*Please note - all information contained is fictional, used for example purposes only.

Case Study – Medication Error

Event Description

Ellie was an 85 year old resident who was returning to the nursing home on 11/5/08 from the hospital following a left hip fracture. She had an ORIF done. Prior to her fall, Ellie had been a resident of the nursing home only a week when she sustained the fracture. She has a history of congestive heart failure with frequent exacerbations. Admission vital signs were BP 132/76, HR 82, RR 18.

Ellie's transfer form from the hospital included an order for Lasix as well as a number of new medications. Lasix was part of her original nursing home medication list prior to being transferred to the hospital. All medication orders from the transfer form were re-written on the new Medication Administration Record (MAR), but the old MAR from the previous stay was not removed. When the nurse checked the new orders, she mistakenly interpreted the new Lasix order on the MAR as an unintentional duplication in transcription and yellowed out the line on the MAR. She was interrupted to take a phone call and did not complete the process of checking the new orders. She asked another nurse to complete the process. The second nurse completed double checking the orders and noted the old MAR was still present. She removed the old MAR and let the first nurse know she had completed the task.

The nurse who was passing medications noted the line for Lasix had been yellowed out, which she interpreted to mean the medication was discontinued. She was the same nurse who passed the medications on the unit for three days in a row. On 11/7/2008, having interpreted that the medication was discontinued earlier, removed the Lasix from the medication cart to be sent back to the pharmacy. It was picked up to return to the pharmacy on 11/8/2008.

Ellie was weighed on November 8th with a noted 3 lb. weight increase from admission. The weight was recorded in her chart with an indication that a call would be placed to Ellie's physician. No new orders were recorded following that entry.

On 11/09/08, at 2 a.m., Ellie was noted to be having extreme difficulty breathing. She had +4 pitting edema, BP was 190/110, HR 120, RR 28. Her lungs were assessed and were moist with crackles throughout. The attending physician was called. The physician ordered Ellie to be transferred back to the hospital. While awaiting the ambulance, Ellie went into cardiac arrest and could not be resuscitated.

RCA Exercise

- Review event description
- Together with others at your table, identify at least three questions you would ask to help get to the contributing factors and root cause(s) for this event. What additional information would you want to know to understand what happened and why it happened?
- Identify one person at your table who will capture your ideas and be able to share them with the large group