AWARENESS OF NURSES REGARDING MEDICATION ERRORS IN THE CLINICAL SETTING

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Abstract

Miss J was performing my duty in Obstetrics unit as acting head nurse. Her colleague Miss Z registered nurse was also performing her duty in Labor-Room within unit. RN was very busy in her duty and a second year nursing student was also buddy with her. Meanwhile, a 25 years woman pre-natal was admitted for emergency C-Section. Patient shifted to Operation-Room for emergency C-Section with free operation medicine kit by the Labor-Room. After surgery, patient was re-shifted to the Labor-Room along with unused remaining operation-medicine. Client was complaining of postoperative pain. So, on-duty doctor prescribed her injection Tramadol for pain control.

Methodology: Observational report.

Ethical considerations: the pseudonym used for the characters. It is an observational report; it doesn't require the inform consent.

Results: A medicine error is failure in the treatment practice that may cause actual or potential harm to the patient. A sentinel error is unacceptable event in healthcare system that causes serious physical, psychological injury or death of the patient that is not related to natural progression of client disease (Neriman, 2018).

Recommendations: Nursing teachers and clinical nurses should closely supervise the nursing students in the clinical area. The anesthesia drug should be locked and dual check before administration. Nursing teachers should provide proper training to the nursing students before sending them on clinical rotation. There should be proper policies of the hospitals regarding medication errors preventions.

Critical Incident Scenario

On 8/10/2017, Miss J was performing my duty in Obstetrics unit as acting head nurse. Her colleague Miss Z registered nurse was also performing her duty in Labor-Room within unit. RN was very busy in her duty and a second year nursing student was also buddy with her. Ward was full with the patients. Meanwhile, a 25 years woman pre-natal was admitted for emergency C-Section. Patient shifted to Operation-Room for emergency C-Section with free operation medicine kit by the Labor-Room. After surgery, patient was re-shifted to the Labor-Room along with unused remaining operation-medicine. Client was complaining of postoperative pain. So, on-duty doctor prescribed her injection Tramadol for pain control. The patient-attendance called RN for giving prescribed medicine, but she was busy with another patient. So she sent student nurse for injection. Student took inject from patient medicine bag and inject it to the patient. Unexpectedly, patient become restlessness and expired. Patient relatives start shouted and created panic in emergency. Suddenly, medical team rushed toward incident place. When, they checked the injection ampule, it was injection Atrelex which is a neuromuscular blocking agent used for anesthesia as muscles relaxant. The ampule was also looked like...
to injection Toradol (pain control injection). So, the team identified that student nurse injected wrong injection to the patient. However, attendance started physical violence on employees and they damaged hospital property. Security of the hospital was also alert in panic condition. All admitted patients and their families become aggressive in unit and they refused to take medications from nurses due to young patient death. The public went on protest against nurses in the hospital. The issue was highlighted in the media. The management handled panic condition, and called inquiry against nurses. In inquiry result, student removed from her training and Registered Nurse was fired from her job.

Incident Causes

A medicine error is failure in the treatment practice that can cause actual or potential harm to the patient (Cheragi et al., 2013; Khan & Tidman, 2022). The medication administration errors can affect patients in form of adverse drug event, increase length of stay, morbidity and mortality and hospital cost of the patient (Kang, Kim & Lee, 2014; Naeem & Coronato, 2022). The sentinel high alert medication event is correlated with patient harm, and it can cause severe risk on misusing that can cause serious injury or death (Cohen, 1999; Naeem & Coronato, 2022). A sentinel error is unacceptable event in healthcare system that causes serious physical, psychological injury or death of the patient that is not related to natural progression of client disease (Neriman, 2018). The medication administration blunder can occur through failures in not following the rights of patient safety medication e.g. right patient, time, medication, dose and route of administration (Kim & Bates, 2013; Naeem & Coronato, 2022). This medication mistake may be result of individual mistake or gap in the knowledge or practice. There are many reasons in this incident that cause error in medication administration. Initially, the cause of early medication error arises because of returning of anesthesia medicine from operation room to Labor-Room. The OR staff shows irresponsibility of sending operation medicine from OR to Labor Room ward, which create serious event in the unit. The patient handing over and receiving record was missing before and after shifting for surgery.

Moreover, the inadequate supervision environment leads to medication error when undergraduate nurse did not get adequate supervision from her senior nurse. As, nursing students need proper supervision and role modeling to inspire them self for performing of client medication in safe routine (Khan & Tidman, 2022). The occurring of this event is also lack of application of knowledge, skills, inappropriate supervision, competency and absence of role model during clinical shift that cause medication error. Mainly, the medication administration error occurred due to over burden of the patient in the unit. Such as, the ward was full with the patients there were only one register nurse that was accompanied with novice nurse on emergency day. So, due to emergency and overflow of the patient the RN were unable to supervise novice nursing student during her duty. Furthermore, there was lack of supervision for nursing student because the nursing student was new and she needs proper supervision for her learning from their teachers. Unfortunately, RN sends her alone to administer medication to the patient without proper supervision. Subsequently, the cause of this medication error could be lack of pharmacological knowledge to the student. Therefore, she did not apply her pharmacological knowledge in patient drug administration. She injects the injection without knowing affect and side effect of medication that leads to patient life harm. The student nurse did not perceive risk of medication, so she administers the drug to the client without knowing it effect on patient health. Furthermore, both injections were looking similar in packing that make big mistake in understanding of drug. Finally, there were lack of communication between doctor, register nurse and nursing student that cause a big medication error in the hospitals.

Outcomes of Wrong Medication Administration

The loss of a precious one can be divesting. The medication fault might be result in severe patient harm or death. Although error is minor, there is massive spectrum and certain are fatal (Athanaskis, 2012; Khan & Tidman, 2022). On 8/10/2017, a young 25 years female was injected with anesthesia drug rather than injection Trmadol, an error that should never arise. This error was sentineling occurrence that involving unexpected death of the patient. The unforeseen outcome of the incident was expiry of the patient on her treatment bed. The patient was expired after wrong medication administration, the healthcare team tries to save patient life but it was too late. It was very difficult situation for patient family members because of unexpected and sudden death of the young patient. The family of the client was unaccepting sudden death of their patient. The family find difficult to cope with unexpected bad news so the relatives become very sensitive toward hospital team and environment.

Incident Future Implications

Drug errors have significant implication on client safety. Error detection through an active supervision and effective reporting system might discloses medication blunder and encourage safe nursing practice (Khan & Tidman, 2022). There are two types of implications are positive and negative implications in this incident. The inquiry committee reviewed patient file and submitted it to the multi-disciplinary committee to identify major causes of medication administration error. On basis of inquiry report result, curative interventions that consist of targeted training program for nurses, doctors and other healthcare were conducted. Ward based clinical pharmacist system
was introduced in the hospital to manage pharmacy work load and risk management. The inquiry committee develops medication administered standards for medication error risk reduction. The standards of handed over and taking over before and after surgery were also introduced in the system. If we investigate undesirable negative implication was removal of nursing staff from her job. She was fired from her service after the multi-disciplinary committee final decision. The undergraduate nurse was also terminated from her nursing training. The termination of both nurses put their future in dark. The media negative publicity gives very negative impact in the society. The nurse’s clinical practices become challenge in the hospital. The loss of young woman was serious incident for family and his newborn baby. The minor mistake leaves very long impact on family, healthcare team and hospital.

Recommendations

There are few proposed suggestions and recommendations that nurses may use to prevent the future medication errors. Nursing teachers and clinical nurses should closely supervise the nursing students in the clinical area. The anesthesia drug should be locked and dual check before administration. Nurses should encourage handed over and taking over practice before patient shifting. There should be ongoing trainings and workshops for clinical nurses, teachers and students. Nursing teachers should provide proper training to the nursing students before sending them on clinical rotation. There should be proper policies of the hospitals regarding medication errors preventions.

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References