Anyone Who Says They Don't is Lying: Medication Error

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I made my first medication error as a student. I thought it would be my last, but real-world nursing was a wakeup call.

Like most students, I thought the 5 Rights of Medication Administration were a little... bogus. I wasn't a kid; surely I could be depended on to have common sense. Weren't the 5 Rights almost insulting to nurses? I had been giving medicine to myself, family members, children at the summer camp where I worked, residents at the assisted living facility where I was an aide before nursing school, for years. I never gave Tylenol where I should have given Benadryl or accidentally gave a medicine one hour later instead of four hours later. Certainly I never gave medication to the wrong camper or resident. I relegated nurses who made medication errors to that unfortunate class that includes nurses with substance abuse problems... a category I would never visit.

I made my first medication error (that I know of) in my second semester of clinical, on an oncology unit. My single patient, an elderly man with acute myelogenous leukemia, was ordered for IV Zosyn. I had checked this carefully, made a care plan, wrote down in detail when I was to give the medications. Halfway through the morning, the doctor came through and increased the dosage. I think I was dimly aware of this, had read the order. At the time for the medication, I went to the refrigerator, checked the right patient and right drug. I knew it was the right time and the right route. I told the nurse I was giving the medication now, and she nodded and gestured me away. My clinical instructor was on call if I needed him. I hung the medication for the sweet old man without incident.

An hour later, the patient's nurse came to me, holding a bag of zosyn. "Why didn't you give this?" she asked. "I did!" I responded, alarmed and defensive.

We went to the bedside and found the zosyn I had hung. Right patient, right drug, right time, right route... wrong dose. The pharmacy tech had brought the new bag without removing the old one, which had already been prepared. When I picked up the bag from the refrigerator, I didn't notice there were two for that patient, and I never rechecked the dose. I felt cold and hot and nauseated. How could I have done such a thing?

The nurse berated me for not checking properly and began to fill out an error reporting form. I heard her telling the other nurses about it. "Oh, just a student not paying attention," she said with an air of weary superiority.

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When she finished making the report, she came to me. "You know your clinical instructor needs to know about this," she said. "I can tell him about it if you want." I sensed an eagerness in her voice. "I'll tell him about it myself," I said, insulted.

I was surprised at how calm my instructor was. I didn't know him well, but from the nurse's reaction, I expected a blowout; possibly a suspension. "Okay," he said. "Do you know why that happened?" I explained that I hadn't checked the dosage. "I don't think you'll make that mistake again," he said. "There's a form you have to fill out for the school, and I think you aren't allowed to make more than two errors, but you're going to be okay." In his record of the incident, the instructor included the line: "To the student's credit, she took ownership of the incident and reported it to me personally."

In my previous jobs I occasionally had to deliver discipline to employees, and I felt like I hadn't been disciplined enough. I looked at the situation as if I were one of my junior camp counselors, and went to the theory professor with a plan: I wanted to explain to the first semester students what I had done so they would know it can happen. They listened to my experience with interest, although I knew they were all thinking "but I would never do that". Maybe I prevented a few errors. I know I provided an example.

Naturally, I thought this would be the last medication error I would ever make, and to my knowledge I didn't make any more during nursing school. My first job was at a busy hospital with a high nurse/patient ratio; I usually had 7-10 patients during the day. It was months before I felt like I had time for anything more than running around dispensing medication. One of my friends from orientation made the first medication error in our group. She confessed it to the charge nurse, a woman I had already grown to admire enormously as someone who always knew the right thing to do. "Well, call it in to the reporting line," she said straightforwardly. "We all make medication errors. Any nurse who says she doesn't is lying."

My friend felt better, and I was startled. I had never heard this put so bluntly before. My instructors said it was easy to do, but they never quite got across to me that everyone does it. I filed this line away in my mind.

I've made several medication errors since then. I mixed up a John and a Tom and the IV bags were found by the next nurse-the worst error that I'm aware of committing. (No harm to patients.) I've hung the right antibiotic at the wrong time. I've given whole pills where I should have given half. I've given medications that were discontinued a few minutes previously.

Recently I gave a class on medication errors to a group of students, with examples. "These are all taken from my practice or were done by nurses I know," I said casually. The students were shocked. "YOU did that?" one of them asked. "No, my friend did," I said. Through my years as a nurse, with experience on various committees that look into incident reports, and many late-night confessionals among night nurses, I haven't become immune to med errors--but I have come to understand them as part of nursing life. I'm quite sure I don't make more errors than the average nurse; I hope I make less. I don't usually make the same error twice (the exception being those half-pills-I was relieved when I moved to a hospital where all pills are split in the pharmacy). And I've counseled many students and new graduates through their first medication errors.

And because I've learned that every medication error is a systems error: I report, report, report, and encourage others to do the same.

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