TRANSCRIPTION

cpsi Canadian Patient Safety Institute
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[0:00:10] I'm here today to share a story about a medication error that I made more than 30 years ago. And even though more than three decades have passed since that day, it feels like every moment of the time is ingrained with crystal clarity in my mind. And I hope by sharing it, to share some lessons that other health providers can learn from.

[0:00:31] I'm a registered nurse and I was practicing in a neurosurgical intensive care unit back in 1985. I had been a graduate for about two years at that point and had moved from a ward setting into an intensive care unit. And in that setting, the pace is fast and I was fairly new. I'm going to say I was there less than six months in that setting and was so impressed with the rapid thinking, apparent intelligence, competence of the nurses around me, and you want to be like them. So I think when I think back to what happened, I do think some of it was trying to be better, faster maybe than I was.

[0:01:20] So on the day this incident happened, I had two patients, which was normal in that unit. And the situation of the two patients I had was that one had high potassium, which means he shouldn't have any more potassium given to him. And the second patient had low potassium and they were in beds side by side and I had those two patients through the day.

[0:01:45] Through a series of errors, I ended up giving medication to the wrong patient. The physician called about the patient with the low potassium and transmitted a message, an order for potassium medication to go to that patient, gave his order to the nurse in charge at the desk, so I didn't personally have the conversation. And she wrote the order, which is normal. We call that transcribing. She wrote down, “Give medication X to patient A.”

[0:02:22] And in the course of calling me to the desk to tell me that this had happened, she held up the order sheet. And nurses and docs and people in hospitals will know there's usually a little identifier on the corner of the sheet. And she had her hand over it, simply, you know, picked up the paper and said, “Here's the order,” which is the normal thing you would do, “give it to patient A.” And I, wanting to appear competent and to act quickly – it’s a critical care unit – drew up the medication and then failed to do a really important thing, which is to cross check the order which had been shown to me. So remember, I had seen it, so I thought, “Okay, that makes sense.” And I knew the patient had low potassium, so it all made sense.

[0:03:14] I went to the bedside and checked the patient, made sure I had the right patient, which I didn't, because I was rushing. So I took the medication, which I had drawn up potassium, and was about to give it to the patient. And this was a big lesson for me and my entire career. I thought something was wrong. Something was triggering me. “Something's wrong with this.” What I didn't do was stop. I pushed it in slowly, but pushed it in. And it wasn't two seconds after I finished, I thought, “Oh, it's the wrong patient. It's the guy with the high potassium that I just overdosed with a whole bunch more potassium.” And literally, I nearly collapsed. And I mean, I thought, “My career is over. I'm not going to lose my license. He's going to die.” And I, to this day, don't know why I didn't stop when in fact, what had happened was – everything in the chain of events had been done correctly, except when she said, “Give it to patient A,” she was wrong because it was for patient B. her hand was covering it and I didn't look at it and I didn't double check. “Are we talking about patient A or patient B?” I just said, “Okay, I know about this potassium problem,” went over, shoved it in.

[0:04:40] To add to the complexity, it was a physician himself. The patient was a physician known to other physicians.

[0:04:48] I don't totally remember, but I think someone took over the care. It's the only part that I can remember because I think I was so upset that they basically put me in the staff lounge. And I think I spent the whole evening shift there just waiting and wondering because I couldn't go home and rest. I thought, “He's going to die.” And I knew that I had pushed it in.

[0:05:11] You know, it's 32 or 33 years ago that that happened. And it is still cemented in my mind, everything about the lighting in that room that day, the look of people around me, how I felt, what I learned about, you know, when the little man on your shoulder says, “Slow down,” you should slow down before you hurt somebody. And I always tell that to students and other nurses, “Just take that one second. Don't complicate the situation by rushing that way.”

[0:05:46] In this case, it's a perfect example of what we see often in medicine and nursing, which is, the errors happen at points of handoff in care. We see it from docs and nurses; in this case, the doc to the charge nurse to Michael. And all capable people, right? In a rush. Not unusual to have a mix of very, very sick people side by side. And part of your duty as an RN in a critical care unit is to have that in mind. Each patient might have five or six or ten lines of medications running in. That's part of the job.

[0:06:22] I think that a complicating factor is when physicians give orders to some intermediary person. So right away, you have the potential for an error, which happened with us; just the wrong patient. Everything else was right except the words came out of people's mouths wrong. We see it in handoffs, even in home care from registered nurses who provide plans of care and delegate care to a licensed practical nurse who may delegate that to a nursing assistant or a personal support worker, and a point of great error

onto families because families provide a lot of care. So it's not just a critical care unit issue or a hospital issue. It's across the health care system that points of handoff – and the more of them there are, the more chances that there are for an error.

[0:07:09] Even though I was young and scared, I did the right thing, which was, as soon as it was done, I went, “Oh my,” and immediately got help and said, “I did, this is what I did.” And that's probably what also saved my career and my license, that I wasn't cavalier about it. I didn't try to hide it.

[0:07:25] I remembered that they had asked me just to wait in the staff lounge, which was attached to the intensive care unit. And I think I spent basically a whole second shift sitting back there in a panic, worried about him. I was worried about my license and my job, of course, because I had just done many, many years of school and was proud of what I had done, you know, to get to this point. And I think there's a huge cloud of fear across nursing and I think medicine, too, from the second you graduate, that if anything happens, you'll lose your license. So there's a terrible fear of error.

[0:08:13] But I admitted right away what I did and got help right away and sat in the back for that entire shift. And I knew, I think, by about four or five hours in, because they were treating him with – there's a ways you treat that to reduce the potassium – that he wasn't going to die at that point. My concern is, he was already very sick. He was unconscious under my care before the incident. So he was quite ill. But as the time went by, I felt the relief mostly that he didn't die, because I really thought, what a terrible thing, to hurt somebody.

[0:08:56] And so then I had the chance to speak with my, at the time was called head nurse, who was fantastic. And I was expecting, when she came in, that I might be disciplined, I might be sent home. And her comment was, “What did you learn?” The head nurse was fantastic, unbelievably supportive, and basically said, “You know, when that little man on the shoulder says stop, it's like the yellow light at the intersection. You shouldn't speed up; you should slow it down.” And I learned a huge lesson.

[0:09:24] Even now in my administrative roles and my teaching roles, if I sense something's wrong, I just say to people, “I need a day to think about that.” I try to not make snap decisions and I think my decisions are better. It’s certainly shaped what I talked about in the roles I had after. So I was the instructor in that unit, became a clinical nurse specialist, eventually managed the unit for five years. And that was something I talked about with all young nurses coming in or novice nurses, not necessarily young, but young to the job.

[0:09:55] For me, the big lesson is, if the triggers in your mind that something's wrong, something's probably wrong. Stop what you're doing, even for a minute, and think it through a second time. And I talk about that. Well, here we're talking about it 30-plus years later. I talk about it in every job with students and so on.

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