

POPINVITED: ID# 101028

Title:

Reducing Errors Associated with Intravenous Medication Administration

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ACCEPTED

Session Title:

Rising Stars of Research and Scholarship Invited Student Posters

Slot:

RS PST1: Sunday, 17 November 2019: 11:45 AM-12:15 PM

Applicable Category:

Clinical, Academic, Students, Leaders, Researchers

Keywords:

Errors, Intravenous and Medication

References:

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Abstract Summary:

In 2014, the World Health Organization (WHO) found that nearly 85 percent of medication error fatalities come from intravenous medication errors. This quality improvement project emphasizes a step-by-step protocol of setting up, administering IV medications, and monitoring the patient after.

Content Outline:**Reducing Errors Associated with Intravenous Medication Administration**

Introduction: In 2014, the World Health Organization (WHO) found that nearly 85 percent of medication error fatalities come from intravenous medication errors.

Main Point #1: Reasons why IV medication errors occur

- IV medication errors often occur due to having the wrong drug, dose, rate, time, or concentration
- They also occur due to errors related to aseptic technique, allergies, labeling, and patient identification.

Main Point #2: Nurses' Perception of why errors occur

- The physicians' medication orders are not clear, the names of many medications are similar, or the pharmacy did not label the medication correctly are a few reasons.
- Poor communication, lack of staff to patient ratio, fatigue from hard work, nurses' heavy workload, and working night shift are reasons stated by nurses as to why IV medication errors occur.

Main Point #3: Step-by-Step Protocol to Reduce IV Errors

- The main focus to reduce errors is making sure nurses follow the correct protocol in IV medication administration.
- Also, monitoring the patient after giving the medication is critical.
- Making sure the IV infusion pump is up to date with the correct medication and dosage along with continued education for nurses to keep them up to date on how to work the pumps.

Conclusion: A combination of standardized practice, technology improvements, and targeted education is required to reduce errors.

Topic Selection:

Rising Stars of Research and Scholarship Invited Student Posters (25201)

Abstract Text:

In 2014, the World Health Organization (WHO) found that nearly 85 percent of medication error fatalities come from intravenous medication errors. Medication errors are defined as “any preventable event that may cause or lead to an inappropriate medication use or patient harm while in the control of the health care professional, patient or consumer. (Fahimi, 2015). IV medication errors need to be reduced because IV medications go straight into the person’s veins; it’s the quickest route and fastest onset of action which can cause immediate and sometimes effects. Intravenous (IV) medication errors occur due to the wrong drug, wrong dose, wrong rate, wrong concentration, incorrect aseptic technique, known allergies, omitted medications, wrong time of administration, incorrect labeling, patient identification, and no order for the infusion. The most common error made in the hospital setting is missed or untimely doses. A literature review of 32 research articles identified that nurses’ perceptions of why medication errors occur included physicians’ medication orders are not clear, the names of many medications are similar, pharmacy did not label the medication correctly, poor communication, lack of staff to patient ratio, fatigue from hard work, nurses’ heavy workload, and working night shift. This quality improvement project emphasizes a step-by-step protocol of setting up, administering IV medications, and monitoring the patient after. As nurses, we clearly need to be more careful with the step-by-step process of medication administration. This starts with gathering the order for the medication, to preparing the medication to be given, to making sure you are giving the medication to the right patient, all the way through to correctly programming the pump. Using IV smart infusion pumps with built in libraries can help make infusing IV medications safer and the majority of adverse drug events related to the infusion pumps are incorrect or incomplete programming. It’s important to keep the pumps up to date and to make sure the nurses have knowledge on how to use the infusion pumps correctly. Allotting enough time to go through all the steps and eliminating distractions is crucial. A combination of standardized practice, technology improvements, and targeted education is required to reduce errors.