Made a Med Error? *Tell* Everyone!

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I have been an emergency nurse for more than 20 years and have spent much time precepting new nurses. I have noticed that many novice nurses make the same medication errors that I myself made when I was inexperienced.

I clearly remember how ashamed and inadequate it made me feel to make medication errors, and early in my career, I became a big fan of nursing journals with medication error sections where nurses could report medication errors anonymously. I always believed that if someone else could make a mistake, then so could I. As I frequently scanned medication error sections to jot down errors that were pertinent to ED nursing, I began to notice a pattern. Often the serious errors that had a high potential to harm patients involved the same drugs. A good example was Epi 1:1,000. For most allergic reactions, this concentration should only be given subcutaneously, but often it was mistakenly given by intravenous push (IVP). This concentration given IVP can cause sudden increases in blood pressure, tachycardia, ventricular fibrillation, shock, or cerebral hemorrhage. Another error that appeared repeatedly in the journals was that lidocaine IVP was given to a patient in third-degree/complete heart block or a ventricular escape rhythm. This can cause suppression of all ventricular activity resulting in cardiovascular collapse.

Every time I became aware of a warning about a medicaton error, I would add it to a small handwritten pocket guide that I was assembling for the new nurses I was orienting. In 1996, our emergency department's education committee decided to publish the guide, and it evolved into our current ED Orientation Survival

Guide. The pocket-sized guide includes many high-risk drugs such as insulin, heparin, labetalol, 1:1,000 Epi and t-PA *and what the common errors are*. It is still very popular, even with many of our experienced nurses.

Several years later, our ED nurse representative to the hospital-wide committee that discusses medication errors and how we can prevent them (our hospital is proactive about errors in this and many other ways) left, and I volunteered to take her place. I was introduced to the Institute for Safe Medicine Practice's (ISMP) "non-punitive system-based approach to error reduction." They advocate providing incentives for reporting errors without fear of disciplinary action.

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This concept was totally new to me. A new medication error reporting form was developed by our hospital that did not require a signature so errors could be reported anonymously. In addition, at each monthly meeting, we began reviewing the errors published in the ISMP's Medication Safety Alert bulletin.* With each error, we asked, "Could this error happen in *our* hospital?" We found that many of those tips were invaluable.

I began to encourage other ED nurses to take the time to document medication errors. I put up flyers with messages like, "Thank you for taking the time to report your med errors. The safest hospitals are the ones with the highest reporting rates." I must admit that at first the flyer got a few laughs, until I explained what it meant. It took a while, but our nursing staff slowly became more comfortable and less fearful about reporting mistakes. Our reporting rates began to increase. Our nurse manager, unit educator, and I began to meet to discuss and analyze errors to find contributing factors. We talked about what changes we could make to prevent more errors.

Recently, I had an experience that was a perfect example of the benefits of a culture of sharing information about medication errors. After returning to work following a lengthy absence, I discovered that the pharmacy could no longer obtain Solu-Medrol. There was a note on our automated medication dispenser, Pyxis, to substitute 20 mg of Decadron for 125 mg of Solu-Medrol. Although I should certainly have known better, I asked one of our nurses if it was okay to give it the same way—that is, IVP. She answered yes, so I proceeded to give the Decadron IVP. My first patient had no problem. The second patient I gave the drug to complained of severe burning in the genital area. I immediately researched the drug and discovered the maximum amount of Decadron that can be given IVP is 10 mg. Thankfully, my patient suffered no permanent harm. Perhaps emboldened by the fact that I was on the Medication Error Quality Improvement Committee, I told other nurses how badly I felt about the discomfort and worry that I caused my patient. The more nurses I talked with, the more I realized that many of my colleagues were doing the same thing. Some of their patients had also complained of burning in the genital area. I decided to post a flyer on the Pyxis to alert staff that 20 mg of Decadron should be diluted and given intravenous piggyback. After the flyer went up, I had several *more* nurses tell me that they had had the same thing happen to *them*.

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Several months later, I was surprised when one of our best and most experienced nurses said to me, "I have learned something valuable from you. Now, when I make a med error, I tell *everyone*." It was as though a light bulb went off in my head!! We had used the same principal as

*The ISMP Medication Safety Alert bulletin can be obtained at ismpinfo@ismp.org or telephone 215-947-7797 for $140 per year (25 issues). It comes by E-mail and can be distributed within the hospital.

ISMP, just on a smaller scale. This was real progress!! When I talked with my sister (also a registered nurse on the night shift in our emergency department) about this concept, she said that whenever she hears anyone talking about a medication error, she always perks up and listens. We all do.

I now add errors that are reported in the ISMP to my Orientation Survival Guide on a regular basis. For example, the ISMP bulletin reported that after Lovenox is given subcutaneously, you need to wait 12 hours before starting heparin. In several other hospitals, neglecting to do this had caused intracranial bleeds. I included the fact that you need to give the new rapid-acting insulins, Humalog and Novalog, right with the meal. For years we had given insulin 30 minutes prior to the meal, so this was a big change.

I do not believe the concept of sharing errors has to be limited to medication errors. Our emergency department recently purchased a new pediatric crash cart. I was in triage one morning and a mother walked in with a 2-week-old baby who was having difficulty breathing. After one look at the baby, I immediately took the mother and baby back to the main emergency department. Although there had been an orientation to the new cart in a Skill Update several months before, I could not find the handle to the laryngoscope. It turns out it was now in the bottom drawer, rather than the top drawer, where it had always been. In the end, we just ventilated the baby with the ambu bag a little longer and the baby was fine. However, I made a point of telling everyone. I believed that if I could not find it, then other nurses might not be able to find it either.

At the last ED staff meeting, when I gave my monthly report on medication errors, I decided to share this idea with our nurses. The feedback was great. Another experienced nurse began to share her own recent medication error. She had set the rate on the infusion pump at 20 mL per hour and went back in to discover the rate was 200 mL per hour. Being on the medication error committee, I mentioned that it was entirely possible she had set the rate correctly and the pump had malfunctioned. Our nurse manager advised us that if this occurred, besides taking the pump out of service, labeling it, and calling Bio-med, we also should leave the settings on the pump just as they were so that Bio-med could actually trace what had malfunctioned. Leaving the settings the same was new information for every nurse in the meeting, and there were many very experienced nurses there. So, once again, the benefits of sharing were apparent.

All in all, the nurses at the meeting were very receptive to the idea, and even a non-nursing staff member came up to me after the meeting and said, "I really like your idea of sharing errors." While I would like to think that nurses have been doing this for years and I just have not noticed, I do not think that is true. Often, it seems, the simplest concepts may improve the care of patients the most.

Send descriptions of procedures in emergency care and/or quick-reference charts suitable for placing in a reference file or notebook to:

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