POSITION ON MEDICATION ERROR

Developed and revised by the MNA Congress on Nursing Practice
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Medication errors happen. And in today's complex patient care environments, medication errors can occur in the practice of even the most diligent nurses.

The Institute of Medicine estimates 7,000 deaths and 1.3 million injuries occur each year because of medication errors in American hospitals (August 31, 2011). USA Today reported that medication errors are among the most common medical errors, harming at least 1.5 million people every year (July 21, 2006). And according to the Agency for Health Care Quality, medical errors are the leading cause of death and injury in America.

Only the most serious errors come to our attention through the media. Registered nurses know there are many more errors than are actually reported. Nurses have always accepted the responsibility for their medication practice, and nurses who administer medications practice the six rights of medication administration: the right patient, the right medication, the right dose, the right route, the right time and the right documentation.

However, the act of administering medication is only one action in a system with complex processes involving multiple steps and disciplines. Adding to this complexity are computerized medication ordering systems, and dispensing and

scanning systems for medication administration. Some hospital medication systems have all of these processes in place while others have partial systems. Each one of these systems (order entry, medication dispensing and procurement, monitoring and patient documentation) may require each nurse to enter multiple user names and passwords. This further contributes to the complication of medication administration and increases the risk of a medication error.

Other factors cited by nurses that contribute to error include stress, a high volume of work, inexperience with particular clinical events and a lack of familiarity with the practice setting.

In 1999, MNA's Congress on Nursing Practice developed a new "Six Rights for Nursing Medication Administration" which is now copyrighted and included in basic nursing textbooks. It is as follows:

1. The right to a complete and clearly written order
2. The right to have the correct drug route and dose dispensed
3. The right to have access to information
4. The right to have policies on medication administration
5. The right to administer medications safely and to identify problems in the system
6. The right to stop, think and be vigilant when administering medications

These rights can only be practiced in a safe environment with a safe patient assignment that contributes to a "Just Culture Environment." A Just Culture Environment finds a middle ground between errors caused by systems failure (staffing, lack of adequate equipment, incompatible computerized programs) and the nurses' ability to practice safely. Just Culture builds on the fact that nurses and systems are not perfect. Under Just Culture conditions, individuals are not blamed for honest errors but are held accountable for willful violations and gross negligence. Just Culture supports an atmosphere of trust and supports learning from errors in order to improve the safety awareness through sharing of information.

In 2007, the Massachusetts Board of Registration in Nursing conducted its own study involving complaints of preventable medication errors. The BORN report recommended a number of environment-based error prevention strategies that included:

- Insure medication administration workspaces are free of distraction and noise

- Design nursing workflow to reduce interruptions during medication administration
- Include unit level nursing staff in the systematic evaluation of clinical policies and procedures
- Systematically monitor the effectiveness of changes made to the practice environment as the result of nursing errors and "close calls"
- Collaborate with unit-level staff in the creation of a non-punitive environment

MNA supports and encourages all best practice initiatives embraced by the Massachusetts Coalition for the Prevention of Medical Errors. Barriers to the implementation of these best practices should be eliminated. The coalition has been at the forefront of national discussions on how to prevent medical errors, emphasizing best practices, communication and collaboration.

MNA nurses too often find that their expanded patient care assignments are unsafe. Fewer nurses are assigned to more patients with higher acuity and more complex medication regimens.

The MNA asserts that:

- The "giver" of a medication is only one part of the medication delivery system
- It is ineffective to focus only on error and should include the entire medication delivery system
- A systems-oriented approach to medication error is essential
- A non-punitive environment is essential for error reporting
- Proactively moving from a mind set of blame/punishment to an "error/correction philosophy" is crucial

The MNA continues to be the voice of support for each nurse's effort to provide the highest quality care.

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