Risk Management Considerations for Medication Administration

It was a busy day at the nursing home. The doctor had given a verbal order to one of the nurses for 0.5 mg morphine for a patient that was experiencing pain. The nurse wrote it in the chart as ".5 mg". The secretary then transcribed the order onto the medication profile as 5 mg morphine. The "." got lost in the shuffle. The patient was given 5 mg of morphine instead of 0.5 mg of morphine. That is TEN TIMES the prescribed dosage! The patient became confused and suffered from shallow breathing and a weak pulse. Luckily, a nurse noticed the symptoms and was able to counteract the overdose before the patient's heart stopped completely.

Helpful Steps to Mitigate Medication Risks:

1. Design a safe area for drug dispensing.
2. Instruct staff to not remove the original packaging as it contains important instructions.
3. Have correct medication dispensing tools for liquid medication, such as oral syringes. Kitchen utensils such as teaspoons and tablespoons should not be used.
4. Separate ear drops from eye drops.
5. Speak to the individual or their guardian about the medication you are to administer. If in doubt or unclear about what they say, ask permission to call the individual's doctor or pharmacist.
6. Always take care when transcribing patient orders. Include a zero before a decimal place and avoid short forms that can have duplicate meanings.
7. Anyone giving medication should always follow the 'Five Rights':

    1. Right Drug
    2. Right Dose
    3. Right Client
    4. Right Time
    5. Right Route