Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

A client was admitted to the intensive care unit 3 days ago for acute pancreatitis. The client has been receiving IV fluids for rehydration and has a NG tube hooked up to suction. The nurse that admitted the patient has been on the patient's case since their admission. The patient frequently uses their call light to ask for the nurse. Upon entering the patient's room the client likes to talk about the weather and what's on TV. The nurse believes that the patient is experiencing boredom and has become very irritated with the situation. Due to staffing shortages, the nurse is taking care of three clients instead of two and feels that she does not have time to talk with the patient. While on her lunch break, a nurse aid approaches the nurse and reports that her patient is experiencing some pain and would like to receive their prescription of hydromorphone. The patient has not received their hydromorphone since the night shift and the patient did not report any pain while the nurse was in the room prior to lunch. The nurse enters the medication room and sees that the patient is prescribed 1mg of hydromorphone PRN every 4 hours. The hydromorphone comes in a 2mg/mL vial that has 10 mL total. The nurse asks her nursing friend to come cosign and witness her wasting the extra amount of hydromorphone. She tells her friend that she is annoyed that the patient is calling her every 15 minutes so she is going to give a "nurse bolus" of hydromorphone to the patient in the hopes that they will relax and go to sleep. The friend agrees stating, "maybe the patient will finally give the call light a rest" and cosigns for the medication. While talking the nurse draws up 2mL of the hydromorphone in order to give her nurse bolus believing the concentration is 1mg to 1 mL ratio. The nurse then returns to the patient's room to give the medication, pushes it quickly, and leaves the room with the intention to return to reassess pain in 15 minutes.
5 minutes later, the patient uses their call light and a nurse aid answers. The patient sounds muffled and the nurse aid cannot understand. The nurse aid decides to go to the patient's room to see what is going on. The nurse sees that the nurse aid is about to go into the room and asks that she be quiet so as to not wake the patient. The nurse aid reports to the nurse what she had heard over the call light and the nurse decides to enter the room also. Upon entering the room, the patient looks pale and the nurse cannot see the rise and fall of the patient's chest. The nurse checks the continuous vital sign machine and realizes it is not reading a pulse, respirations, or oxygen saturation. The nurse checks for a pulse and the pulse is absent. The nurse initiates a code blue and explains to the team that she gave the patient more hydromorphone than prescribed. The code team was able to give naloxone and reverse the effects of the hydromorphone and get the patient's vitals stable.

The patient care was lacking due to the nurses attitude towards the patient. The nurse became frustrated with the situation and instead of talking with the charge nurse in order to ask for help, the nurse decided to step outside of her scope of practice to "quiet" her patient. Unfortunately, it is hard to determine if these sort of events are a common occurrence or not. Many nurses may be able to get away with "nursing boluses" especially if the patient does not have an adverse reaction.

What circumstances led to the occurrence?

The circumstances that led to the occurrence above can directly correlate with the nurse's attitude. The nurse felt that they were too busy during the day to continue responding to the patient's call light. Because of this attitude, the nurse decided to step outside her scope of practice and purposefully give the patient more medication than what was ordered. Also, because the nurse was not fully paying attention while drawing up the medication, the nurse did not realize that she drew up 4 times the regular dose, rather than the 2 times that the nurse intended to give. Ultimately, it came down to the nurse's decision to give the patient a higher dose to sedate or calm him.

In what way could you measure the frequency of the occurrence? (interviewing nurses, examining charts, patient surveys, observation, etc)

Measuring the frequency of occurrences such as this could prove to be somewhat tricky. One could interview nurses about their use of "nursing boluses"; however, because this could lead to these nurses losing their license if reported, the likelihood of a nurse self-reporting themselves would probably be unlikely. A potentially more reliable way to measure these occurrences could be to monitor and examine incident reports to see how prevalent the occurrence may be. One last way to measure this occurrence could be to visit the Texas Board of Nursing website to see what reported cases have been disclosed; however, this would not depict the prevalence in one specific unit inside a hospital or the hospital itself.

What Evidence based ideas do you have for implementing interventions to address the problem?

Hospitals should implement and reinforce teaching on the 7 Rights of Medication Administration. Hospitals should implement the importance of accurate documentation and potentially institute an incentive program for attempting to decrease or eliminate adverse events such as these.

- Evidence based practice shows the importance of the use of the 7 Rights of Medication Administration. Using the rights such as Right Dosage could have prevented these occurrences from happening. If nurses took the time to use these rights on an everyday basis, now only would medication errors decrease but so would incidences such as this one. These rights may remind nurses of the importance of keeping the patient safe, rather than fulfilling their own agenda or wishes.
- The importance of accurate documentation is a vital part of what healthcare workers do. Documenting correctly should be encouraged more. In this event, the nurse and her nursing friend signed and cosigned stating that the patient was receiving the correct dose and the correct amount was wasted. Implementing that nurses are present for the wasting of medication and verifying the correct dose before signing or cosigning should be followed for all medications requiring double verification.
- Implementing an incentive program regarding correct documentation and decreased medication errors/"nurse boluses" may increase compliance on a unit and improve patient safety.
- Implementing the use of risk management workshops may decrease the use of nurse boluses as well as reduce incidence of patient harm.

-After an incident such as this, implementing safe administration of opioids workshop may reduce harm to patients also as well as remind nurse of the risk “nurse bolusing” has on patients.

How will you measure the efficacy of the interventions?

Measuring the efficacy of the interventions can be done by monitoring patient chart audits and incident reports. Although monitoring that the 7 Rights of Medication Administration are being utilized may be difficult, monitoring for a decrease in adverse medication events in patients may show an improvement. Ensuring that nurses are following the appropriate guidelines for witnessing and cosign could also be difficult to monitor but improvement could also be witnessed by the decrease of adverse events and decreased incident reports. The implementation of risk management and safe administration of opioids workshops should decrease the amount of adverse events in many areas, not just with medication errors.