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Shaping systems for better behavioral choices: lessons learned from a fatal medication error.

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This article discusses how a hospital responded to a fatal medication error that occurred when a nurse mistakenly administered epidural pain medication intravenously to a pregnant teenager. Findings from the root cause analysis of the error revealed underlying factors including fatigue (the nurse had worked a double shift the day before), failed safety systems (the hospital had recently implemented a bar coding system, but not all nurses were trained and workarounds were routine), and human factors engineering (bags containing antibiotics and pain medications were similar in appearance and could be accessed with the same type of catheter). A range of safety interventions were implemented as a result. However, the related editorials by leaders in the safety field (Drs. Sidney Dekker, Charles Denham, and Lucian Leape) take the hospital to task for focusing on narrow improvements rather than using complexity theory to solve underlying problems, and for creating a "second victim" by disciplining the nurse (who was fired and ultimately criminally prosecuted) rather than acknowledging the institution's responsibility and the caregiver's emotional distress. The article and commentaries provide a fascinating, in-depth look at the true impact of a never event.