Best Practices to Decrease Infusion-Associated Medication Errors: Quality Improvement

Abbie Morman

Lakeview College of Nursing

Dr. Ariel Wright

June 17, 2022

Best Practices to Decrease Infusion-Associated Medication Errors: Quality Improvement

Infusion-associated medication errors involve the incorrect administration of fluids through an IV or other routes, including electrolytes, medications, and other products (Robison & Hughes 2019). These kinds of medication errors have the potential to cause the most significant harm (Robinson & Hughes, 2019). This topic is essential because of the permanent injury and death that can occur because of this kind of mistake. Nurses are at a higher risk of being a part of an infusion-associated medication error because of the number of medications they administer and the complexity of the administration process (Robinson & Hughes, 2019). This article relates to the QSEN competency of quality improvement. Numerous approaches were developed within this study to reduce medication errors. Charts and diagrams were used within this study to compare other types of medication errors (Robinson & Hughes, 2019). These researchers appreciate and value what healthcare professionals do and developed ways to improve patient care (QSEN Institute, 2020).

Article Summary

This article discusses the medication errors that exist within the infusion route. These kinds of mistakes led to the identification of various best practices that support patient safety (Robinson & Hughes, 2019). This article highlights why these errors occurred along with staff education for quality improvement (Robinson & Hughes, 2019). This article relates directly to the nursing topic of medication errors chosen by this student. The primary purpose of this article is to inform on the severe risks that exist with infusion medication errors and how to reduce the chances of it happening. This article relates to the QSEN competency of quality improvement.

Numerous approaches were developed within this study to reduce medication errors. Charts and diagrams were used within this study to compare other types of medication errors (Robinson & Hughes, 2019). These researchers appreciate and value what healthcare professionals do and developed ways to improve patient care (QSEN Institute, 2020).

Different strategies were developed within this article to eliminate infusion-associated medication errors. Policy and procedure changes, along with educational sessions, will assist in the prevention of these mistakes (Robinson & Hughes, 2019). Best practices included developing a learning culture and reinforcing the double-check medication process in the hospital. Repeating orders back and tracing IV tubing was also reinforced within this study (Robinson & Hughes, 2019). Other strategies consisted of producing ongoing announcements and in-service education on infusion pump safety, medication-specific knowledge, and prescription-improvement methods (Robinson & Hughes, 2019). Resources that must be made available during the implication process consist of education done by the nurse educator and audits on administering infusion medications. During the pre-implementation phase, a discussion on what resources would be beneficial would have to occur. In the intra-implementation phase, audits and education pieces would occur. The post-implementation phase would see decreased medication errors because of the actions. These changes would have an overall positive effect on patients, staff, and facility finances. By implementing education pieces and reinforcing nursing basics, patient satisfaction and safety would increase, as errors would decrease. These changes would reduce the risk of patients being readmitted to the hospital. Staff members would become more educated by receiving frequent education pieces, which would create more confidence within nursing members. Nurses would have fewer malpractices and event reports related to medication errors,

which would improve nurse satisfaction and safety. Facility finances may increase, for more resources would need to be available for changes.

References

QSEN Institute (2020). *QSEN Competencies.* https://qsen.org/competencies/pre-licensure-ksas/#quality_improvement

Robison, Z., & Hughes, R. (2019). Best practices to decrease infusion-associated medication errors. *Journal of Infusing Nursing, 42*(4), 183-192. https://doi.org/10.1097/NAN.0000000000000329