

Hospital Medication Errors: Quality Improvement

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Quality improvement constantly enhances the quality and safety of healthcare systems and uses data to monitor the results of the care process and improvement methods to create and evaluate changes (QSEN Institute, 2020). Overall, quality improvements' main goal is ensuring healthcare is safe. This concept relates to other topics such as knowledge, skills, and attitudes. Knowledge is vital in the nursing profession. It can find differences in clinical versus research and explain how evidence plays a role in determining the optimum clinical practice. Skill adequately collects, reads, questions, and consults research and evidence to benefit the field. Lastly, attitudes are what make quality improvement. Attitudes need to be appreciative of research and the need for continuous improvement. This student chose medication errors in the care field, specifically intravenous medication errors. In today's medical era, there has been a rise in medication errors. There can be many reasons for this, and the article researches just one specific medication error. Medication errors can be life or death for the patient, which is why quality improvement plays a role in this topic. Quality improvement will allow for these errors to be monitored and find ways to improve these situations through evidence-based practice.

Article Summary

Every day there are multiple medications given in the hospital by different routes. The most common are intravenous medications. Intravenous medications are the highest medication error and have the most severe consequences (Kuitunen et al., 2021). Many of the drugs given this route are high-risk medications and are hard to reverse the effects. With that information, giving these medications is in-depth, causing more room for systemic medication errors. This

article reviews the frequency of errors and the effectiveness of the systemic defense. The study does not go into depth about medication safety issues but informs the audience about systemic errors and the need for improvement.

Introduction (note that the key points is flush to the far left)

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References

Kuitunen, S., Niittynen, I., Airaksinen, M., & Holmström, A.-R. (2021). Systemic causes of in-hospital intravenous medication errors: A systematic review. *Journal of Patient Safety*, 17(8), e1660–e1668. <https://doi.org/10.1097/pts.0000000000000632>

QSEN Institute (2020). *QSEN Competencies*.

https://qsen.org/competencies/pre-licensure-ksas/#quality_improvement

*As you can see the reference is centered and is bolded. The first line is NOT tabbed over, all other lines are, this is called hanging indentation. All references are double spaced. All sources should be listed in alphabetical order. Be sure to use the APA 7th edition and guide for your reference page.