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Quality Improvement Activity: Chemotherapy administration

Describe the scenario.

In the pediatric floor, there were multiple patients that day that were admitted for their chemotherapy. The nurses were excitedly talking about their weekend plans. Some of the nurses had the chemo bag at the nurse's station for when they were ready to verify together. One of the nurses while talking had placed their chemo bag next to someone else's without realizing it. The nurses suddenly got really busy and just went to the rooms to administer the chemo. The nurse felt confident providing the chemotherapy since they had administered it often. The nurse had failed to read the chemo bag label not realizing they were giving it to the wrong patient. The nurse had already started administering it before even scanning the bag and checking the eMAR. After a few minutes the nurse started login to the computer to scan the chemo. When the nurse tried scanning the chemo, the nurse noticed there was an error. The nurse read the label and realized it was the wrong patient. The chemotherapy was for another patient. The nurse had grabbed the wrong chemo bag. The nurse immediately stopped the infusion pump. Without telling the patient or parent the nurse left the room to go tell the charge nurse. While the nurse called pharmacy the charge nurse took the crash cart near the room just in case, they would need it and went to go check on the patient. They also went to notify the other nurse with the chemo for this patient before they administered it to the wrong patient as well. Fortunately, the pharmacy cleared the patient from danger and the chemo the patient was receiving would not cause any harm to the patient.

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

The nurses put the patients at danger the moment they took the chemo to the nurses' station. The nurses got distracted by conversating about their weekend. The nurse not noticing where they were putting down the chemo was another mistake. The nurse failing to identify the patient when walking into the patient's room was another mistake. The nurse administering the chemo before even scanning the chemo or even verifying against the eMAR was a major mistake. Another mistake was not having another nurse observing them administer the chemo. This is a common occurrence when nurses don't follow the procedures and policies when administering chemo. Therefore, the nurses that follow each step carefully are least likely to commit this error.

What circumstances led to the occurrence?

Distraction, lack of discipline, and carelessness led to this occurrence. The nurse should not remove the chemo from the medication room unless they are ready to go directly to the patient's room. The nurse should never take the chemo to the nurses' station due to distraction and many medical mistakes occurring such as putting patients at danger. The nurse should have another

nurse available to go with them to observe the administration making sure everything is done correctly and properly. The nurse should never administer the chemo without another nurse watching and have them cosign for a procedure not correctly observed. The nurse should always verify the patient and medication brought into the room. The nurse should have verified chemo at the bedside computer with patient present verifying they have the correct patient and chemo. The nurse should have scanned the chemo before administering to the patient for safety. There was so many chances for the nurse to catch the mistake. This is the reason why it is very important to follow the steps of verification carefully because chemo is a very strong medication that could cause death if not administered carefully and correctly.

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

Observation would be the best measure to measure frequency. This will allow for observation of mistakes being done or where we can improve. We want to ensure nurses are following the procedures and if possible, prevent them from committing any mistakes. We rather correct it before it is an irreversible mistake. We also want to interview nurses to inform us what can be done to prevent further mistakes and where there could be improvement. Observation and interviewing would be the best components to measure the frequency of occurrences.

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

We want to ensure nurses are strictly following policy when handling chemotherapy. We want to make sure we are putting to use the policies procedures when administering chemo or any medication. We want to make sure nurses are not removing medications from the medication room unless they are going directly to the patient's room with the medication. We want to make sure nurses are verifying the patient and chemo. We want to make sure the nurses are strictly following the two-nurse administration to chemo and that the second nurse is actually in the room present during the whole procedure. These steps will allow to ensure a decrease in mistakes when administering chemotherapy.

How will you measure the efficacy of the interventions?

Having charts and interventions is a way that we could measure the efficacy of interventions. We could have charts showing the improvement that has been made within the staff. Also showing on charts the decrease of mistakes that have occurred when administering chemotherapy. We could even have a count of the number of days we have gone with chemotherapy mistakes free. Also interviewing the nurses on what they feel they have improved when providing chemotherapy and going over what has helped them follow the procedures.