

## **A Reduction of Medication Errors – Annotated Bibliography**

Michelle Shufelt

Old Dominion University, School of Nursing

NURS 412 – Ethics, Law, Policy & Economics: Application to Quality Nursing Practice

Dr. Donna Rose

August 1, 2024

Schmidt, K, Taylor, A., Pearson, A. (2017). Ruduction of Medication Errors: A Unique

Approach. *J Nurs Care Qual*, 32 (2), 150-156. [Articles to select from:](#)

[202330\\_NURS412\\_35416 ETHICS, LAW, ECONOMICS, POLICY \(odu.edu\).](#)

The purpose of this group was to establish a system or routine to reduce medication errors with intravenous (IV) fluid and medications. They created a mnemonic called the “3C’s” (Schmidt, Taylor, & Pearson, 2017) to reduce the number of medication errors in the clinical setting. They aimed to minimize the mistakes per 10,000 medications to reduce patient harm. With their unique system that they evaluated with sociotechnical probabilistic risk assessment (ST-PRA), they saw a reduction of twenty-two percent in medication errors after implementing their system. They applied their theory only to IV medication and fluid administration in which the 3Cs stood for connections, clamps, and confirm pump settings. This mnemonic was used so nurses could easily remember the steps during their medication administration check-off. This system successfully prevented and reduced errors with IV fluid and medications in the hospital where it was used.

I would recommend this article to others because it provided me with a way to prevent these medication errors. This has happened to me a couple of times in the clinical setting. We are all humans and make mistakes, and I once did not realize until hours later that I did not connect

the IV tubing to the patient's IV site. Another time, I forgot to open the clamp to the secondary tubing, and the patient received the medication late. I will use this system to reduce these errors myself. This can easily be applied in the clinical setting or any unit because it is easy to remember. It could help reduce medication errors with IV fluid and medication administration. One of the limitations of this system is that I do not know how to apply it to other medications. We still have medication errors in the hospital, not just with IV medications but with intramuscular (IM), subcutaneous (SQ), and parenteral (PO). I noticed no bias or assumptions from the authors. I hoped the article would also suggest focusing during medication administration and not getting distracted. However, I probably could do some research to try to find some techniques. Overall, the article is excellent and has a perfect way of remembering what to look for and what to do to reduce errors with IV fluid and medication administration.

Honor Code:

I pledge to support the Honor System of Old Dominion University. I will refrain from academic dishonesty or deception, such as cheating or plagiarism. I know that as a member of the educational community it is my responsibility to turn in all suspected violations of the Honor Code. I will report to a hearing if summoned.

*Michelle Shufelt*