

**Preventing medication errors in the NICU: Quality Improvement**

Harley Epley

Lakeview College of Nursing

Dr. Ariel Wright

6/16/2022

## **Preventing medication errors in the NICU: Quality Improvement**

Quality improvement is critical in all working areas, especially in nursing practice. Quality improvement helps improve a problem that needs attention to improve the safety and care of patients. There are many ways to improve quality, such as technology-based, continuing education, or developing standard procedures (CMS, 2021). According to QSEN, quality improvement projects will improve the quality and safety of future nurses by preparing them with knowledge, skills, and attitudes. By providing nurses with training such as continuing education, skills labs, and mentor programs, their knowledge can improve the care given and promote patient safety. As a team working together to improve quality and safety, future nurses can develop a better attitude towards the quality of care by seeing improvement, appreciation, and value in the care given (QSEN, 2020). Medication errors happen in every department of nursing. One area-specific that has a high impact is the Neonatal Intensive Care Unit (NICU). Medication errors can be decreased by working together as a team and developing ways to minimize errors and improve the patient's overall safety. Establishing changes to the department, such as double-checking medications, bar code scanning, pharmacist involvement, further education, and computerized physician orders, can all assist in improving the overall quality improvement in the NICU to reduce medication errors (Rishoej et al., 2018). Improving the quality of care and safety to reduce medication errors in the NICU is a significant area of improvement. The NICU directly cares for preterm and critically ill infants that are at a higher risk for problems associated with medication errors. By exploring current problems and areas

that may lack skills and knowledge, decreasing the number of medication errors will benefit the patient and the nurses by improving their knowledge and confidence.

### **Article Summary**

Medication errors are increasing in hospitals worldwide, leading to patient harm and, in some cases, death. One department in specific that has an increased potential for harm is the Neonatal Intensive Care Unit (NICU). The NICU cares for premature and ill infants in a fragile stage and needs the most direct and careful care. This study explains why medication errors happen and ways to reduce them. Physicians and nurses were interviewed at three different NICUs to discuss why medication errors happen and suggestions on how to prevent them. The QSEN research article shows ways to improve patients' overall quality and safety by providing patient-centered care, teamwork, collaboration, evidence-based practice, and informatics. (QSEN, 2022).

Reducing medication errors can range from technical and non-technical elements to help improve the overall safety and quality in the NICU (Rishoej et al., 2018). The setting used in this article involved the inpatient neonatal intensive care unit. During the pre-implementation stage, the author focused on discussing with the physicians and nurses their thoughts on why there were so many medication errors and ways it could improve. During the intra-implementation stage, the author took the data collected from all groups and created tables to show why errors were happening and ways to improve. Lastly, in the post-implementation stage, the author went through tests to implement in the NICU to help reduce medication errors in the future. The suggestions made by the frontline staff include suggestions that would not cost the department but also those that could cost the department money. Patient satisfaction would increase because there would be fewer harmful and potential side effects done to the patient. Nursing satisfaction

would increase due to medication errors being down and patient safety increasing. Overall, reducing medication errors can help improve patient safety and nursing safety by causing less stress on the nurses from incidences by improving the quality and safety of the patient.

## References

CMS (2021). *Quality Measurement and Quality Improvement*. Retrieved from

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Measure-and-Quality-Improvement-#:~:text=Quality%20improvement%20is%20the%20framework,%2C%20healthcare%20systems%2C%20and%20organizations.>

QSEN Institute (2020). *QSEN Competencies*.

[https://qsen.org/competencies/pre-licensure-ksas/#quality\\_improvement](https://qsen.org/competencies/pre-licensure-ksas/#quality_improvement)

Rishoej, R. M., Lai Nielsen, H., Strzelec, S. M., Fritsdal Refer, J., Allermann Beck, S.,

Gramstrup, H. M., Thybo Christesen, H., Juel Kjeldsen, L., Hallas, J., & Almarsdóttir, A.

B. (2018). Qualitative exploration of practices to prevent medication errors in neonatal intensive care units: a focus group study. *Therapeutic advances in drug safety*, 9(7), 343–

353. <https://doi.org/10.1177/2042098618771541>