Reflection on Drug error:

An error occurred when Gentamicin was given when it was not due and had not been prescribed.

The mistake was realised by myself and a colleague immediately after the dose had been given and my initial concern was for the safety of the baby. The registrar was informed and measures were taken to ensure that the infant was monitored accordingly and that no harm had occurred. I felt disappointed in my clinical practice and role as a nurse, and the impact this had had on a baby and the team around me. I was well supported by colleagues and my manager.

The error has encouraged me to reflect upon my clinical skills and practice, in particular, the way in which I draw up and administer medications. There is a prescription chart and check list already in place for the process of administering Gentamicin, however, myself and my senior colleague failed to adhere to it accordingly on this occasion, resulting in a baby being given a drug prior to it being due. Although this had no adverse effects for the baby, it potentially could have.

Although this was an upsetting event it has made me again realise the importance of carrying out all of the relevant checks outlined by the Unit to ensure patient safety at all times. Although not excusable, at the time, myself and my colleague were administering multiple antibiotics all due at a similar time, as well as caring for our own patients (who were ITU) and supporting junior members of the team, including a newly qualified nurse, when the Unit was not fully staffed with adequate skill mix. On reflection, I feel this situation was unavoidable, and care was given to the best of our ability, however, knowing how the circumstances could have potentially ill affected the process of giving antibiotics; I should have been more aware and made an even greater effort to ensure all the relevant checks were made before giving and time should have been prioritised more accordingly, although this would have been challenging.

I do not feel that anything can be added/changed in order to prevent this happening again, however, I do need to develop my own professional role to ensure that I adhere to protocol at all times and adjust my workload/escalate inadequate staffing/skill mix to ensure that a mistake like this does not occur

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