**Reflective Journal: Witnessing a Medication Administration Error**

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NURS 1612: Clinical Practicum III

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**Student statement:** By submitting this reflection, I am acknowledging that it is my own work. Comments are my own and have not been used in any previous work (inside or outside the institution). I have followed the rules outlined by my instructor and am compliant with the University of Windsor, St. Clair College, and/or Lambton College Academic Integrity Policy.

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| **Category** | **Student Reflection (must be typed)** |
| **Look Back****(L)** | An experience that was impactful for me was watching a patient pretend to take their meds while the nurse was watching. The nurse walked in to administer the patients meds while Natalie and I were assessing her vitals. The patient was very vocal about not wanting to take certain meds at that specific time and wanted to talk to the doctor. Eventually it seemed as though the nurse encouraged her enough to take the meds. The patient then put the pills in her mouth and the nurse left. As soon as the nurse left the patient spit the meds back out and put them in a cup to store in her side drawer. Natalie and I looked at each other in shock and immediately went to find the nurse. The other thing that Natalie and I were concerned about was breaking the clients trust. We knew we had to tell our nurse but by doing that our patient may have lost some trust in us. When we went back in the patients room she asked us if we told the nurse but Natalie handled the situation very well and it seemed as though the patient understood that me had to tell the nurse. This situation was very scary to watch as some of those medications were crucial to the clients condition as she just had a surgery the day before. This experience really solidified to me the importance of proper medication administration. In pharmacology class we learned to always wait until the patient has swallowed the meds before leaving the room. Now I have witnessed why that is so important and I think it was a very important lesson to learn. When I am able to administer meds I am going to 100% make sure my patient has taken there meds before leaving the room to avoid a situation like this. Overall I am just very relieved that Natalie and I were there to witness this and report it to the nurse so that the patient was able to take their proper meds at the right time.  |
| **Examine Experience****(E)** | An article written by Kang et al. (2015) talks about medication errors that occur with nurses. The article mentions that medication errors tend to increase when nurses are burnt out and have higher workloads. In a study they proved that the number of patients adverse events is directly related to nurse workload. In this situation it shows that as nurses have to take care of more patients the quality of their care can decrease however that should not happen. Personally I do not know what was going on with the nurse who made this error but it could be due to nurse burnout. That day on the floor was extremely busy and I’m sure that the nurse had multiple patients to care for. I agree with the author in the sense that overload should be managed in order to avoid situations like this. I still do not think that patient overload should be used as an excuse for making critical errors in the delivery of care.  |
| **Appraise** **and** **Analyse** **(A)** | After this situation occurred Natalie and I talked about what we saw and our opinions on it. Natalie said that she was shocked that the nurse left the room before the medications were swallowed. We both were taught that we are supposed to wait in the patients room until the med is swallowed. Her and I shared many opinions on this experience. We both talked about how important it is to safely administer meds and that now after experiencing this we would always triple check everything. Natalie also explained to me how nervous she was going back into the patients room after we reported what happened. Her and I already built a good relationship with the patient and it was nerve racking having to talk to her after breaking her trust. I also discussed the situation with my mom when I got home. She was also surprised that something like that had happened but she was relieved that I was there to witness it and make sure that the patient got their meds. As a nurse my mom knows how important it is for patients to take there meds at the right time everyday and to take their entire dose so she understood how severe this incident could have been.  |
| **Research** **and** **Revision****(R)** | This clinical experience was a very good learning experience for me. I learned just how important proper medication administration really is. When I learned it in school I obviously studied and understood all the lectures about it. We even learned about situations like the one I witnessed. But actually watching it happen right in front of you is very frightening. I have learned now to always safely administer medications. When I become a nurse even if I have a heavy workload or I am burnout I will always manage my time and properly do the things I was taught. I honestly do not think there was anything I would have done differently in this experience. I think that I handled the situation in a professional and calm manner which I am very proud of. Natalie and I talked to the nurse in private and did not tell anyone about it until our debrief at the end of the day. Also when the patient asked us if we reported her we explained to her in a way that didn’t make her feel bad about what she did. This was a stressful situation but I think Natalie and I handled it in a very professional way.  |
| **New Perspective****(N)** | I don’t think there is any advanced or new knowledge that needs to be taught or implemented. I just think there needs to be more accountability to execute the knowledge and skills nurses already have. I am in first year and one of the first things we learned in pharm class is how to properly administer meds. This is the foundation of giving meds and should be engraved in nurses brains. I think maybe some nurses think that they don’t have time to do each thing properly. Almost like they have something else to do so why would I need to wait for the patient to swallow their med or why would I have to check the med 3 times before administering. Something that could help is having nurses brush up on their safe med administration each year just to ensure they are accountable if they make errors. Lilley’s Pharmacology for Canadian Health Care Practice textbook is a great resource for this. It can help give nurses a refresher on proper med administration.  |
| **Concept Identification** | This situation relates to the curricular concept of safety. This whole situation put the patients safety at risk. If Natalie and I were not there, that patient would have missed an entire dose of all her meds. It shows how even the smallest error can cause a drastic change in a clients health. We learn that client safety is the most important thing which proves once again how crucial it is to take all precautions and proper steps when giving meds. This experience also related to the concept of professional practice. Being only in first year and being put in this situation was scary and new. We have never been taught really what to do if we were put in a situation like this. Natalie and I needed to use professional practice and handle it as professionals. We did not go around telling everyone what happened and we did not panic. We acted as professionals in this situation and that was what we have been taught to do.  |
| **References and APA Format** | **Student Reference(s) in APA Format:** Kang, Kim, C.-W., & Lee, S.-Y. (2016). Nurse-Perceived patient adverse events depend on nursing workload. *Osong Public Health and Research Perspectives*, *7*(1), 56–62. <https://doi.org/10.1016/j.phrp.2015.10.015>  |
| **Grade:** | **□ Satisfactory □ Excellent**  |  **□ Unsatisfactory**  |  |
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**References**

Kang, Kim, C.-W., & Lee, S.-Y. (2016). Nurse-Perceived patient adverse events depend on nursing workload. *Osong Public Health and Research Perspectives*, *7*(1), 56–62. <https://doi.org/10.1016/j.phrp.2015.10.015>