Assignments **Week 8 Assignments**

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» Discussion

» Mastery Exercise

» Portfolio Project

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Portfolio Project: (350 Points)

Click here to download a copy of a case study from the 1st edition of your textbook. Read and carefully analyze the case study.

Prepare a scholarly composition using references to support your thoughts and ideas. Denote the source of information included in your paper. Your paper should address the following points in an academic tone:

1. A risk manager's role in addressing the events described in the case studyThe Joint Commission requirements for reporting sentinel events for a hospital
2. Steps a risk manager must take to address these events
3. Processes and techniques that a risk manager would take to investigate, prevent, and control these types of events now and in the future
4. Internal and external individuals and entities that might be involved in this situation, why, and in what capacity
5. The practicality and implications of one or more theories on accident causation

- Measures to assess the performance of the organization and the risk management plan in this area as it relates to patient care and compliance
- Impact these events could have on organizational performance, compliance, and accreditation

Include at least six references, two of which must be scholarly articles (which can be accessed from the CSU Global Virtual Library).

You will be required to submit a one-two page outline of the portfolio paper by the end of Week 5 and a properly APA-formatted bibliographic list of the sources for that project by the end of Week 6. No points will be assigned for these deliverables, but points will be deducted from your final grade on the Portfolio Project is you fail to submit these on the weeks required (see the Portfolio Project Rubric). Additionally, you will be expected to account for the instructor's feedback in the final version of the assignment.

Your paper should be 8-10 pages in length, well written, and formatted in conformity with the CSU-Global Guide to Writing and APA Requirements.

HCM370 Quality and Risk Management in Health Care Organizations

Portfolio Project Case Study

An infant was born to a mother with a prior history of syphilis. Despite having incomplete patient information about the mother's past treatment for syphilis and current medical status of both mother and child, *a decision was made to treat the infant for congenital syphilis*. After consultation with infectious disease specialists and the health department, an order was written for one dose of "Benzathine Pen (penicillin) G 150,000U IM."

The physicians, nurses, and pharmacists, unfamiliar with the treatment of congenital syphilis, also had limited knowledge about this drug, which as not in their formulary. The pharmacist consulted both the infant's progress notes and *Drug Facts and Comparisons* to determine the usual does of penicillin G benzathine for an infant. However, she *misread the dose in both sources as 500,000 units/kg, a typical adult dose, instead of 50,000 units/kg*. Due to lack of a pharmacy procedure for independent double checking, the *error was not detected*. Because a unit dose system was not used in the nursery, the pharmacy *dispensed a tenfold overdose in a plastic bag containing two full syringes of Permapen 1.2 million units/2mL each*, with green stickers on the plungers reminding the provider to "note dosage strength." A pharmacy label on the bag indicated that the 2.5 mL of medication was to be administered IM, to equal a dose of 1,500,000 units.

After glancing at the medication, the infant's primary care nurse was concerned about the number of injections it would be necessary to give. (Because 0.5 mL is the maximum that providers are allowed to administer intramuscularly to an infant, a 1,500,000-unit does would require five injections.) Anxious to prevent unnecessary pain to the infant, the nurse involved two advanced-level colleagues, a neonatal nurse practitioner and an advanced-level nursery nurse, who *decided to investigate the possibility of administering the medication IV instead of IM.*

NeoFax was consulted to determine if penicillin B benzathine could be administered IV. The *NeoFax* monograph on penicillin G did not specifically mention penicillin G benzathine; instead, it described the treatment for congenital syphilis with aqueous crystalline penicillin G, IV slow push, penicillin G procaine IM. Nowhere in the two-page monograph was penicillin G benzathine mentioned, and no specific warnings that penicillin G procaine and penicillin G benzathine were to be given "IM only" were present.

Unfamiliar with the various forms of penicillin G, the nurse practitioner *believed that "benzathine" was a brand name for penicillin G*. This misconception was reinforced by the physician's method of writing the drug order, written *with "benzathine" capitalized and placed on a line above "penicillin G" rather than after it on the same line* (See Figure 7.1). It is noteworthy that *many text use ambiguous synonyms when referring to various forms of penicillin*. For example, penicillin G benzathine is frequently mentioned near, or directly

FIGURE 7.1. ***Entry for Benzathine on the Patient's Chart.***

associated with, terms "crystalline penicillin" and "aqueous suspension." *Believing that aqueous crystalline penicillin G and penicillin G benzathine were the same drug, the nurse practitioner concluded that the drug could safely be administered IV. While the nurse practitioner had be taught in school that only clear liquids could be injected IV, she had learned through practical experience that certain milky white substances, such as IV lipids and other lipid-based drug products, can indeed be given IV.* Therefore, she *did not recognize the problem of giving penicillin G benzathine, a milky white substance, through an IV.*

Complicating matters further in this example, hospital policies and practices did not clearly define the prescriptive authority for nonphysicians. Partly as a result of this lack of clarity, the neonatal nurse practitioner assumed that she was operating under a national protocol, which allowed neonatal nurse practitioners to plan, direct, implement, and change drug therapy. Consequently, the nurse practitioner *made a decision to administer the drug IV*. The primary care nurse, who was not certified to administer IV medication to infants, transferred care of the infant to the advanced-level nursery RN and the nurse practitioner.

As they prepared for drug administration, *neither of these providers noticed the tenfold overdose or that the syringe was labeled by the manufacturer "IM use only."* The manufacturer's warning was not prominently placed. The syringe needed to be rotated 180 degrees away from the name before the warning could be seen. The nurse *began to administer the first syringe of Permapen slow IV push*. After about 1.8 mL was administered, the infant became unresponsive, and resuscitation efforts were unsuccessful.