Nurse Spotlight: Medication Administration

Nurses Service Organization (NSO), in collaboration with CNA, has published our 4th Edition of the NSO/CNA *Nurse Liability Claim Report*. It includes statistical data and case scenarios from CNA claim files, as well as risk management recommendations designed to help nurses reduce their malpractice exposures and improve patient safety.

You may access the complete report, and additional Risk Control Spotlights, at: www.nso.com/nurseclaimreport.

Nurses are responsible for providing the correct medication, in the correct dose, to the correct patient, via the correct route and at the correct time – and for remaining vigilant about preventing medication errors. Medication administration is a complex nursing activity that demands caution and attentiveness. Nurses play an important role as final gatekeepers of the medication use process through detecting and correcting potential prescribing and dispensing errors. This Nurse Spotlight focuses on the analysis and risk recommendations regarding one of the most significant topics in the report for nursing professionals: **Medication Administration Liability**.

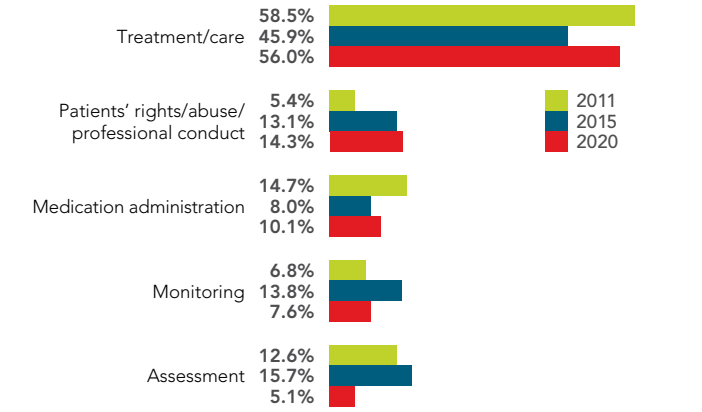
Many of the **medication administration claims** were difficult to defend as the **nurse used "work-arounds"** to bypass the facility's established safety procedures or **failed to follow** established **facility policies** and procedures or diverted medications.

Medication Administration Liability

Medication administration allegations in the 4th Edition of the NSO/CNA *Nurse Liability Claim Report* ("2020 claim report") were compared to the prior 2011 and 2015 CNA/NSO nursing liability claim reports. Although these allegations decreased significantly in the 2015 claim report when compared to 2011, in the 2020 claim report, the distribution increased.

13 Comparison of 2011, 2015 and 2020 Closed Claim Count Distributions by Allegation

Closed Claims with Paid Indemnity of ≥ $10,000



The average total incurred for medication allegations in the 2020 claim report was $214,035. Notably, wrong dose allegations represented the highest distribution of all medication-related closed claims, with an average total incurred of $109,644. The common theme associated with wrong dose claims includes incorrectly administering intravenous (IV) medications via infusion pumps. For example:

- Administering Cyclosporine at 100ml/hour instead of the prescribed 10mg/hour.
- Administering Flecainide at 8mg/0.8ml instead of the prescribed 4mg/0.8ml.

Figure 2 Distribution of Top Closed Claims by Medication Administration Allegations

Closed Claims with Paid Indemnity of ≥ $10,000

Allegation	Percentage of closed claims	Average total incurred
Wrong dose	26.1%	$109,644
Wrong route	17.4%	$236,346
Failure to notify patient's provider	13.0%	$340,753
Wrong medication	10.9%	$271,725
Overall Average Total Incurred for Medication Administration Allegations		**$214,035**
Overall Average Total Incurred		**$210,513**

In both the 2015 and 2020 claim reports, many of the medication administration claims were difficult to defend. These claims involved the nurse using "workarounds" to bypass the facility's established safety procedures or failure to follow established facility policies and procedures or diverted medications. While infrequent, the average total incurred for claims involving bypassing medication safety processes was $358,513. An example of a claim bypassing medication safety processes included:

- A nurse bypassed the electronic medication verification process and started an infusion of IV calcium gluconate with IV sodium phosphate, which are incompatible. Bypassing the electronic medication verification process resulted in the patient suffering from respiratory distress and death. If the nurse had followed the established medication verification processes, the IV incompatibility of calcium gluconate with sodium phosphate would have been identified.

In addition to professional liability claims, medication administration errors also contribute to complaints made to the State Board of Nursing with respect to nurse license protection matters. Allegations related to medication administration constitute 6.2 percent of all license protection closed matters resulting in an expense payment in the *Nurse Liability Claim Report: 4th Edition*, with an average expense payment of $5,084. In license protection matters where the type of medication error was specified, more than half (51.1 percent) of those errors involved either an alleged wrong patient or wrong dose medication error. For example:

- Four months after obtaining her registered nurse licensure, an RN noticed that, following administration of hydromorphone, the patient's lips changed color, and he exhibited signs of respiratory distress. The RN's preceptor came into the room and instructed her to call a Code. Narcan was administered, which effectively treated the patient's respiratory difficulty. Initially following the incident, the RN reported that the patient self-administered 4.4mg of hydromorphone via patient-controlled analgesia (PCA). However, it was later determined that it was the RN who had mistakenly given the patient 4.4mg of hydromorphone, rather than 0.2mg, bypassing the protocols for safe medication administration for PCA pumps. The State Board of Nursing issued a warning and ordered the RN to complete a remediation program designed to assess her nursing competency. Expenses paid to defend the RN exceeded $4,800.
- An RN working on a telemetry unit administered medications to a female patient in her late 80s, who had been diagnosed with heart failure, high blood pressure, and shortness of breath. However, these medications had been ordered for another patient, a female in her late 50s who had been diagnosed with depression and opioid withdrawal. The RN bypassed the verification step in the process and administered methadone, Lexapro, desipramine, and Lisinopril to the patient in her late 80s. Following the medication errors, the patient experienced respiratory depress, an altered level of consciousness and a drop in blood pressure. Two days later, she expired. Pursuant to an inquiry by the State Board of Nursing into the matter, the RN chose to voluntarily surrender her license.

Notwithstanding numerous patient safety initiatives, medication administration errors continue to occur, with serious and sometimes fatal consequences. According to the American Nurses Association:

> *Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations. (American Nurse Association, 2015, p. 1)*

According to The Joint Commission's National Patient Safety goals, medication safety continues to be a prominent patient safety issue, as national patient safety initiatives have focused practitioners' attention on the need to improve medication management and error reporting processes. However, dispensing and administration lapses, which are often difficult to defend in the event of a malpractice claim, continue to occur. By following the suggested actions, nurses can assist in reducing the liability associated with medication errors:

- Follow established medication protocols. If "workarounds" persist, consult with the facility's nursing leadership about methods to enhance staff monitoring and compliance (e.g., bedside shift reports, and structured interprofessional rounds). With respect to the interdisciplinary team, routinely review and address potentially problematic systematic or protocol design flaws.
- Understand that while bar-code scanning of the patient's armband to confirm identity can reduce medication errors, this method is not foolproof. Consistently use the "six rights" when administering medications to patients:
  - Right patient
  - Right drug
  - Right dose
  - Right route
  - Right time
  - Right documentation

Know the medication(s) being administered to the patient. Although nurses do not prescribe, they are responsible for administering medications. Therefore, they must understand why the patient is taking a specified medication, as well as interactions, side effects or adverse reactions that may occur.

Medication administration errors raise critical concerns, especially in high stress/high patient acuity locations. Whether in an acute care facility or their own home, patients have the right to receive safe care. Therefore, nurses must be cognizant of the medications they are administering, their side effects and the potential drug-to-drug interactions.

WAYS TO REDUCE ADMINISTERING THE WRONG MEDICATION

- ☐ **Know** the patient
- ☐ **Know** the drug
- ☐ **Keep lines of communication open** with the patient and other providers
- ☐ **Double check** high-alert medicines
- ☐ **Document** each drug administered

Nurse Spotlights

For risk control strategies related to:

- Defending Your License
- Documentation
- Communication
- Home Care
- Liability for Nurse Managers
- Depositions

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Medication Safety: Self-assessment Checklist for Nurses

The self-assessment checklist below may be used as a guide for nurses to assess their own medication administration practices and assist them with improving their knowledge of safe medication practices. For additional risk control tools and information see **www.nso.com**.

Medication Safety	Yes/No	Comments/Action Plans
I complete a patient drug history, including current prescription medications; over-the-counter drugs and supplements; alternative therapies; and alcohol, tobacco and illicit drug use.		
I utilize electronic or hard -copy medication profiles when readily available at the point of care.		
I review allergy notations on medication profiles prior to administering any medications.		
I record patient's weight and height measurements in metric units to avoid possible confusion.		
I review laboratory values and diagnostic reports prior to administering medications, and inform practitioners of any abnormalities.		
I utilize bar code medication administration to check patient identity and drug data prior to administration of drugs or, if this is not possible, I verify patient identity using two patient identifiers (such as patient ID number and birthdate) from the original prescription.		
I utilize only medication containers prepared in advance, ensuring that intravenous and oral syringes, vials, bowls and basins are appropriately labeled with the name of the patient and the drug's name, strength and dosage.		
I document simultaneously with medication administration to prevent critical gaps or oversights.		
I store unit doses of medications in packaged form up to the point of handoff/administration, in order to facilitate a final check of the medication administration record.		
I accept verbal drug orders from practitioners only during emergencies or sterile procedures, and, before transcribing the order, I read it back to the prescriber and document the read-back for verification.		
I communicate potential drug side effects at points of transition and document them on accompanying patient care plans and/or handoff reports.		
I include patients in the handoff dialogue, when possible, in order to prevent errors, reinforce their awareness of the medication regimen and strengthen post-discharge compliance.		
I follow procedures to prevent wrong dosages or concentrations of identified high-alert drugs (e.g., anti-coagulants, muscle relaxants, insulin, potassium chloride, opioids, adrenergic agents, dextrose solutions and chemotherapeutic agents).		
I ensure that high-alert medications are accompanied by standardized orders and/or computerized safe-dosing guidelines, and are verified by two persons before administration. I follow my employer's guidelines for high-alert medications.		

Medication Safety	Yes/No	Comments/Action Plans
I ensure that pediatric medications are accompanied by standardized orders and/or computerized dosing guidelines. I follow my employer's guidelines for both adult and pediatric patients' dosages, formulations and concentrations of drugs.		
I seek out and complete education about minimizing the risks associated with look-alike and sound-alike products, and I document my training.		
I follow my employer's policies and procedures to separate drugs with look-alike and sound-alike names.		
I receive notification when medication stock is relocated or storage areas are reorganized, in order to reduce the likelihood of confusion or error.		
I have pharmacists available on-site or by telephone for consultation regarding prescribed medications.		

Resources

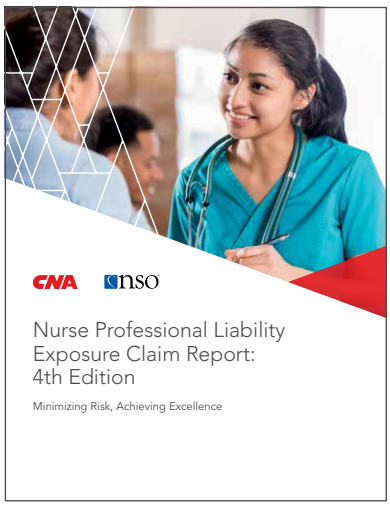
American Nurses Association. (2021). *Nursing Scope and Standards of Practice* (4rd Ed.). Silver Spring, MD: ANA.

American Nurse Journal. (2020). 2020 nursing trends and salary survey results. *American Nurse Journal*, 15, 17-22.ISSN 1930-5583.

Institute for Safe Medication Practices (2007). *The Five Rights: A Destination Without A Map.*

The Joint Commission (2021). *Hospital National Patient Safety Goals.*

Medcom. (2016). Medication Errors in Nursing: *Common Types, Causes, and Prevention.*



This information was excerpted from NSO and CNA's full report, *Nurse Professional Liability Exposure Claim Report: 4th Edition*. www.nso.com/nurseclaimreport

1100 Virginia Drive, Suite 250
Fort Washington, PA 19034
1.800.247.1500 www.nso.com

151 N. Franklin Street
Chicago, IL 60606
1.888.600.4776 www.cna.com

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