



A nursing perspective of medication incidents:

Then and now

By Donna Walsh & Christine Koczmar

When we graduated from nursing school many years ago, any

discussion about medication incidents (i.e. errors) was uncomfortable to say the least. The presumption was that medication incidents were the result of an individual nurse's inattention, carelessness, or incompetence. Perfection in medication administration was expected. So ingrained was the notion that an individual could perform perfectly, that some hospitals would fire a nurse if she or he had three documented medication incidents on record.

The "dos" and "don'ts" of medication administration were taught, including: the five rights, triple checks during preparation of medications, and always checking the patient's name band. The assumption was that if the nurse followed the rules of medication administration, an error could not and would not occur.

Of course, medication incidents did happen. Blame was commonly placed on the individual involved and little if any thought was given to the many factors that might have contributed to the medication incident (e.g. interruptions, dangerous abbreviations, look-alike labelling and packaging). The culture at the time was punitive. Adjectives such as careless, lazy, reckless, irresponsible, and easily distracted were common labels for the person involved in an incident. There was a sense that somehow if the "bad apples" were weeded out, errors could be eliminated.

And, we nurses (similar to other health professionals) perpetuated the notion that nothing short of perfection was satisfactory – from ourselves and from others. If involved in a medication incident, self-blame was common and overwhelming. Intellectually we felt completely responsible, and emotionally we felt terrible.

So, how is the response to medication incidents changing?

Individual versus systems approach

In the past five to 10 years, hospitals have begun to move toward a culture of safety that includes a systems approach. When a medication incident occurs, hospitals no longer focus solely on "who" because incidents can recur regardless of the individuals involved. Hospitals having the

greatest success in promoting a culture of safety ask: "What happened?" "Why did it happen?" and "How can we prevent it from happening again?" This approach leads to

a more complete understanding of medication incidents and provides opportunities to make broad changes that ultimately create safer hospitals for our patients.

Learning from incident reports

Fundamental to the systems approach is the understanding that an incident occurring in one area of a hospital can take place in another area of the same hospital and also in other hospitals. Sharing the learnings from incident reports within and among hospitals is a way to enhance patient safety. At ISMP Canada we hear firsthand that

nurses appreciate seeing that an incident they reported resulted in distribution of a country-wide ISMP Canada Safety Bulletin. Nurses want to reduce the potential for the same incident to recur in their own institutions as well as others.

Providing feedback

It is very important for staff to receive feedback about

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submitted incident reports. An initial response that is non-punitive helps to encourage future reporting. Nurses and other health-care professionals who see system improvements implemented as a result of incident reports are more likely to see the value of reporting. Knowing that a report makes a difference is a powerful feedback tool.

Educate nursing staff and students

A culture of safety, focusing on systems and processes rather than individuals is developing – across all departments and programs, from unit managers to senior management, and in the schools of all health-care disciplines. Nursing schools are incorporating the learning principles of an open and just culture. Teaching and shaping attitudes early are important

for the promotion of a patient safety culture.

Progress is being made in the response to medication incidents. Hospital systems are changing. Nurses (and other health professionals) are learning to shift their beliefs from "we are perfect" to "we are human." The reward is learning how to implement system-based safeguards to prevent errors and a safer health-care system for our patients.

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