Safe Medication Practices in the Operating Room

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Welcome to the Medline University course, “Safe Medication Practices in the Operating Room.”

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Objectives

The objectives for this course are as follows:

1. To identify and discuss factors that affect the medication administration process in the perioperative environment.
2. To explain potential risk factors for medication errors in the perioperative department.
3. To describe interventions that can help to minimize the risk of medication errors occurring.
4. To identify AORN recommendations regarding the safe administration of medications in the perioperative department.

Module One

This module will define what a medication error is, and will help the learner to understand why medication errors occur.

What is a Medication Error?

According to the National Coordination Council for Medication Error Reporting and Prevention, “a medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer” (National Coordinating Council for Medication Error Reporting and Prevention, 2015).

Six Phases of Medication Administration Process

In order to understand how medication errors occur, we must first discuss the six phases of the medication administration process. The six phases are procuring, prescribing, transcribing, dispensing, administering, and monitoring. Medication errors can occur at any point in these six phases, and healthcare personnel should understand risk factors that are present in each phase (Conner, 2015).

Procurement is the process by which facilities obtain and stock medications. This step is important because it ensures correct, up-to-date medications are stocked (Conner, 2015).

Prescribing is the process in which a medication is ordered by an authorized team member. Errors in prescribing can trigger a cascade of errors throughout the subsequent phases of medication administration, leading to medication errors. Many errors can occur in the prescribing phase, including ordering the wrong drug, dose, or route, or ordering drugs for a patient with a known allergy to that drug (Hughes & Blegen, 2008).

Transcription is the process by which an order is written and verified. Often, within the operating room setting, nurses are the ones transcribing, dispensing, and administering medications. Pharmacists may also be involved in transcription and verification of correct medication orders, as well as dispensing, and can be an important second set of eyes to prevent medication errors (Hughes & Blegen, 2008).
Dispensing is a process that begins when the pharmacist assesses the medication order and ends when the medication is released to another health care professional (Hicks, Wanzer, & Goeckner, 2011).

Administration is the action of the health care professional giving the medication to the patient (Hicks, Wanzer, & Goeckner, 2011).

The monitoring phase of medication administration can continue beyond the operating room. Effective hand-offs and communication between team members is essential to ensure that patients are adequately monitored for drug responses (Hughes & Blegen, 2008).

Common Medication Errors
A study by the Adverse Drug Event Prevention Study Group identified more than 15 types of medication errors, including wrong dose, wrong drug, wrong time, wrong route, drug-drug interaction, and inadequate monitoring. This group also evaluated which errors were more common among physicians versus nurses. Among the errors that were more frequent in the nursing group, the most common were associated with the wrong dose, wrong technique, or wrong drug (Leape, Bates, Cullen, Cooper, Demonaco, Gallivan, et al., 1995).

The “Five Rights” of Medication Administration
The “five rights” of medication administration are checkpoints to address potential errors. The “five rights” include the right patient, the right drug, the right dose, the right route, and the right time. The Institute for Healthcare Improvement suggests that achieving the five rights should be the goal for all nurses to reduce medication errors (Federico, 2015).

Medication Errors & Sentinel Events
Effects from medication errors can range from mild to quite severe, depending on the type of error. Sometimes, medication errors can be considered “sentinel events.” The Joint Commission defines a sentinel event as an event not primarily related to the natural course of the patient’s illness or underlying condition resulting in death, permanent harm, or severe temporary harm with intervention required to sustain life (Joint Commission, 2015). Even in the operating room, where the patient's status is constantly monitored, medication errors can lead to serious complications or death.

Multifactorial Causes
Many factors contribute to medication errors occurring. These will be discussed in detail later in this course.

In the often hectic environment of the operating room, the conditions surrounding medication administration pose unique challenges that can increase the risk of medication errors occurring. For example, the clinician prescribing the medication may also be the one administering it. This leaves little chance to detect the error before it reaches the patient. Even if one clinician prescribes a drug and another administers it, communication of the order is typically verbal. Verbal orders can be misinterpreted and are associated with an increased error rate. Because of this level of risk in the operating room, it is important to understand and identify risk factors and system failures that could result in a medication error (Conner, 2015).

Why Medication Errors Occur
Why do medication errors occur? The answer comes down to human error, which can be viewed in two ways: the person approach and the system approach. The person approach focuses on what the individual has done wrong, and places blame on that person for inattention or forgetfulness. The system approach focuses on the conditions under which individuals are working, and seeks to build safe-guards into the system to prevent errors. Healthcare organizations benefit the most and achieve higher levels of patient safety when they focus more on the system approach. The system approach helps them determine methods for building a better system to reduce error rates rather than blaming individuals for failures (Reason, 2000).
Swiss Cheese Model

The Swiss Cheese model is often used in healthcare to understand accident causation and risk analysis and management. Ideally, there are intact levels of defense built into the healthcare system to prevent adverse events, such as medication errors, from happening. However, in reality, the layers of defense are more like slices of Swiss cheese, having a number of holes. These holes change and shift. When they line up just right, an action can pass through the layers of defense and cause harm. The holes in the layers of defense can be latent conditions or active failures. Latent conditions are flaws within the system. These include understaffing, inadequate training and education for employees, and inadequate equipment or facilities. Active failures are unsafe actions performed by people who are in direct contact with the patient. Active failures include lapses, mistakes, or procedural violations. Typically, a series of latent conditions lead up to the active failure (Reason, 2000).

High-Reliability Organizations

High-reliability organizations have been evolving over the past several years. These organizations become preoccupied with failure, and focus on improving system functions in order to avoid adverse events in complex environments prone to error. The Joint Commission has been a key player in the push toward high-reliability healthcare organizations. The Joint Commission reports that certain changes need to occur within healthcare organizations in order for them to move toward high-reliability. These changes include leadership committed to attaining zero patient harm, achieving a fully functional culture of safety permeating the organization, and implementing widespread utilization of highly effective process improvement tools (Chassin, 2013).

Reducing Medication Errors

Understanding the Swiss Cheese model and high-reliability principles can help reduce a variety of errors and adverse events, including medication errors, within healthcare organizations. The remainder of this course will discuss methods of improving the system where you work, and will describe interventions to minimize these risks.

MODULE TWO

This module will discuss factors that affect the medication administration process in the perioperative environment.

10 Key Factors Affecting Medication Administration

The Institute for Safe Medication Practices has identified ten key factors that can affect medication administration and lead to errors. These include:

- Patient information
- Drug information
- Adequacy of communication
- Drug packaging, labeling, and nomenclature
- Medication storage, stock, standardization, and distribution
- Drug device acquisition, use, and monitoring
- Staff education and competency
- Patient education
- Quality process and risk management
- Environmental factors
  (Anderson & Townsend, 2010)

Each of these factors includes specific risks that can contribute to medication errors. These will be discussed in more detail in the following sections.
Patient Information

Accurate patient information is essential in preventing medication errors; recall that the first “right” of medication administration is “right patient” (Federico, 2015). Patient information should include the patient’s name, weight, allergies, diagnosis, current lab results, and vital signs. Scanning the barcode on patient wristbands is one way hospitals try to ensure the correct identity of the patient receiving the medication. However, the system is not fail proof, as there may be issues with the scanner or with the patient’s wristband. Additionally, scanning the barcode can increase administration time, particularly in the operating room where things tend to happen at a rapid pace. When trying to save time, healthcare personnel may bypass this important safety check (Anderson & Townsend, 2010).

Drug Information

Current medication information should available in protocols, text references, order sets, electronic information systems, medication administration records, and patient profiles. When this information is not readily available, drug interactions or side effects could be missed (Anderson & Townsend, 2010).

Adequate Communication

A number of medication errors result from inadequate communication. This can be a particularly challenging issue in the operating room, where things can be loud and chaotic. Medication orders in the operating room are often given verbally, and can easily be misunderstood. Confusion regarding the medication order can result due to muffled verbal orders delivered through surgical masks.

It is important for operating rooms to foster a culture of safe and effective communication. Nurses should not be afraid to ask for clarification, or for an order to be repeated if they did not fully understand the initial order (Anderson & Townsend, 2010). Additionally, across the perioperative department, from preoperative holding, to the OR, to the PACU, and finally to the ICU or medical/surgical unit, there are multiple patient hand-offs between care providers. Care may be provided by multiple healthcare workers at any given time. These factors significantly increase the likelihood that important medication information is not appropriately communicated (Conner, 2015).

Drug Packaging, Labeling, & Nomenclature

Errors can occur when there are issues with drug packaging, labeling, and nomenclature.

Medications should be in clearly labeled unit-dose packages for institutional use. In the operating room, high-alert medications may be available in multiple dose forms and concentrations. It is important to have these clearly labeled and defined. Perioperative staff members must be familiar with the distinctions before caring for patients.

Look-alike or sound-alike medications can be a source of error. Look-like and sound-alike medications should not be stored in close proximity to one another as this could lead to confusion. The Joint Commission requires that healthcare organizations identify look-alike and sound-alike medications annually, and that there are processes in place to prevent medication errors related to this issue (Anderson & Townsend, 2010).

Medication Storage, Stock, Standardization, & Distribution

Medication storage, stock, standardization, and distribution can be a problem within the operating room. Automated dispensing cabinets have improved the problems related to storage and stock over the years. However, errors can still occur with these cabinets, particularly when medications are not double checked once they are retrieved (Anderson & Townsend, 2010).

Drug Device Acquisition, Use, & Monitoring

Medications and devices for drug administration should be appropriately acquired and utilized, in accordance with institutional policies and manufacturer instructions, in order to prevent errors from occurring. It is important
for healthcare personnel to have a thorough understanding of how to appropriately utilize medical devices for medication storage, dispensing, and administration. Healthcare personnel must also understand the appropriate monitoring that is required when using drug delivery devices. When healthcare personnel working with these devices do not have a clear understanding of all aspects of the device, errors can occur (Anderson & Townsend, 2010).

**Staff Education and Competency**

Education is the key to preventing any medication error. Ongoing education should be provided for nursing staff to help reduce medication errors. New medications, devices, and protocols warrant a high teaching priority (Anderson & Townsend, 2010).

**Patient Education**

Patients should have an understanding of the medications they are taking, appropriate method of administration, dosage, and side effects to watch for. This is not possible for medications administered within the operating room. However, both preoperatively and postoperatively, patients should have an understanding of the medications they will be receiving and have received. It is important for patients to understand their home medications so that any side effects or interactions with new medications can be anticipated and prevented (Anderson & Townsend, 2010).

**Quality Process & Risk Management**

As mentioned in Module 1, quality improvement is necessary for healthcare organizations pushing towards high-reliability. Hospitals should constantly be improving the medication administration process in order to eliminate medication errors. This includes addressing issues, such as understaffing, that contribute to nurses being overworked, fatigued, and more prone to making errors. Facilities need to have a culture of safety that encourages discussion of the errors that have been made and ideas for improvement. This type of open dialogue can prevent harm to future patients (Anderson & Townsend, 2010).

**Environmental Factors**

Environmental factors are a key consideration in the perioperative environment. In this setting, there are unique factors that can affect the process of medication administration. Some examples include the following:

- The transfer of medications onto the sterile field aseptically. Medications are often removed from their original manufacturer’s packaging so that they can be aseptically transferred onto the sterile field. Inconsistent labeling of medications both on and off the sterile field can contribute to medication errors.

- The presence of a scrubbed-in intermediary who receives and transfers the dispensed medication to the scrubbed-in practitioner (typically the surgeon). The medication may be handled by multiple individuals before reaching the licensed individual administering the medication. This creates room for error. Additionally, medications prepared in the operating room are not reviewed by a pharmacist, who can oversee preparation or provide consultation.

- Time-sensitive conditions. The complexity of patient care in the operating room often requires rapid intervention.

- Sensory distractions are inherently present within the operating room and add an increased level of complexity to the medication administration process. (Conner, 2015)

**MODULE THREE**

This module will discuss best practice recommendations to improve medication safety.
AORN Guidelines

The Association of perioperative Registered Nurses, or AORN, provides guidelines for perioperative practice, including safe medication practices. The goal of these guidelines is to provide best practice recommendations for nurses. The implementation of these guidelines will be discussed in depth in this module.

Multidisciplinary Team Approach

AORN recommends that a multidisciplinary team approach should be implemented for medication management and the prevention of medication errors in the perioperative department. Although a nurse is typically the primary caregiver who is administering medications, the entire healthcare team needs to be involved in medication management. This healthcare team includes nurses, physicians, and pharmacists. By involving all team members, effective communication is fostered. A pharmacy and therapeutic committee or medication safety committee should also be established within healthcare organizations. This committee should focus on medication safety issues and ensure effective interactions between healthcare providers. The multidisciplinary team should develop a medication management plan that provides structure and safety measures for each of the six phases of medication administration. The medication management plan should incorporate integrated technology when possible. This includes the utilization of automated dispensing storage systems, smart infusion pumps, electronic medical records, automated medication dosage calculations, and barcoding technology. Additionally, pharmacists should be available for consultation with perioperative team members, even in the operating room (Conner, 2015).

Medication Reconciliation

Upon admission, a medication reconciliation needs to be performed for each patient. Additionally, the patient's weight should be documented in order to appropriately calculate weight-based doses for certain medications. Nurses should collaborate with the pharmacy department preoperatively to perform an adequate medication reconciliation. This ensures that there is thorough documentation of the patient's home medications, including supplements and over-the-counter medications. It is also important to note medication allergies and reactions. The medication reconciliation should be recorded in a format that is easily accessible to other nurses and healthcare personnel caring for the patient throughout the perioperative department and onto the medical/surgical unit post-surgery. Perioperative nurses should review the medication reconciliation, as well as all current medication orders, confirm the patient's weight, and assess the patient prior to administering medications (Conner, 2015).

Safe Procurement Practices

Medication errors can sometimes be tracked back to the procurement phase, which is the first phase of the medication administration process. Medications and all related supplies should be procured and stored in a manner which facilitates safe and efficient delivery in accordance with manufacturer storage requirements. Additionally, medications should be stored in a standardized manner across all perioperative areas. Organization schemes should separate high-alert medications, provide separate bins or dividers with clear labeling for all medications being stored, avoid alphabetical storage, and position medication containers in a way that labels are clearly visible. Healthcare organizations should keep the following key points in mind when developing policies regarding medication procurement:

• Procedures should be in place for current or potential product shortages, discontinuations, or recalls
• Processes promoting accurate medication stocking and restocking should be implemented
• Procedures should be enacted for verification of medications upon receipt (Conner, 2015)

Medication Storage

AORN recommends that when medications are stored, they should be rotated based on the expiration date on the label. Recalled items should be removed from storage as soon as possible, and should be returned to the
appropriate location. Substitutions for discontinued or recalled medications and information about drug shortages should be communicated to staff members in order to decrease the risk of prescribing, dispensing, or administering an inappropriate medication (Conner, 2015).

Look-Alike & Sound-Alike Medications

Healthcare organizations should develop policies regarding look-alike and sound-alike medications. A list of these types of medications can be obtained from national safety organizations. These lists should be compared with the inventory of the organization in order to set a plan of action regarding procurement and storage (Conner, 2015). The FDA's Name Differentiation Project has taken look-alike drug names and has revised their appearance to help minimize confusion. The FDA has encouraged manufacturers of these medications to differentiate the labeling of their products and have used capitalized letters to emphasize the key differences in the name of their particular drug (U.S. Food and Drug Administration [FDA], 2013).

Single-Dose vs. Multi-Dose Vials

AORN also recommends that perioperative nurses work together with pharmacists to store single-dose vials, rather than multi-dose vials. Vials that contain more of the medication than the typical amount given put healthcare workers at risk of misinterpreting the amount in the vial, or the amount that should be used. Additionally, healthcare workers may use the vial for more than one patient, in order to avoid waste. This can lead to cross-contamination from one patient to another. The use of single-dose vials helps reduce confusion with labeling and expiration dates, and simplifies issues of proper disposal and inconsistent documentation of waste. If multi-dose medication containers are used, they must be dated to indicate the expiration within 28 days of opening. Once the vial is opened, the manufacturer's expiration date is no longer valid. Multi-dose vials should also be stored separately from single-dose vials in order to prevent confusion (Conner, 2015).

Preventing Errors in Prescribing

Prescribing personnel should provide accurate medication orders that are unambiguous. Surgeons, anesthesiologists, and advanced practice nurses are all licensed to prescribe medications. This could be a verbal order, verification of a standing order, or a written order. Prescribers should have full access to all pertinent patient data and reference material. Standing orders and preference cards need to be reviewed annually by the perioperative team to ensure accuracy. Verbal orders should be limited as much as possible, particularly when high-risk and sound-alike medications are involved. Background noise, accents, and muffled voices behind masks can contribute to misinterpretation of verbal orders in the operating room. Nurses in the OR should verify medication orders, particularly verbal orders, and should ask for clarification if something does not make sense. When possible, computerized-provider order entry systems, or CPOE systems, should be used to reduce the opportunity for errors (Connor, 2015).

Safe Medication Order Transcription Processes

AORN recommends that safe medication order transcription processes should be implemented. Transcription is the point in the medication administration process where an order is recorded or transferred by someone other than the prescriber so that the order can be processed. Errors in this phase can lead to inappropriate medications or doses being administered. Omission errors can also occur when the medication is not transcribed and the patient does not receive the medication (Conner, 2015).

The Role of Pharmacists

Pharmacists should be actively involved in dispensing medications throughout the perioperative department. Pharmacists should review medication orders, including standing orders. Decentralized, or satellite pharmacies in the perioperative area provide additional support to perioperative staff members. These satellite pharmacies are able to help with mixing, diluting, and compounding medications. Pharmacists should oversee automated dispensing storage systems (Conner, 2015).
Safety in the Administration Phase

Prior to administering medications, nurses should always perform final checks to ensure that all patient and drug information is correct. The patient's weight, medication history, and current medications should be verified and a patient assessment should be performed before medications are given (Conner, 2015).

Importance of Monitoring

Monitoring, which is the final phase of medication administration, allows nurses to detect both therapeutic and adverse effects of medications given. Perioperative nurses should observe the patient to assess the effectiveness of the medication, and should document the patient's response. Monitoring is important for detecting errors. It can also identify adverse effects of the medication and lead to both the treatment and documentation of these adverse effects. Perioperative team members should report potential hazards, near-misses, and actual medication errors in accordance with institutional policies (Conner, 2015).

Patient Education

Once patients are out of the operating room, PACU nurses and floor nurses should coordinate patient education plans based on the medications the patient has received. Each patient should have an understanding of the medications they received while in the operating room, and specific aftercare instructions based on those medications (Conner, 2015).

Nursing Medication Plans

Across all areas of the perioperative department and through all phases of the medication administration process, it is essential for nurses to develop and implement medication plans. AORN recommends that perioperative nurses utilize their knowledge of pharmacology, as well as their understanding of each patient and their unique condition to develop a medication plan that is tailored to the patient before obtaining or giving medications (Conner, 2015).

MODULE FOUR

This module will discuss the importance of policies and procedures regarding safe medication administration and how they can be applied across the six stages of medication administration.

Policies and Procedures

Safe medication policies and procedures should be developed by healthcare organizations and should be readily available to clinicians. They should address direct patient care situations as well as organization-level issues. These policies should span all stages of medication administration, and should be reviewed at least annually to ensure accuracy. Education regarding these policies and procedures should be provided to healthcare personnel. The purpose of having these policies and procedures in place is to establish authority, responsibility, and accountability within the organization (Conner, 2015).

Procuring

There are several important factors to consider when developing policies and procedures around the procurement of medications. First, there are therapeutic considerations for formulary management. This includes the addition of new products to the formulary. Packaging should also be considered, taking into account standardization, look-alike and sound-alike medications, and unit of use. Security should be ensured for medication inventory, regardless of whether medications are scheduled or non-scheduled substances. Medications are considered “scheduled” if there is a higher potential for abuse or addiction related to use of the medication (DEA). Plans for medication disposal should be in place for unused or outdated products, as well as plans for product returns (Conner, 2015).
Prescribing

Policies regarding prescription of medications should include what constitutes prescribing and parameters for who can prescribe. The format of prescribing, whether verbal, written, or electronic, should be delineated with factors specific to each mode clearly addressed. Policies should emphasize clear medication orders that do not use unapproved abbreviations. They should address environmental conditions that can interfere with successful prescribing such as loud noise or interruptions in the operating room. There should be a process for creating, maintaining, and reviewing preference cards and standing orders in the perioperative department. It should be noted that when electronic systems are used for prescribing, such as Computerized Physician Order Entry systems, prescribing policies should align with information technology policies and procedures (Conner, 2015).

Transcribing

Policies and procedures related to the transcription phase of medication administration should include details of the documentation process. This includes explanations of specific forms unique to the organization, such as medication administration records. There should also be processes in place for documenting when orders have been transcribed and for transmitting the order to the pharmacy for processing, if needed. These policies and procedures should include appropriate verification of patient identity at each step. The roles and responsibilities of all clinicians involved in the transcription process should be clearly delineated (Conner, 2015).

Dispensing

Institutional policies regarding dispensing medications should clearly define what constitutes dispensing and who can dispense medications. The pharmacy should have oversight of the medication management process. The process for retrieving and returning medications from automated dispensing machines or other storage areas needs to be clear and well-understood by all staff (Conner, 2015).

Administering

Policies and procedures surrounding administration of medications need to encompass many different factors. First, policies should define what constitutes administration and who can administer medications. Policies should include weight-based dose conversion charts, which should be readily available to staff members. The verification process needs to be clearly defined here, incorporating the use of at least two patient identifiers. Thorough documentation policies should be in place for medication administration. It is important that institutional policies and procedures are in compliance with federal regulations (Conner, 2015).

Monitoring

Parameters for monitoring the patient's response to medication should be included in policies and procedures on monitoring following medication administration. Methods for documenting the monitoring process must also be included in these policies and procedures.

It is important, particularly in the perioperative environment, to define the roles of perioperative team members in this process (Conner, 2015).

Policies and Procedures

When it comes to the six steps of the medication administration process, policies and procedures can become quite extensive. It is important for healthcare organizations to clearly communicate these policies and procedures, and to make them readily available for all staff members to reference.

MODULE FIVE

This module will discuss education, quality improvement measures, with a focus on root cause analysis and event reporting.
Education
AORN recommends that perioperative personnel should receive initial and ongoing education regarding safe medication practices. Those working in the perioperative department should demonstrate competency in the performance of safe medication practices on an annual basis at least. Periodic educational programs allow for the opportunity to reinforce information that has previously been learned, and to introduce new, up-to-date practices. Education and training should address the medication use process, risky behaviors, barriers to safe medication administration, the role of the nurse in medication reconciliation, medications associated with emergency care, educational tools for patients regarding prescribed medications, policies regarding pharmaceutical waste, and new updates to regulations, procedures, and technology. Education and competency training should be documented (Conner, 2015).

Quality Improvement
When medication errors do occur, it is important to understand what failures occurred leading to that error. Healthcare organizations need to analyze the medication administration process to learn why and how the error occurred in order to prevent future errors. One way to do this is through a root cause analysis (Agency for Healthcare Research and Quality [AHRQ], 2014).

Root Cause Analysis
Root cause analysis, or RCA, is a technique used to ensure that the underlying issue is solved and that efforts are not simply treating a symptom. RCA locates the primary cause of the problem so that a facility can determine what happened, why it happened, and figure out what to do to reduce the likelihood that it will happen again. There are three basic types of causes:

• Physical causes – Tangible, material items that failed in some way.

• Human causes – People did something wrong, or did not do something that was needed. Human causes typically lead to physical causes.

• Organizational causes – A system, process, or policy that people use to make decisions or do their work is faulty. (MindTools, 2015)

RCA Steps
The goal of an RCA is to continually dig deeper so that the true cause is addressed, not just the most obvious one. These five identifiable steps are key to the analysis process:

• Step One: Define the Problem
• Step Two: Collect Data
• Step Three: Identify Possible Causal Factors
• Step Four: Identify the Root Cause(s)
• Step Five: Recommend and Implement Solutions. (MindTools, 2015)

RCA Utilization
Root cause analysis is one of the most widely utilized tools for improving patient safety. Performing an RCA may help the facility gain insight into why the medication error occurred by reviewing the timeline of events that led up to the patient being harmed. It may also help to uncover deviations from the facility's safe medication guidelines. Each medication error has its own unique set of circumstances. Therefore, remember that RCA is not intended to pronounce blame or punish staff, but is utilized as a learning opportunity to understand what happened and prevent future harm (AHRQ, 2014).
Joint Commission Reporting

One more way that healthcare facilities can reduce error rates and improve the quality of their care is by reporting their errors to governing and accrediting bodies. Publicizing error rates can act as an additional motivation for improvement. The Joint Commission does not mandate reporting of sentinel events, including medication errors, but does strongly encourage all accredited organizations to report. They state the following benefits of reporting:
- Support and expertise can be provided by the Joint Commission during the review process of a sentinel event.
- There is an opportunity to work with a patient safety expert from the Joint Commission.
- An increased level of transparency develops within the organization, which improves the safety culture.
- A message is sent to the public that the organization is doing everything possible to determine the cause of the error, and to prevent future patient safety events
(Joint Commission, 2014)

CONCLUSION

Medication administration in the perioperative environment can be complex and prone to errors. Each phase of the process carries unique risks that can lead to medication errors. Understanding risk factors and actions that can be taken to mitigate them can improve the medication administration process and enhance patient safety. All perioperative personnel should be well educated and intimately familiar with the policies and procedures instituted by their healthcare organization regarding medication administration. This will maximize patient safety.
REFERENCE LIST


