

High Alert Medication Program

Kaiser Permanente Northern California

Educational Module

Directions:

- Read the attached material and complete the post tests.
- RETURN your answer sheets to your manager You must pass the test with 100%.



Preventing Medication Errors Self Study Packet-Traveler RN

Objectives:

After reading this packet and completing the quiz, the learner will be able to:

- Discuss the five rights of medication administration
- Identify examples of poor communication that lead to medication errors
- Identify the importance of bio-availability in determining administration schedules for medications.

Preventing Medication Errors

Beth is having a busy day on the general medical/surgical unit where she works part-time. As a very conscientious and thorough nurse, Beth attempts to provide the highest quality of care to the patients she is assigned. She receives an order for Actinomycin-D for her patient with Wilm's Tumor. Because Beth has never administered this drug and is unfamiliar with its normal dosage range, she transposes the dosage from 2.7 mg to 7.2 mg. Her failure to confirm the dosage results in the death of her 34-year-old patient.

Beth's situation is similar to that of thousands of other nurses who face the same stressors everyday. Her lack of familiarity with the prescribed medication, failure to refer to the unit drug reference, double check the order with the doctor or call the hospital pharmacist resulted in tragic circumstances.

Medication Error Defined

The Food and Drug Administration estimates that medication errors cause at least one death every day and injure nearly 1.3 million people in the United States every year. The 'National Coordinating Council for Medication Error Reporting and Prevention' defines a medication error as

“any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is under the control of the health care professional, patient or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packing and nomenclature; compounding; dispensing; distribution; administration; education monitoring and use” (2003).

It is important to note that this definition includes all aspects and systems related to drug administration, from manufacturing to the patient's bedside; from the bedside to the patient's home.

The Five Rights

Nurses are legally responsible for applying the five rights of medication administration as a Standard of Care.

Right Drug:

Administration of the wrong drug is the most common error that occurs. Factors that contribute to wrong drug error include similar labeling and packaging of products, medication with similar names and storage of these similar products together. In addition, poor communication is a common cause of administering the wrong drug. When transcribing verbal orders or verifying transcription of orders, a few simple precautions can help avoid errors:

- When taking a verbal order, write the order as it is being given by the provider, read it back to the provider, and spell out “sound-a-like drugs”
- Avoid using dosage and product abbreviations.
- Never assume route of administration— if necessary, call the provider to obtain clarification.
- Never use trailing zeros (write 25 not 25.0).
- Never try to decipher illegible orders—call the provider to obtain clarification.
- When in doubt, always check with the prescriber, pharmacist or literature.
- Always check the drug label and dose.
- Do not administer any drug if you are unsure of its intended use for your patient
- DO NOT ASSUME ANYTHING

Right Dose:

If dosage must be calculated, always recheck your math and have someone else verify your final dosage. It is important to consider the patient's age, size, and vital signs when deciding if a dose is appropriate. Newborns, pediatric and elderly patients are particularly susceptible to slight changes in medication dose.

