**Supplemental Digital Content**

***Case Study in Reflective Practice: Medication Error***

**DOSAGE ERROR**

As a per diem staff nurse for the float pool, Lisa found herself assigned to a patient who had received opioids via epidural catheter during his recent surgery. Her patient had returned from the post-anesthesia department with a periodically low respiratory rate accompanied by lower than normal pulse and blood pressure (BP). Narcan was ordered PRN to be given in doses of 0.2 mg intravenously (IV) should the patient’s respiratory rate fall below 10. Lisa was in the process of checking vital signs on her patient every 30 minute after he returned to the surgical unit. Upon his return, she assessed a respiratory rate of 8, pulse rate 50, and BP 88/60. According to the physician’s order, she prepared an IV dose of Narcan to bring the patient’s vital signs up to the appropriate parameters left with her by the anesthesiologist.

After Lisa had injected the medication into the IV port, she immediately started to chart the medication she had given. In horror she looked at the empty vial in her hand. It was labeled “2 milligrams per 1 milliliter (ml)” and she had just injected the entire 1 ml vial. Quickly, she reported the mistake to her charge nurse and hurriedly returned to her patient’s side. Within minutes, the patient complained of nausea. Lisa immediately took his vital signs again, to find that his respirations, pulse and BP had come up to normal rates, and her patient was much more alert than he had been. Lisa then called the attending physician and anesthesiologist to report her mistake and the patient’s present condition. Both told her to just watch her patient closely, stating that it may have been just what the patient needed.

A sense of relief came over Lisa, and yet her mistake almost overpowered her ability to finish the shift. She knew that, had she given 10 times a normal IV dose of most other medications, her patient would be in dire consequences and likely transferred to the Intensive Care Unit with subsequent death being a real possibility.

Lisa filled out an incident report as required and headed home. She had been able to stay composed until she walked in the door of the house, but as her husband asked about her day she broke into tears and headed to the bedroom. She could not quit thinking about how easily she could have “killed her patient.”

*PAUSE AND REFLECT:*

1. Apply aspects of the process of reflection from Beam, O’Brien, & Neal’s Model for Reflection (2010, p. 133) (see Table 1):
	1. Put yourself in Lisa’s place and ask, what happened?
	2. How you might feel after making this mistake? Would you be tempted to blame the setting (too many patients to care for, not enough time, too many interruptions in the medication administration room, etc.)? What might you be saying to yourself?
2. What is true regarding Lisa’s thinking about the medication error, and what is not true?
3. What could you say to Lisa and/or yourself in this situation that would be true? Helpful?

**HELPFUL REFLECTION**

How could reflection “in action” and “about action” help? What had led to Lisa’s mistake? Lisa knew the “Five Rights” about giving medication –right patient, time, medication, route, and dose. She had learned this early in her nursing education, but now three years after becoming an RN, she had not practiced what she knew. Did she need to consciously go through these 5 Rights each time she gave a medication? She had done this early in her nursing career, but lately she had been taking her knowledge in giving medications for granted. She realized she must go back to reviewing these five rights each time she gave a medication.

As a Christian, Lisa knelt beside her bed that night and talked the problem over with God. A realization came to her; she recognized she had been extraordinarily fatigued that day. Her baby had been up three times during the night, and Lisa had been up each time to feed and comfort her child. She decided that this, too, must be changed. She had gone back to work without taking all of her maternity leave. Apprehending this was unnecessary for the financial needs of the household, she talked with her husband about waiting to return to the hospital until they had successfully gotten the baby to “sleep through the night.”

The most difficult part of her reflection concerned forgiving herself for a mistake that could have caused serious harm to a patient. This disturbed her so much she said to herself, “I can never go back to work.” Rationally, she knew this was unreasonable. Yet, she did not feel comfortable in going to her supervisor or fellow nurses as she was not sure that in the present situation this would be a safe reflective environment. Her husband was a great support, but she needed something more. She remembered a friend from church who was a nurse and they had shared good and bad work experiences. She decided she would carefully approach this nurse and talk to her about what had happened, knowing the friend would listen carefully, respectfully, and prayerfully.

Reflecting the next day, she picked up a brochure included with her last paycheck. It advertised the Employee Assistance Program at the hospital reminding employees of the free service that included counseling for work issues. Perhaps this, too, would be an avenue of reflection and support as she sought to forgive herself.

Lisa also reached for her Bible, looking for verses that would speak to her need. Psalms 86:5 came to mind, “For you, Lord, are good, and ready to forgive, and abundant in mercy to all those who call upon you” (NKJV).

Over time, Lisa’s reflection about her mistake led her “back to the basics” in the work setting, and led her to a new place in her spiritual life—one of humility and dependence upon God. Wholistic transformation was taking place in her daily routine.

*PAUSE AND REFLECT:*

1. What steps did Lisa take that were constructive? What steps were not as constructive?
2. How could Lisa use this error to help make the work environment more conducive to reflective practice? Suggest specific actions Lisa could take.
3. Apply more aspects of reflection from Beam, O’Brien, & Neal’s Model for Reflection (2010, p. 133) (see Table 1).
	1. What was good about the experience? Difficult?
	2. What did you learn from the experience?
	3. What would you have done differently?
	4. If something like this happens again, what would you do?
4. What additional scriptures would you recommend Lisa meditate on in this situation?