

Beyond blame - A nurse perspective

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Medication errors can be made during any one (or more) of the four stages of prescribing, transcribing, dispensing and administering. Nurses are vulnerable to making an error in two of these three stages: those of transcribing and administering. Nurses are often responsible for copying the prescription ordered by the physician (perhaps verbally) onto a requisition used by the pharmacist to dispense the appropriate dose. Nurses are also responsible for administering the ordered medications to a number of patients, by one or more routes. Medication administration is one of a myriad of functions the nurse performs for a number of patients during the course of a twelve hour tour of duty.

Historically, Nursing developed stringent procedures to define the exact steps to be taken during the medication administration process - these procedures included such precautions as having a colleague double check the order during transcription, reading the labels of the containers three times and asking the patient his or her name as well as checking the name band. Whenever medication administration errors were discovered, a report was completed, and often the nurse was taken to task for her failure to adequately follow the procedures that had been developed. There was an unspoken assumption that, had she 'followed the rules', the error wouldn't have occurred.

In spite of these precautions, errors occur. Why? There is growing acknowledgment that errors don't occur because people are reckless or stupid, but because organizational systems are not designed to prevent them, and the highly complex environments in which health professionals are working encourage the emergence of gaps in care.

Restructuring, downsizing and work redesign have all had an impact on the practice of nursing in hospitals over the past three to five years. Nurses are looking after more and sicker patients with fewer supports and more complicated technology. People are more likely to make mistakes if they are overworked, overtired, stressed, and under pressure. Now more than ever, it is time for hospital administration to critically analyze the sources of error in the system, and implement appropriate strategies to correct the deficits.

Cohen¹ identifies six sources of medication errors: failed communication, poor drug distribution practices, dose miscalculations, drug- and drug device-related problems, incorrect drug administration, and lack of patient education. Given the integral role that the nurse plays in the administration of medications, any of these sources of error may be experienced and result in the nurse being held responsible for having made a mistake in care delivery. These 'mistakes' may have virtually no consequences, or may result in significant negative effects (up to death) of the patient.

Given the intensity of care requirements today, we can no longer afford to blame health professionals for their 'mistakes' – we must address the root causes of error and put mechanisms in place to correct them. There are two approaches that need to be taken in order to reduce the number of medication errors that occur in hospitals: the first is ongoing and relentless pursuit of the correction of the systemic sources of error; the second is the institution of a blameless reporting system to encourage health professionals to identify errors and the contributing factors as they perceive them. These two strategies implemented in tandem would eventually result in improvements to the system as well as providing appropriate support to nurses and other professionals who are dealing with ever-increasing complexity and therefore additional opportunities for error.

1. Cohen, Michael R., Editor, Medication Errors: Causes, Prevention and Risk Management
Jones and Bartlett, Massachusetts, 1999