Nurse License Protection Case Study: Falsifying the record of a medication error

Nurses and License Protection Case Study with Risk Management Strategies
Presented by NSO

A State Board of Nursing (SBON) complaint may be filed against a nurse by a patient, colleague, employer, and/or other regulatory agency, such as the Department of Health. Complaints are subsequently investigated by the SBON in order to ensure that licensed nurses are practicing safely, professionally, and ethically. SBON investigations may lead to outcomes ranging from no action against the nurse to revocation of the nurse's license to practice. This case study involves a registered nurse (RN) who was working as a traveling nurse on an oncology floor.

Summary

The insured registered nurse (RN) involved in this matter was a traveling nurse working on an oncology floor. The RN took a dose of pregabalin capsules out of the automated medication dispensing cabinet and requested that another nurse on the floor, who was also a traveling nurse, administer it to her patient. The second nurse took the medication and gave it to a patient. The second nurse soon realized she had given the medication to the wrong patient. She immediately called the physician on call and notified the Charge Nurse that the wrong patient had received a dose of pregabalin. The RN then recorded the medication error in the patient healthcare information record per hospital policy.

While the RN and the second nurse told the physician on call and the Charge Nurse what actually happened with the pregabalin dose, both also agreed to record the improperly administered pregabalin dose as a waste on the Controlled Substance Discard Record. The RN then went to the pharmacy to obtain a new dose of pregabalin for her patient. When the pharmacist asked why she needed another dose, the RN stated that she had accidentally dropped the other capsule on the floor and had disposed of it in the sharps container.

The pharmacist later ran a report on the automated medication dispensing cabinet to track how much pregabalin was dispensed the date of the incident. While the pharmacist expected to find two doses administered to the correct patient that day and one dropped/wasted dose, she found that two were administered to the correct patient and one had actually been administered to the wrong patient. The pharmacist reported this discrepancy to hospital administrators, who initiated an internal investigation into the nurses' conduct.

Investigation

The RN later admitted to hospital personnel that she was untruthful to the pharmacist about wasting the pregabalin. Both nurses stated that they had been untruthful about wasting the medication so that the RN's patient would not be charged twice for the dose of pregabalin due to their mistake.

The hospital investigators also concluded that the RN falsified the signature on the Controlled Substance Discard Record. The signature on the record was illegible. When the RN was asked who had signed the record, she gave the name of another nurse who worked on the floor. This statement was soon revealed to be untrue when it was discovered that the nurse the RN named had not been working on the date of the incident.

At the conclusion of their internal investigation, hospital personnel terminated the RN's contract and reported the RN to the State Board of Nursing (SBON). The hospital also complied with the subsequent SBON investigation into the RN's alleged conduct.

Resolution

At the conclusion of their review of the facts of the matter, the SBON admonished the RN for failing to follow appropriate procedure for obtaining a second dose for the correct patient. The SBON also lamented that the RN documented false information about the medication error in the Controlled Substance Discard Record without any need to do so- she had already disclosed the medication error.

The SBON decided to place the nurse on probation for three years. The total costs incurred to defend the nurse in this case exceeded **$7,000**.
(Note: Monetary amounts represent the legal expenses paid solely on behalf of the insured registered nurse.)

Risk Control Recommendations

Nurses can reduce risks associated with medication errors by following suggested actions:

- ***Remember that no medication safety method is infallible***. Understand that while technologies such as bar-code scanning can help reduce medication errors, this and other medication safety methods are not immune to system or human error. This is why it is important to employ multiple, concurrent safety measures, including consistently verifying the "six rights" when administering medications to patients:
    - Right patient;
    - Right drug;
    - Right dose;
    - Right route;
    - Right time; and
    - Right documentation.
- ***Know the medication(s) being administered to the patient***. Although nurses do not prescribe, and only rarely dispense medications, they are responsible for administration. Nurses represent the last line of defense to prevent medication errors from reaching the patient. Therefore, they must understand why the patient is taking a specific medication, as well as interactions, side effects, or adverse reactions that may occur.
- ***Eliminate sources of distraction and interruption***, as much as possible, when administering medication.
- ***Follow established medication protocols***. If "work-arounds" persist, consult with the facility's nursing leadership about opportunities to improve medication protocols and systems, and methods to enhance staff monitoring and compliance.

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