Medication Errors: Quality Improvement

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Quality improvement is a practice used to refine a process to improve outcomes using data (QSEN Institute, 2020). In quality improvement, one must articulate strategies and find avenues of changing a process for the better. The gathering of information, use of tools, the value of teamwork, results-based decision-making, and willingness to accept changes for the better are essential to the quality assurance process. Quality assurance is much-needed when dealing with medication administration and preventing medication errors. Despite all the mechanized systems and different processes employed, medication errors are still happening; they are preventable and can lead to injury and worse for our patients (Ragau et al., 2018).

Article Summary

Many healthcare environments focus on facility protocols and mechanisms to reduce medication errors, forgetting the human element (Ragau et al., 2018). Medication errors are still occurring despite adding procedural improvements and fine-tuning to the medication administration process. Implementing a Hunger, Anger, Lonely, Tired (HALT) approach can help address the human element of the medication administration process and significantly reduce medication errors. Facilities should rethink their approach to addressing medications errors by addressing the needs of nurses.

Introduction

Medication errors are a significant concern for the healthcare team and institutions (Ragau et al., 2018). Past interventions in medication administration have not adequately addressed the

conditions of nurses that provoke medication errors. A HALT approach has successfully reduced medication errors by 31%. The Ragau et al. (2018) research article is linked to nursing in that it focuses on the wellbeing of nurses so they can carry out proper medication administration.

Overview

This research article reviews case studies of medication errors in which it identified multiple areas contributing to medication errors (Ragau et al., 2018). HALT is a tool that looks at medication errors in a new light. Using HALT can raise nurses' awareness, giving them the ability to see a bad situation, allowing them to act before the situation precipitating the error starts. The article Ragau et al. (2018) recognizes that nurses affect patient care outcomes related to medication administration, use HALT as a tool, and appreciate that research is ongoing, accomplishing QSEN competencies for quality improvement (QSEN Institute, 2020).

Quality Improvement

HALT can potentially apply to any healthcare setting, but more research is needed (Ragau et al., 2018). Educating nurses about how their emotions and wellbeing can influence patient safety and a healthy risk-analysis program is foundational when implementing HALT. In practice, administrators and leaders would have to address nurses exhibiting signs of stress and confront them using HALT; further, leadership can ensure staff members are well-fed, hydrated, and have a five-minute break if needed. After implementation, the employee could be referred to an employee assistance program to augment HALT. These changes could have a low financial cost to a facility while saving the institution from legal suits that could cost thousands to millions of dollars. HALT can positively affect nurse safety and satisfaction by improving their wellbeing through awareness and culture change. The safety of patients could stand to improve with HALT

due to decreased medication errors by nursing staff. Medication errors can cause fear and heartbreak to the patient and their families due to decreasing health or death; implementing HALT has the potential to raise patient satisfaction by reducing these incidences.

Application to Nursing

Applying the HALT model to a 32-bed medical ward helped curb medication errors significantly (Ragau et al., 2018). This experiment allows for a new outlook on preventing medication errors and how the human condition affects them. Being hungry, angry, lonely, and tired can cause medication errors and affect the safety of patients.

Practice

Currently, best practices favor changes in medication safety, equipment, and processes to lower medication error occurrence rather than targeting nurse wellbeing; an example of this is Wolf (2018). In practice, applying HALT through social means is critical. HALT may involve giving nurses a break off the unit for 5 minutes to reorganize if they feel hungry, angry, lonely, or tired (Ragau et al., 2018). Logistically, reorganizing the workload of nurses to allow for breaks helps put HALT into practice. Simple interventions such as doing hourly rounds together help nurses feel more part of a team; this decreases stress and is congruent with HALT. It may be appropriate to put a more senior team member on shift with a nurse experiencing HALT signs. It is imperative to pay attention to fellow nurses and facilitate communication as quickly as possible using this tool.

Education

Current practices in seeking to prevent medication errors are based on changing or perfecting a process, yet ignore the wellbeing of nurses giving medications, such as in Billstein-Leber et al. (2018). Though this article helps recommend processes, it ignores the human element. Educating staff in HALT requires time to meet and discuss self-awareness (Ragau et al., 2018). Team members are to intervene immediately when a coworker looks overburdened; this can be as simple as asking if they need help. Knowledge of body language is critical in HALT; this allows for an individual to initiate HALT well. Implementing HALT will educate individuals to recognize their weaknesses as well as the weaknesses of their coworkers.

Research

Research should consider human factors that play into medication errors, not just processes (Ragau et al., 2018). Future research for HALT requires a larger sample size for higher confidence. This research has only taken place in a minor medical ward; other locations such as surgery could yield different results. Research for reducing medication errors may be more efficient by looking at the human dimension, not only processes.

Conclusion

Quality Improvement helps spot pitfalls in care by questioning, testing, and changing existing processes to find better results (QSEN Institute, 2020). HALT improves care by providing a conscious mindset of individual limitations, integrating teamwork, and supporting nurses, providing intervention before a medication error occurs (Ragau et al., 2018). HALT assists in quality improvement by reducing medication errors by 31%, thereby aiding patient safety and wellbeing.

References

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