A Near Miss

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The error that happened in the case was the wrong medication. The patient was given five times a high concentration of potassium chloride. The medication error is a crucial issue in nursing. A report indicates that more than 60% of nurses made medication errors. The child was lucky whose mother was from the healthcare field. As a pharmacist, she knew that her kid does not require much quantity of the potassium chloride (Saskatchewan Health Authority - Saskatoon area, n.d.). The cooperation and trust of the physician on the mother helped in sorting out the error. However, it is important for nurses to identify and solve these kinds of medication errors.

The first factor that could lead to medication error was the lack of pharmacological knowledge. It could be identified through the kidney condition of the patient which suggests that the normal quantity of potassium chloride was enough. Therefore, the nurse could prevent the error by preventing the wrong infusion rate and dosage. The second error observed was the communication gap. The communication between the nurses, nurse with physicians, and nurses with parents is really important for safe practice. It helps when the thing goes out of hand. Therefore, the nurse could reduce the communication gap to avoid any complication in the case. The last thing where the nurse could prevent the error was the handwritten report. The report indicates that numbers of time medication error happen due to the abbreviation used by the nurses. In the video, it can be observed that nurse cut the words various time. Hence, technology advancement is important. The report should not be handwritten instead it should be typed through the computer for better understanding. The bottom line is that the nurse could prevent the error through pharmacological knowledge, better communication, and digital reporting system (Cheragi, Manoocheri, Mohammadnejad, & Ehsani, 2013).

**References**

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