

SIMULATION MEDICATION ERRORS REFLECTION QUESTIONS

**Directions:** Provide in-depth, thorough answers to each of the following questions by \_\_10/3/25\_\_. Answers should be added directly into this document and must total at least 400 words. Please submit to your personal Edvance360 Dropbox along with the completed Variance Report. Include all medication errors on one Variance Report.

1. Explain errors in the process that could have contributed to this incident.  
The errors in the process that could have contributed to the medication error that was made was the confusion of what bag of medication running that we would piggyback off. Also another process that could have contributed to this is not knowing the correct way to piggyback and set the IV pump the correct way meaning not knowing how to work the IV pump in general to know how to run the piggyback at the correct rate by setting the brain of the pump to identify there is another medication running with the fluids already hung. Another error could have been not double checking your work after doing the intervention to see if it is done and running correctly.
2. What are the potential complications that could have occurred to this patient related to the medication error(s)?  
Some potential complications for this medication error is that when the mother gives birth because she is GBS positive the bacteria can spread to the baby when the baby makes its way through the canal. When the baby is exposed to this bacterium it can cause infection or sepsis. This can have a very big impact on the baby leading to a lot of interventions needing done which leads to a longer hospital stay or leading to the worse of neonatal death. So, running the correct amount of penicillin will help decrease the exposure of bacteria to the baby during birth.
3. What follow-up care would you provide to the patient related to the medication error(s)?  
If the patient has not given birth yet and you realize the mistake you will start the correct dose immediately and notify the health care provider of incident. If the patient has given birth, you would monitor the infant for signs of infection till discharge. You would also educate the mother on signs and symptoms of infection so she could seek medical help for the infant if needed. You would also let the patient know of the error and let her know the potential complications that her infant could experience due to it. It is important to educate the mother on the error and what the infant could experience because she will be the one spending the most time with the infant and it will be important for her to know why you are monitoring her baby closely.
4. How would you prevent this type of event from occurring in the future?  
I would prevent this error from happening in the future by double checking the pump to make sure it is running the medication just hung as well and watching the drip rate to make sure it is being administered. Another prevention I would do is if I am unsure of an intervention I just did, I would ask for assistance before walking away as well as asking

someone to double check my work. I could also ask for help hanging the medication if I am unsure how to work the technology. I could also go back into the room about 10-15 minutes after hanging the medication to see if the bag is less full than the amount of fluid the bag started with. I could also check the pump multiple time to see if the pump is set correctly to the correct medication and check the current rate it is running at.

5. Write an SBAR to the healthcare provider regarding this incident.

Situation- I have patient in room 3104 on the maternity ward floor. She had just given birth. Patient was ordered penicillin at 200 mL/hr and there was a medication error and the pump was running at 150 mL/hr and not set to the correct medication. Currently the infant isn't showing any signs of infection.

Background- Patient had been tested for GBS and the test came back positive during her prenatal appointment. She had adequate prenatal care throughout the pregnancy. Patient was ordered penicillin at the start of active labor and attempted to administer.

Assessment- The patient and infant are stable and patient is aware of the medication error and the potential complications it may cause for the infant. Infant is not showing any signs of infection at the moment.

Recommendation- I recommend that we monitor the infant frequently for at least 24 hrs to assess for infection and educate the mother on the medication error and effects it could have on the infant over 24 hrs. I would also recommend ordering and administering the infant antibiotics to help decrease the chance of infection.