Medication Errors in Pediatrics: 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 upon hospital admission to pediatrics. In today's medical era, there has been a rise in medication errors. There can be many reasons for this, and the article researches medication discrepancies. 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

The article covers medication errors that occur upon pediatric admission regarding medication discrepancies. In the study, 230 pediatric patients participated by the convenience sampling method. The child must have been younger than 18 years old, received at least one chronic medication prior to admission, such as a regularly taken medication, and have one parent or guardian staying with the patient for more than 24 hours in the hospital (Abu Farha et al.,

2018). The study takes place in the pediatrics unit at Jordan University Hospital. To do the study, two clinical pharmacist researchers looked at patient demographic, medical, and admission medication. The pharmacist interviewed parents to gather the children's Best Possible Medication History. After data collection, the results were unintentional documentation or intentional documentation errors.

Introduction

Medication errors happen very often in all fields of the nursing profession. All medications and medication information is collected for patient safety when a patient admits to the hospital. A quarter of medication errors happen due to incomplete medication history upon admission, transfer, or discharge (Abu Farha et al., 2018). In pediatrics, medication errors can be more alarming than in adults. Medication errors in this field are three times higher than in adults (Abu Farha et al., 2018). This study focuses on the medication reconciliation service and determining the effectiveness of their service with hospital admissions. This topic is significantly linked to the nursing profession because medication errors are the difference between life or death for a patient.

Overview

This issue has a significant impact on the entire nursing world. It is the nurse's fault if they make a medication error related to system issues or another department, affecting the patient population. Many patients are curious about what medications and doses they take because they fear for their safety. Often, a nurse will let the patient know what they are giving them. Others will not inform them. This article is significantly related to quality improvement. As discussed earlier, quality improvement is about improving and making nursing safer, and this article will

reveal what needs to be changed. For example, one of the results found that intentional undocumented discrepancies were common (Abu Farha et al., 2018). Quality improvement will help this issue by providing the nursing facility and staff with better knowledge, skills, and attitudes to make medication reconciliation upon admission safer.

Quality Improvement

Quality improvement may come up with a plan to implement more strict policies on medication documentation to reduce these errors. In order to do this, management would need to make sure they organize and have a proficient plan before introducing it to staff. Once they have introduced the plan to staff, they must do mandatory staff training. After post-implantation, it will be necessary to research if things have changed or if more changes need to happen. If this change happened, it would positively affect patient and nursing satisfaction and safety. Nurses will feel more comfortable at work knowing there is a lesser chance for issues, making for a better work environment. The patients will be comfortable upon admission and be trustworthy of their hospital and nursing staff. It will also positively affect the institution financially because they will not have to deal with the issues that occur with multiple medication errors, such as a lawsuit.

Application to Nursing

The section below will introduce the practice, education, and research regarding medication errors in pediatrics. The practice section will be an overview of the best practice to help this situation, such as medication reconciliation. Education will go over what type of education the profession needs to put that practice into play. Lastly, research will introduce the continuing research topic to improve this situation.

Practice

The best practice for medication errors is through medication reconciliation. Medication reconciliation will allow the care team to find any possible medication discrepancies such as medication addition, duplications, omissions, or inappropriate current medications (Abu Farha et al., 2018). This process has proven to reduce errors if done in-depth. Joint Commission International has mandated this practice in all hospitals for the safety of the patients.

Education

Medication reconciliation is vital in patient care and highly stressed in the nursing profession to all professionals. One of the first things these professionals learn in training is to identify the high-risk patients, such as the pediatrics, and high-risk medications like insulin (Rattray et al., 2018). When a patient arrives, staff will conduct a medication interview and get a patient information list of their current medications from the patient's legal guardian. Staff will inquire about all medications, including over-the-counter, vitamins, and herbals. The staff will also gather information such as dose, route, strengths, and time of the last dose. All information collected is written or typed for documentation. Then the pharmacy will use their education to double-check and ensure that the list is safe with new and existing medications. Lastly, it is imperative to be aware that medication reconciliations can vary depending on the facility, so it is essential to make sure as a nurse we become comfortable and familiar with the process before doing it alone (Rattray et al., 2018).

Research

Further study should occur on this topic, specifically observational study. The research concluded that a policy change would need to occur but to what extent is unknown. For this to be

known, another research will investigate the actual rate of medication discrepancies in pediatrics and evaluate the seriousness of those on the patient's health (Abu Farha et al., 2018). This research did not go into depth on the health effects on pediatrics, just the number of mistakes made.

Conclusion

Quality improvement related to nursing is vital to keep the healthcare system up and running safely. This topic is composed of three main topics as discussed. These are knowledge, skill, and attitudes (QSEN Institute, 2020). These three topics are important because they are essential qualities to be in the nursing profession. Nurses must have knowledge, excellent skills, and good attitudes. These qualities must also show in the aspect of research. Nurses must be willing to gain knowledge, learn new skills, and have good attitudes towards the new research. Medication is an excellent example of implementing these skills because they change often. Medications significantly impact nursing because that is how we treat sick people, and if we cannot do that safely, there is a problem. Changing the protocol on medication reconciliation is significant to the field because this can save many lives in the pediatric world. If we cannot do this, the impact will be dangerous, and lives will be in danger, along with the nurses' jobs.

References

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