Legal Issues in Nursing; Medication Errors

Submitted by Chris Rokosh RN, Legal Nurse Consultant

Third in a series of four articles on the 5 most common allegations associated with nursing negligence lawsuits.

According to the National Coordinating Council for Medication Error Report and Prevention, a medication error is defined as 'Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional…' Based on a U.S. Food and Drug Administration study of fatal medication errors between 1993 and 1998, the most common causes of medication errors were performance and knowledge deficits (44%) and communication errors (16%). Children and older adults were identified as particularly vulnerable population groups for medication errors.

Have you ever made a medication error? I know I have; and to date I have never met a nurse who hasn't. Sadly, these errors occur much too frequently. In fact, medication errors constitute the greatest number of adverse events in healthcare. Fortunately, many of the errors do not result in harm. For instance, a nurse may give a patient Tylenol when Ibuprofen was ordered. As long as the patient doesn't suffer significant injury or serious adverse reaction, this would be considered a breach in the standard of care but would not make for a successful lawsuit.

On the other hand, if a nurse administers a medication that results in serious injury or death, the patient can sue the nurse and may also sue the doctor, pharmacist and hospital. Multiple parties can be sued with medication errors based on the fact that there may be many contributing factors, and many individuals, who play a part in the ordering, dispensing, administration and developing the processes for medication administration.

Medication administration is considered a basic nursing skill, one of the most common and frequent tasks performed. Nurses have long been required to administer medication by a well-known set of 5 'rights'; right drug, right dose, right patient, right route, right time. Those 'rights' now include the right reason, right response, right documentation, right to refuse and right to education. Nurses are expected to stay knowledgeable about the actions, side effects and contraindications of all medications they give. This is no small task, but a highly necessary one, particularly when caring for high risk population groups or administering multiple medications to the same person. Nurses are also expected to question any medication orders that are unclear, unusual or unsafe. Doctors make mistakes and they sometimes order the wrong medication or the wrong dose. It's considered nursing responsibility to recognize errors before administering the medication and to clarify the order with the doctor. Let's learn more about this by examining a fictional case study involving a medication error with an adverse outcome.

Case Study:

At 5:20 p.m., 82 year old Elizabeth presented in the Emergency Room of a rural hospital with complaints of abdominal pain. Over the past 3 days, she had been experiencing crampy left lower quadrant pain and had been unable to have a bowel movement. She was nauseous, feeling unwell and her abdomen was distended and tender. Bowel sounds were barely audible. Temperature was elevated to 38.2 degrees Celsius and her white blood cell count was elevated. Medical history included a previous stroke with right-sided weakness, high blood pressure, smoking, mild dementia and a history of bowel cancer. Current medications included Calcium and Vitamin D supplements, Valsartan HCT for high blood pressure and low-dose aspirin. Elizabeth was severely allergic to Penicillin and bees. She was admitted to hospital with a working diagnosis of bowel obstruction and told to remain NPO overnight. The E.R. doctor ordered IV fluids, IM Morphine, IV Gravol and IV Ancef. Consultation was arranged with a Gastroenterologist and diagnostic testing was requisitioned for the following morning.

At 10:25 p.m. Elizabeth arrived on the medical surgical unit and was assigned to Nurse Belinda. Belinda completed an initial physical assessment and filled out the admission paperwork. She clearly marked the Penicillin allergy in all of the required places and placed an allergy band on Elizabeth's wrist. Vital signs were stable and Elizabeth denied pain at the time of admission. She had been given a dose of IM Morphine in the Emergency Room. Elizabeth was drowsy, so Belinda settled her into bed, oriented her to her room, reminded her to remain NPO and showed her how to use the call bell. Belinda went back to the desk to complete her charting, and then into the medication room to prepare the initial dose of IV Ancef.

At 12 midnight, Belinda was on her break. Nurse Winnie, who was covering for her, quietly entered Elizabeth's room and hung the mini bag of IV Ancef that Belinda had prepared. Elizabeth seemed to be sleeping soundly, so Winnie did not wake her or check her armband.

Shortly after 1:00 a.m. Belinda made rounds and stopped in to see how Elizabeth was doing. She seemed to be sleeping, but Belinda noticed that she was restless; frequently rubbing her eyes and scratching her arms. The IV Ancef had infused and Belinda removed the mini bag and left the room without speaking to Elizabeth.

At 2:15 a.m. Elizabeth rang her call bell, saying that she felt like she couldn't catch her breath. When Belinda entered the room, she found Elizabeth sitting up in bed, struggling to breathe. Her face was swollen, her lips were blue and she was finding it difficult to swallow. She complained of abdominal pain and her skin was covered in bright red hives. Belinda attempted to assess vital signs, but Elizabeth was so restless that she was unable to obtain either a blood pressure or a pulse. Belinda rang the call bell and asked her charge nurse to come right away. The charge nurse arrived and quickly left to page the doctor on call who, in this case, was the E.R. doctor who had admitted Elizabeth to hospital.

At 2:27 a.m. Elizabeth collapsed onto the bed and stopped breathing. The E.R. doctor was called and he paged the anesthetist as he made his way to Elizabeth's room. The doctors were unable to intubate Elizabeth due to significant swelling in her airway.

At 3:12 a.m. Elizabeth was pronounced dead. The cause of death was listed as an anaphylactic reaction to IV Ancef. Seven months after Elizabeth's death, her daughter filed a lawsuit against both the doctors and nurses. She alleged, among other things, that Nurses Belinda and Winnie were negligent in administering Ancef to a patient who had a serious allergy to Penicillin without careful observation for signs of an allergic reaction. She further alleged that if Nurse Belinda had recognized and responded to Elizabeth's restless eye rubbing and arm scratching shortly after 1:00 a.m. as potential signs of an allergic reaction, steps could have been taken to save her mother's life.

Do you think the nurses met the standard of care? Learn the rest of the story at: https://www.ConnectMLX.com/index.php?option=com_content&view=article&id=60:case-outcome-3&catid=2:uncategorised

This article was written by Chris Rokosh RN, PNC(C), Legal Nurse Consultant and president of Connect Medical Legal Expert. Chris is a popular speaker on legal issues in nursing across Canada and the US. If you want to learn more about this topic, go to the website www.ConnectMLX.com for a list of available courses.

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