

## Team Work and Communication: A Team Error

I am a hospital pharmacist, and as part of my job I round with the ward team on a daily basis. I work with the team by providing simple reminders to reorder medications and confirming safe medication doses, to writing orders for medications (especially weaning protocols), and literature searches when questions arise regarding best practice. I also provide education for families about their medications.

One day during rounds, we were seeing a young child who had been in a terrible accident and had a resultant head injury. The child had a prolonged ICU stay, and was being weaned from narcotics. The child had not tolerated the step-down dose of morphine the day before, so we decided to go back to the previous dose (which was 10% of a full dose), and wean more slowly. As it takes some time to write these orders, I let the team know I would do this after rounds, and the resident would then co-sign the order.

I had a terrible migraine headache that day, but as promised, I re-wrote the morphine wean prior to leaving early from work. This was a Friday, and I was very upset to learn what I had done when I returned to work on Monday.

After I wrote the morphine orders, they were co-signed by the senior resident, who later stated that she was in a hurry and did not read them. She simply signed them as she knows and trusts me and assumed they were correct. The charge nurse to ensure safe doses were being requested checked the orders, as part of standard practice, before submitting them to pharmacy. The bedside nurse gave the higher dose. She had known we were planning to increase it, but had not been paying full attention during rounds, so did not think to question how much of an increase had been ordered. The staff physician returned in the afternoon to see how the child was doing. The nurse informed the staff physician "He was far more settled with the higher dose of morphine and is catching up on sleep". The staff physician did not confirm the dose of morphine at that time, and accepted that the child was simply sleeping and had days/nights mixed up. The parents had returned home for the day, so were not present during rounds or the course of events.

The dosing continued until the following morning when a new bedside nurse noted that the morphine wean when re-written had been increased back up to full doses (2.0 mg instead of the 0.2 mg weaning dose intended). When the physician arrived, the bedside nurse asked why the child was at full doses again. The physician reviewed the chart, and the child had been "sleeping" for almost 24 hours since the increase in morphine. Fortunately, there was no apnea, or any other adverse effects noted. It took almost 24 hours and a fresh inquisitive mind to discover this error.

The event was fully disclosed to the family, who had a good rapport with the care team and was very understanding. When I arrived back to work on Monday, the attending physician privately explained what had happened, and reassured me that my error was only one in the series of events that allowed the unintended dose of morphine to be administered. Following rounds, the team met and discussed the error that had occurred in a supportive manner. Still, I was very upset over the mistake I had made. I was relieved that the little boy did not have significant harm from the event. I was afraid, but faced my fears. Later that day I went on my own to see the family to apologize for my part of the event. Interestingly, this gracious family made me feel better. They were very understanding of what had happened, and actually much to my relief said they would appreciate my ongoing participation in their child's care.