending, work-arounds, and shortcuts are all reflective of the "practice drift" used to achieve specific outcomes. They often seem like the only solution to fixing what is wrong. They become part of the culture and the need to identify and address the root cause of the issue is hidden. We fail to see that we have institutionalized a temporary, inadequate fix. In many cases, it is not until an adverse event requires deeper examination that the underlying conditions that led to unsafe "practice drift" are identified.

Nurses, according to the Gallup Poll, have ranked as the most trusted profession for the last 14 years (ANA, 2015). Nurses strive to do a good job and to provide safe, effective care. We strive to identify more efficient ways to accomplish effective outcomes. Unfortunately, once we get comfortable in doing something, our practice may begin to drift in an attempt to find ways to accomplish more with less or to do something "faster" or "better." We lose sight of the risk inherent in the resulting deviations from established standards of care, policies, and procedures. We assume that risk through the behavioral choices we make. When a patient is injured because we deviated from the standard of care, we bear that responsibility.

The NC Nursing Practice Act (Law) and Rules provide clear direction concerning the variables that determine the responsibilities or assignments that can be safely accepted by an RN or LPN. Likewise, specific criteria designate considerations when assigning or delegating to others. Nurse manager and administrator responsibilities for staff, unit environment, and nursing systems are also spelled out.

STOP READING: Explore the NC Nursing Practice Act (<http://www.ncbon.com/dcp/i/laws-rules->

[nursing-practice-act-nursing-practice-act](http://www.ncbon.com/dcp/i/laws-rules-administrative-code-rules-administrative-code-rules)) and Administrative Code Rules (<http://www.ncbon.com/dcp/i/laws-rules-administrative-code-rules-administrative-code-rules>) to identify sections relevant to this discussion.

All nurses must strive to uncover and address the underlying causes of rule-bending, work-arounds, and shortcuts to affect substantive change. Nurses, nurse managers, and administrators must work together to identify and address the underlying issues in each work environment – both chronic and acute – which influence "practice drift." Nurses must speak out to identify the "practice drift" they and their peers are using; specifically identify the underlying reasons: short staffing, inadequate supplies, unresponsive pharmacy services, inadequate education, etc.; and collaborate with managers and administrators to identify effective, evidence-based solutions. It is essential that safe solutions to underlying problems be implemented. Patient safety and well-being is the ultimate shared goal.

NOW: Go back to your "practice drift" list and make a plan to address at least one variation! How will you alter your own practice to move away from at-risk behavior? How will you communicate the risks of "practice drift" to your co-workers? How will you address the underlying system changes with your manager and administrator?

IN THE FUTURE: Prioritize your "practice drift" list and address one at a time. Enlist support and involvement from your co-workers and manager. Patient safety and well-being is your ultimate shared goal!

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