Maintaining Patient Safety in the Midst of Staff Reductions

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**Problem:** A pharmacist is working alone in a busy hospital pharmacy. He receives a stat order for oral clonidine (e.g., Catapres®, Boehringer Ingelheim) 1 mg and levodopa (e.g., Laradopa®, Roche) 125 mg for a growth hormone stimulation test to be performed on an eight-year-old child. Despite significant pressure from the order and a backlog of work, the pharmacist, who is unfamiliar with the test, takes time to do some research on the topic and discovers that the correct test dose of clonidine for a pediatric patient is 0.15 mg/m². After he calls the physician, the order is changed to clonidine 0.1 mg.

Unfortunately, even successful outcomes, as in this example, are not always appreciated if productivity is sacrificed to enhance patient safety. Nevertheless, numerous errors, reported through the U.S. Pharmacopeia–Institute for Safe Medication Practices (USP–ISMP) Medication Errors Reporting Program, have resulted when practitioners felt pressured to place productivity above patient safety, especially when they were faced with inadequate staffing.

Coping with a reduced number of employees is a harsh reality in health care. Whether the situation is a result of cost-containment decisions to cut staff, unexpected absences, or difficulty in filling open positions, inadequate staffing fosters stress and increases the potential for errors. Compounding the problem, administrative actions that result in reduced staffing send an unspoken but clear message that crucial decisions should be based on productivity. As a consequence, critical tasks—such as redundancies and other standard error-reduction strategies—are often sacrificed to increase productivity, thereby resulting in weakened defense systems. Even under the best of conditions, practitioners must constantly choose between productivity and patient safety. With the added burden of inadequate staffing, they face an enormous dilemma while trying to cope with a difficult balancing act. When an error occurs, the actions of practitioners can unintentionally appear as a poor gamble and a disregard for patient safety.

**Safe Practice Recommendation:** Organizational leaders and individual practitioners share equal responsibility in protecting patients from harm. For instance:

- Leaders must make safety an explicit goal. They need to understand that there can be a fundamental incompatibility between productivity and safety, and they should emphatically reinforce the message that safety should not be sacrificed for the sake of productivity.
- Before any staff reductions are initiated, leaders should allow front-line practitioners to redesign processes to eliminate some production work (but not safety work), such as independent checking systems and other primary safety functions.
- Surveying practitioners intimately involved in the processes can sometimes help to identify both formal and informal safety practices to ensure that all critical defenses remain intact.
- Internal data and research in the literature regarding the relationship between patient outcomes and staffing levels should also be openly discussed and considered during the process redesign.
- To enhance patient safety in the event of unexpected staff absences, realistic contingency plans should be established and implemented. When individual practitioners or managers believe that safe care is not possible, they should immediately notify more senior managers; they should describe the problem in terms of quality and safety and should suggest actions to reduce risks, such as triaging phone calls, delegating tasks within the scope of practice, and redeploying qualified staff. The superior’s response to these safety concerns and the actions taken should be documented later to maintain evidence in case of an adverse event and to facilitate review and learning within the organization.

With continually shrinking reimbursement systems and shortages of specially trained and experienced personnel, staffing levels are unlikely to improve soon. Yet perhaps the effects of reduced staffing have fostered a much-needed multidisciplinary approach to minimizing errors. Reduced staffing has forced us to acknowledge our professional interdependence and the need for collaboration among physicians, pharmacists, nurses, and patients. We must work together to create safe care for the system as a whole instead of working within individual disciplines, departments, or units. In the face of reduced staffing, effective adaptations to enhance safety must emerge from new strategies or novel combinations of safety measures that have previously been performed separately within the various professions.

The good news is that some change is already evident. We are now more likely to see physicians who might delay elective admissions of patients because of temporary staffing inadequacies; clinical pharmacists and patients who will participate in independent checks before drugs are administered; and nurses who can minimize disruptions by prioritizing service calls to the pharmacy.

**References**