Firelands Regional Medical Center School of Nursing

Faculty Manual

SIMULATION MEDICATION ERRORS REFLECTION QUESTIONS

Directions: Provide in-depth, thorough answers to each of the following questions by _____. 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 medication error occurred when 8 mg of morphine was administered instead of the ordered 4mg, several process errors could have distributed to this incident. First, I failed to adhere to the six rights of medication administration, specifically the right dose. Another factor was the extra stress during the simulation impaired my concentration. I also did not do my math correctly which also led to my medication error. I should have stopped taking a deep breath, stopped to check multiple times, checked some more then administered the morphine.

2. What are the potential complications that could have occurred to this patient related to the medication error(s)?

Morphine is an opioid, so it decreases the central nervous system and respiratory drive, because of the fact that the patient has a history of COPD , she is already at an increased risk for impaired gas exchange and decreased respiratory depression, hypoxia, hypercapnia, or even respiratory arrest. Other Potential complications could be hypotension especially with her history of hypertension and that she takes metoprolol, Bradycardia, increased sedation or decreased level of consciousness, worsening oxygenation due to an underlying lung disease, increased fall risk while ambulating, and nausea and vomiting, increasing her aspiration risk pre-operative. With her history of atrial fibrillation, her risk of hypotension or hypoxia could potentially be worse and cause cardiac arrest. This medication error being before her ORIF surgery on her left leg could cause the surgery to get pushed back due to an excessive sedation that could require anesthesia team intervention.

3. What follow-up care would you provide to the patient related to the medication error(s)?

After I made the medication error I would automatically follow up with assessing the patient's airway, breathing, and circulation, as well as doing a set of vitals, specifically respiratory rate and Oxygen saturation. I would also listen to her lung sounds and watch her heart rate and cardiac rhythm. Assessing her neuro status would also be very important to do. I would do a continuous pulse oximetry and have oxygen ready to be administered with the start of two liters and going up from there. Also calling the provider to see if there are any orders they would like to put in and make them aware of my mistake. She has a history of COPD so I would carefully monitor for signs of hypoventilation of CO2 retention watching for things such as headache, confusion, fatigue. I would assess her vital signs every 5-15 minutes depending on how stable she is. I would also have Narcan ready to be administered if respiratory depression occurred.

With the fact that morphine is an opioid an additional dose would be held off unless ordered. I would also call the anesthesia team to make them aware of the medication error, and document the error with complete accuracy, as well as do a variance report and let the right people know about my error.

4. How would you prevent this type of event from occurring in the future?

To prevent this from ever happening again I will strictly adhere to the six rights of medication administration and perform three medications checks prior to administration. For high alert medications such as opioids, I will implement a safety pause to verify dose, concentration, and the patient-specific risks. I will reduce my distractions, avoiding rushing during pre-operative emergencies, and requesting a second nurse to verify when uncertain will help improve safety and prevent me from making this mistake again.

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

Situation: Hi Doctor Woo, this is Alivia. I am the nurse for Sam Smith. She is a 55 year old woman scheduled for an ORIF of her lower left leg, after she fell off a ladder. Her surgery is being moved up due to the belief of her having compartment syndrome.

Background: I'm calling to inform you about a medication error I did. You ordered 4 mg of IM morphine for pain, and at 8:30 am I administered 8 mg of IM morphine in her right shoulder. The patient has a history of COPD, atrial fibrillation, hypertension, and is a 2 packs per day smoker for the past 30 years.

Assessment: Her current vital signs are RR: 18, SPO2 of 94%, BP of 138/76, HR of 86 bmp, she is A and O x 4, at this time the Sam is stable but showing signs of respiratory decline.

Recommendation: I recommend contained close respiratory and cardiac monitoring, would you like to have Narcan at the side of the bed ready to be administered? I would also like to hold further opioid doses if that's okay with you. Are there any other orders you would like me to complete prior to her surgery?