

Week 4: Scholarly Discussion Forum - Risk Management and Patient Safety

Please review the case scenario and answer the questions below.

Diane was an 80-year-old resident who was returning to the nursing home from the hospital following a left hip fracture on Friday evening. She has a history of congestive heart failure with frequent exacerbations. Her hospital discharge medication list was different than the prior medication list at the nursing home, specifically relating to her Lasix prescription. Diane was already taking Lasix at the nursing home before her hip fracture. All of her medication orders were transcribed by hand onto a new medication administration record (MAR). The old MAR, prior to the hospital stay, was not removed. The nurse checked Diane's new orders and wrote "repeat" next to the new Lasix order and yellowed out the line. She was interrupted and was not able to finish reviewing the orders so she asked another nurse to review it for her. The second nurse reviewed the order and saw that the old MAR was still there. She removed the old MAR and finished reviewing the new MAR.

On Sunday, the medication nurse passed meds for Diane, as she had done for the past three days. She saw the yellowed line through the Lasix order and thought that the medication had been discontinued. She sent the medication back to pharmacy. Pharmacy picked up the medication on Monday. On Monday, it was noted that Diane weighed three pounds more since being discharged from the hospital. The nurse recorded the weight and placed a call to the physician, who failed to respond. At 2:00 a.m. Tuesday morning, Diane began to have difficulty breathing. Assessment findings included +4 pitting edema, a BP of 190/110, a HR of 120, and respirations at 28. Crackles were heard through her lungs. The on-call physician was consulted and an order was placed to transfer Diane back to the hospital. She went into cardiac arrest while waiting for the ambulance and was not able to be resuscitated.

Provide your risk analysis for this event. Develop an action plan for the prevention of events like this one in the future. Which theory or model would you apply in developing your action plan?

Hello Dr. White and Class,

This week's discussion centers around risk analysis, the development of a preventative actions plan, and a theory or model used to do so. According to Hoeve et al. (2020), the first step in conducting a risk analysis is to identify the organization's risks. Regarding the case scenario, the risks are impaired patient safety, complications due to medication errors, and patient death. Next, one must collect all available and known data about the risks (Hoeve et al., 2020). Looking back at similar events will help understand how the organization has managed these types of risks and how they cope with and alleviate them. Sorting through policies and procedures, best practice guidelines, and patient charts will help with this. I would also interview the staff members involved in this and previous events. Then, document all the threats that have been identified (Hoeve et al., 2020). This documentation will include the discrepancies in Diane's pre-and post-hospitalization medication list, the dosage and frequency of the Lasix that Diane was given, the staff members involved in this event, and the data, assessment, and vital signs acquired