UPvision Tuesday's Talk

Ownership Series: Medication Errors

Learn more about what it means to be a nurse today.

by Jaimee Gerrie on November 10th, 2020

An ER nurse receives orders to give 2mg of IV Morphine every hour as needed to a patient who is restless and in pain. Pre-filled Morphine is supplied in 10mg per ML dose syringes. This nurse speculates that she will be administering 2mg every hour so chooses not to waste 8mg with every dose and takes the full 10mg to the bedside with an intention of only administering 2mg, saving the remainder for the next four doses. While administering the Morphine she becomes distracted and accidentally administers the full syringe of 10mg.

The patient goes into respiratory arrest and requires ventilator support. The nurse, after review is terminated.

Although this nurse rationalized trying to prevent waste and to save time the error was not made intentionally. It was made as a result of poor nursing judgement and a failure to adhere to standards in medication administration.

Nurses are the final stop or gatekeeper in medication administration. Durham (2015) indicates that at minimum nurses administer 10 doses of medication per every hospital patient day. This author presented statistics that are interesting. She states that 1% - 2% of hospitalized patients are harmed from medication errors. She also cites that 1.5 million preventable drug errors occur annually in the United States and patients are exposed to a minimum of one medication error “each day they are hospitalized” (Durham, 2015).

Medication errors do not only happen in hospital settings. They occur in all settings across the health care continuum and “lawsuits involving nurses’ drug errors are common” (Ferrell, 2016). Owning our practice as nurses means that we accept the responsibility to assure we practice safely. Although, most medication errors are not intentional they still happen. It is because the last person before the medication is administered fails to prevent an error.

Nurses can change these medication error statistics simply by slowing down and assuring patient safety is first and foremost. Health care organizations and nursing management also have a responsibility to assure nurses and nursing care environments are well supported and that cultures are focused on safety.

To protect yourself as a nurse from a law suit involving a drug error requires that you are familiar with your standards of practice for nurses. Liability is determined through the application of the standard of care to the care you provided. Let’s take a look at the fundamentals of medication administration and this standard of care. Standard of medication administration requires that we perform three checks covering the same information prior to administering any medication. Just because the label says it is so does not mean it is so. Beginning with the five rights, although there are at least 12 rights to address, the first five are the foundation.

The right patient: Assuring we have the right patient requires that we are cautious of name alerts, that we double check patient ID bands, assure the patient can state their name and their birthdate. We need to compare the medical record to the patient and to the medication label and assure the name matches. If a patient cannot state their name and birthdate, we must follow the policy of the agency to patient identification. This often includes a family member and or verification with another care provider and the medical record. Scanning name bands is not enough as an arm band could have been placed on the wrong person.

The right drug: We must assure that we have the right drug for administration. We must know everything about that drug. What it does, what it is being used for, how it works, side effects, warnings, risk factors, how it metabolizes, how it is excreted, and so much more. With look-alike sound alike medications review and thorough understanding of the drug you are administering is a priority. Let me share a story of how easy it can be to not have the right drug.

One of our children several years ago required a prescription for ear drops. The medical term for ear is Otic. I took the prescription to the pharmacy without reading the prescription like most people would trusting that my provider wrote the correct medication. The pharmacy filled the prescription. When I got home and opened the package, I discovered that the medication given to me was for eye drops. The medical term for eye is Optic. When I returned to the pharmacy to communicate the error and exchange for the right medication it was discovered that the prescription was written for Optic drops to be given in each ear. Not only did the practitioner write the wrong word, the pharmacist did not notice that Optic drops were to be given in each ear. Now, I am a nurse and I knew this was not correct but what about the patient who does not know medical terminology. Would that patient administer eye drops in both ears?

The right dose: Now nurses do not dose medication but we do assure that the ordered dosing is accurate before it is administered. This does require that we know how to perform dosage calculations. We must know when to question the provider, and seek clarification for dosing that does not seem right. The right dose also includes the volume of medication we are administering to achieve that dose. We would definitely question the need to administer more than 2 pills to achieve the ordered dose for example.

The right route: Now it would be ridiculous to think that a medication ordered rectally would be given orally, but it could happen. Every medication ordered by a practitioner must include a route for administration and we as nurses must assure that the route ordered is a safe route for the patient. We may not change that route without an order to do so. For example, an order for oral Tylenol for fever is given but the patient is vomiting. We cannot change the route to rectal suppository even though this would make sense. This is outside of the license of our scope of practice. We must notify the provider and obtain another order for a different route.

The right time: Unless a specific administration time is ordered by the provider nurses are responsible to set the administration time for a patient's medication. Pharmacists have attempted to make this easier by setting standard administration times for medications to be given. For example, a one time a day medication may be set for 10am for every patient receiving a one time a day medication. This standardization does help with routine and with pharmacy preparation and delivery routines and for the most part works pretty well. As nurses however we must be careful not to assume that the standardized time set is the appropriate timing for the medication to be given. Standardization does not take into account each patient's individual needs. That is our responsibility. We must review each medication and work with the patient to set the appropriate time. Once medication times are set, we must assure that we follow our agency policies and adhere to those times. Administering a medication two hours after it is due to be given is considered a medication error.

Since the standardization of these five fundamental rights of medication administration many more have been identified in an attempt to lessen the risk of medication errors for patients. These are:

- Right reason
- Right documentation
- Right to refuse
- Right education

- Right assessment
- Right evaluation
- Right technique

This is not all. Here is a list (not necessarily all inclusive) to pay attention to in your practice to reduce your legal risk when administering medication:

- Never treat a patient without orders from a Physician or Primary Care Provider (except in a life or death emergency)
- Never prescribe or dispense medications without authorization
- Assure you always check allergies prior to the administration of any medication
- Never leave medications unattended and unlocked
- Never let medications out of your sight during administration
- Never leave medications at a bedside for a patient to take later
- Always directly observe your patient taking the medication you are administering
- Never administer a medication you did not prepare yourself
- Never sign that medication was given before it was given
- Always report any side effects or unfavorable reactions
- Never delegate medication administration to someone who is not licensed to administer medications
- Always follow up and evaluate if you did delegate medication administration to someone licensed to administer medications
- Assure you clarify and understand all standing orders
- Refuse to administer if it is not safe
- Always document attempts to clarify orders

Remember, if an error is made despite all of your efforts to practice safely, own up to it! Follow your agency policy for reporting an incident. Never hide a mistake. The risk to your patients, your organization, and to yourself is not worth a lack of integrity.

Thank you for taking the time to participate in this month's Talk Tuesday. I hope you were able to find at least one take away that you can use to lower your legal risk in nursing practice. Please join me next month when I discuss the topic of Infection control.

Durham, B. The Peer Reviewed Journal of Clinical Excellence. Nursing2020. April 2015 V45(1) p. 1-4. doi: 10.1097/01.NURSE.0000461850.24153.8b

Ferrell, K. G. (2016). Nurse's legal handbook (6th ed). Philadelphia, PA: Wolters Kluwer

Enjoy the rest of your week,

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Learn more about Jaimee and what she has to offer the modern nursing world, on her website. She has blogs, informational videos, a book and more! Explore what UPvison Consulting and Jaimee Gerrie can do for you today.

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