Practice sting Chain reaction of errors

This Practice Sting is particularly interesting for nurses and hospital committees concerned with medication safety

A medication incident is often not the result of one error, but of a series of errors, as shown in the notification below.

Notification

Nurse A has asked Nurse B to prepare an IV antibiotic for Patient 1. Nurse B first prepares a metoclopramide syringe for patient 2. Nurse B does not label the syringe. She wants to give this injection before she prepares the injection for nurse A's patient 1. Nurse B walks into the hallway. Nurse C asks her for help. Nurse B places the unlabeled injection on a table in the hallway. Nurse A sees the injection and thinks it is for patient 1. She administers the injection to the patient without looking at the administration list. She also does not ask a colleague to check on her.

Analysis

The nurses made a number of mistakes. Among other things, they did not work in accordance with the working method as described in the Preparation for Administration Guide (PAG). It went wrong on the following five occasions:

1. Nurse B did not have the PAG actions checked. She also does not label the prepared injection, making it no longer traceable.
2. Nurse B leaves the injection unattended in the hallway. Patients and visitors have the option to take the injection with them.
3. Nurse A picks the injection up without knowing whether it is intended for her patient. She also cannot see which medicine is in it.
4. Nurse A administers the injection without being able to perform the correct administration checks.
5. Nurse A does not ask anyone for a second check when administering "high-risk" medication, such as an injection.

Recommendations

For the hospital committees that deal with medication safety

- Ensure a periodic audit of the process of preparing and administering medicines. Provide instruction and training if necessary.
- Bring the above notification to the attention of all patient care departments.
- Advise the departments to discuss this notification and the following points with the healthcare professionals who prepare and administer medicines:
  - Do these types of errors also occur in your department?
  - Could these errors occur in the future? If so, what could be the cause?
  - Have measures already been taken to prevent these types of errors, and what do we think of these measures?
  - Can we make agreements to prevent similar errors from occurring in the future? How do we evaluate these agreements?
  - How can we monitor that these errors do not occur in our departments?

For nurses

- Discuss this notification with fellow nurses using the above points.