

Quality Improvement Assignment

Topic: Medication errors- package look alike

Scenario:

It is flu season and a family of 5 went to their local pharmacy for their seasonal influenza vaccine. The pharmacist nurse went to the fridge where the vaccine vials were kept and removed one vial for administration. The mother and the father went first to demonstrate to their 3 younger children, ages 12, 9, and 5, that the shots will not be painful. However, the parents began to sweat and complained of feeling lightheaded. The nurse reported the incident to her coworkers, but continued to administer the vaccines to the children. After the extreme adverse reaction of the children, the nurse who gave the vaccines looked at the vial and realized she injected insulin instead of the needed influenza vaccine. Back tracking to the refrigerator the nurse noticed the influenza vaccine vials were placed next to the insulin vials displaying multiple similarities.

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

The big family of 5 may have pressured the nurse to rush through her checks of medication administration. Also, the distraction of children during the administration of the parents vaccine may have played a factor in this error.

What circumstances led to the occurrence?

Because the two vials were located in the same place the pharmacy nurse overlooked the medication and did not complete her 7 rights of medication

administration. This nurse relied on familiar cues, such as location, shape of vial, and clear color.

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

Unless the medication administration error is drastic, some nurses may not report or document the mistake at that time. If the medication error is minimal or causes no harm the nurse may just keep it to herself to avoid potential punishment. Nurses should not be afraid to admit to their mistakes. We are all human. It is best to document the medication error and then notify the charge nurse who should then work the information up the chain to hopefully avoid the mistake again.

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

The best evidence based practice for medication administration is following the 7 rights:

1. Right patient
2. Right drug
3. Right dose
4. Right time
5. Right route
6. Right reason
7. Right documentation

How will you measure the efficacy of the interventions?

The only way to measure the efficacy of the interventions is to determine if the mistake continues to reoccur. If this medication administration error does not happen as often or anymore altogether then the intervention made to avoid this problem was successful.