



Medication Errors

A Nurse's Worst Nightmare

BY GENEVIÈVE M. CLAVREUL, RN, PHD

BY NOW MANY READERS are aware of Nurse Julie Thao and the tragic death of an expectant mother at St. Mary's Hospital in Madison, Wisconsin. For those who aren't, let me provide a very brief synopsis gleaned from news reports.

On July 5, 2006, 16-year-old Jasmine Gant was admitted to St. Mary's for delivery. The labor was complicated by infection, so Thao, an experienced L&D nurse, removed an epidural anesthetic without a doctor's order from a locked cabinet.

Later, she admitted that she thought it was penicillin. Tragically, the epidural anesthetic was accidentally administered, causing Gant to seize and ultimately die. The infant was delivered safely via caesarean.

What followed next were the usual internal and external investigations and apologies. The hospital investigation found that Nurse Thao, who fully cooperated with both hospital and state officials, failed to follow several key hospital protocols, including having a doctor's order,

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scanning the medication's bar code to doublecheck accuracy, and even failing to read the warning on the label. State officials, after completing their investigation, recommended filing criminal negligence charges, which, if Nurse Thao was found guilty, could result in a \$25,000 fine and up to three years in prison, with three years of extended supervision.

Ultimately, Nurse Thao later agreed to a plea bargain of two misdemeanors: possessing and dispensing a drug without authorization, which brought probation and restrictions on Thao's nursing license.

The day I became aware of this situation, I remember asking myself, what was that nurse thinking? How could this truly tragic event occur? Then I began to see the responses of many of my fellow nurses to the charges filed against Thao. Nurses throughout Madison, Wisconsin, and

across the country have weighed in, many angrily.

Supporters of Nurse Thao launched a legal defense fund as well as initiated legislation that will prohibit the state from filing criminal charges in cases of medication error. They argue that shielding healthcare workers from criminal prosecution is the only way to ensure an environment of openness. Otherwise a chill will run through the healthcare community causing healthcare workers to hide errors, not cooperate with investigations, or even leave the field altogether.

Another argument is that a nurse is after all only human and Nurse Thao will have to live with the guilt of causing the death of a teenager and leaving a child motherless—this in and of itself is punishment enough.

Many accuse the Attorney General, J.B. Van Hollen, of overreaching and trying to grab "face-time" in the media. He was pilloried, accused of being on a witch-hunt for nurses, and one blogger even went so far as to suggest that should Van Hollen fall ill, it would behoove him to seek care outside the state of Wisconsin.

THE NATURE OF ERROR

However, as nurses, we need to fully debate what happened that fateful July day, and ask ourselves, did this nurse perform to her fullest as the patient's advocate?

When you read the reports you realize that if she had implemented even one of the many safety checks required there would have been a different outcome. Should nurses who make a medication error face the potential of punishment ranging from possible loss of their license to the threat of jail time, and all degrees of punishment in between? In my opinion, the simple answer is yes. However, punishment and consequences must be in direct relation to the error.

Medication errors made by nurses can occur for a variety of reasons, such as: inexperience, being overly tired or overly stressed, too many distractions during medication preparation, negligence, and lack of familiarity with hospital safety protocols, to name a few.

Additionally, errors can also be categorized into two types: errors of omission, such as: the necessary drug is not prescribed, not dispensed, not administered, or not taken; the other type is an error of commission, such as: the wrong dose or drug, the wrong patient, the wrong timing or frequency, or the wrong route of administration.

WHAT THE HOSPITAL CAN DO

In the not so distant past nurses had a tendency to hide

both suspected and real medication errors. Some would say that this practice continues today because many nurses feel as though their hospital environment is not conducive to free reporting. When the hospital stigmatizes the reporting mechanism, nurses feel in peril and, therefore, try to shift blame, hide mistakes or worse yet, pretend nothing happened. These are systemic problems and hospital management teams can go a long way to make reporting errors as positive and constructive an experience as possible under the circumstances.

Many hospitals, working with risk management teams and nursing departments, have instituted changes that help minimize medication errors. Some of these mechanisms are: using the bar code system to scan both the medication and patient ID to ensure that the right patient is receiving the right medication and dosage, and placing more responsibility on the pharmacy department in the preparation and disbursement of all ordered medications via a centralized, computerized system.

Additionally, hospitals can and do continue to employ some tried-and-true low-tech solutions to catch medication errors. Some of these systems are: having two nurses check each narcotic order as well as potential lethal medications such as potassium, magnesium, digoxin, insulin, or epinephrine; implementing the "five rights" (though in some hospitals there can be as many as eight, and it's rumored even higher in some others). These "rights" are: right patient, right route, right dose, right time, and right medication.

Sometimes a well-intentioned system designed to catch errors may contribute to the problem. For example, not that long ago a private Los Angeles-area hospital invested vast sums to design and implement a new computerized charting model. Of course, recording which medications were ordered and given to any particular patient was

one of the core functions of this new and improved system.

It wasn't long before a glitch was discovered: the medication input section had preset times for all medication delivery, which works rather well in Med/Surg, but does not lend itself as easily to NICU or PICU or other specialty units. So the NICU nurses came up with a workaround in order to record medication administration. They learned to enter the meds as being administered at the time provided by the program, but later amended the time in the notes. Such workarounds laid the groundwork for potential medication errors (and caused the nurses to do extra work, to boot).

Though the program had been designed with all the best intentions, even being sure to include nursing input, it failed to take into consideration how each unit has specific needs that may not always overlap.

Other hospitals have changed the preparation of many injectables to be performed in the pharmacy, rather than at the nurse's work area. On the one hand this seems a positive step, since pharmacists are trained in this task, many done under laminar flow, and nurses often feel burdened by the demands on their time. On the other hand, the nurse must with blind faith administer a drug that he or she did not prepare to his or her patient.

THE NURSE'S RESPONSIBILITY

Granted, much can be done to improve the overall system to help reduce medication errors. However, what is rarely addressed is what nurses themselves can do. For example, not that long ago I was visiting with a friend, a retired MD and Public Health official. As so often happens, we found ourselves swapping stories and she shared with me her recent visit to a friend who had been hospitalized. She mentioned how she had noticed that the nurse had hung a bag of antibiotics, but that the bag had another patient's name on it (a female patient while her friend was male).

When my friend brought this to the attention of the attending nurse, the nurse responded, "We do it all the time." I recognized this situation from my own past experience on the floor. A nurse has to

give his or her patient an antibiotic at a specific time, but that patient's antibiotic isn't ready yet. So the nurse takes the same antibiotic from a different patient (whose medication order has been discontinued or isn't needed until later) and gives it to the first.

This is not the best protocol to follow. However, if the nurse makes a note that they have done this, and then relabels the bag with the correct patient name, then all can be considered copasetic. However, many nurses fail to do any of this.

HOLDING LIFE IN OUR HANDS

Returning to the unfortunate case of Nurse Thao, her supporters seem unwilling to identify any negligence exhibited on that fateful July day. It has been consistently reported by all parties (including Nurse Thao herself) that she failed to use the many safety check mechanisms that were in place. What if the scenario had been one of the following: an airplane pilot fails to perform the mandated preflight checks, takes off, and crashes. Or a person gets behind the wheel of a car and ignores the traffic lights indicating he should stop, and is involved in a fatal car accident. Would we not think these actions reached the level of criminal negligence?

Do I think Nurse Thao meant to harm her patient—hardly. However, when she failed to follow many of the safety mechanisms meant to protect the patient, the nurse, and the hospital, I find it hard to defend her actions.

My statement may seem harsh to some readers, but we must remember nurses are among a select few who hold life itself quite literally in our hands. It's for this reason we are often held to a higher standard than an accountant, or even hospital CEO. Nurse Thao's failure was on a grand scale, and unfortunately the protestations from the nursing community seemed to shift the blame from nurse to hospital "systemic" failure. I read post after post that found excuses for Nurse Thao's mistake.

In the end, Thao agreed to a plea bargain and the charges of criminal negligence were dropped, making the best out of a horrible situation. A young woman's life is lost, a child is born an orphan, and a nursing career is in ruins. This is an extreme example of what happens when nurses fail to follow procedures.

Does Nurse Thao deserve our compassion and empathy? Without a doubt. However, to hold her up as a victim or martyr is not entirely proper either. The Wisconsin State Officials are obligated to protect the people of their state, including young Ms Gant.

This list below details just some of the steps nurses can take to minimize medication errors:

- Use the protocols your hospital has in place. If you are unable to do so for whatever reason, document the event and notify the appropriate person in the chain of command.
- Always have another nurse doublecheck your medication order when appropriate, especially when handling narcotics, paralytics and other such drugs.
- Never give medication without an order.
- Always give the medication to the person for whom it is ordered. If you have to give it to someone else then take a few moments to relabel and make notations.
- If you make a mistake be sure to report the incident immediately, follow all reporting and documentation protocols. (This includes nurses who are in unions, as your union may have a reporting mechanism of its own. If so, use it).
- If you are too tired or unable to take on an additional assignment then do not accept it; remember once you accept the assignment you are legally and morally obligated to care for that patient.
- When in doubt, ask for help from a member of your team or your charge nurse.

No one expects us to be perfect. However, we should be knowledgeable, competent and professional when carrying out our duties. As the patients' advocate, it is up to us to safeguard them from mistakes. In a recent *American Journal of Nursing* article, it was estimated that nurses intercepted approximately 86 percent of all errors, which clearly illustrates the critical role nurses play in catching errors.

When we settle for mediocrity, we fail our profession, our patients and ourselves. Professionalism requires that we face responsibility for our own errors and not place blame on others. **WN**



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