Background
During the morning medication distribution, an 82-year-old resident received another resident's treatment by mistake. The nurse's aide realized her mistake and warned the charge nurse upon her arrival. The doctor was informed and the appropriate surveillance was implemented. That same evening, following a significant decrease in alertness and low blood pressure, the resident was admitted to intensive care. The following morning, the resident was declared dead. A root cause analysis was performed with the support of the "Regional Platform of Support for the Management of the adverse Events".

Purpose
The purpose of this study was to demonstrate the benefits of a root cause analysis in the management of serious adverse events.

Results
The root cause analysis was performed by medical and paramedical professionals as well as management representatives. Corrective actions were proposed:

Ensure “double-check” patient's identity
• Drug distribution procedure
• Training all staff members

Raise team awareness
• By sharing this feedback
• Posters
• Scenario analysis

Identify drug distribution boxes
• Photo ID

Expand the workspace

Conclusion
As a result of the root cause analysis, corrective actions involving all concerned agents have been implemented. These actions not only helped to secure the drug administration but also to educate the teams, set up more secured work environments and to develop identity monitoring. Systematizing the practice of root cause analysis is required in nursing homes as part of the continuous improvement of quality and the safety of patient care. The pharmacist plays an important role in this new risk management.