

Medication Errors from A Nurses' Viewpoint: Quality Improvement

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Medication errors are a significant risk among the pediatric population. Medication dosages based on age, weight, body surface area, and clinical conditions within the pediatric population leave room for potential medication errors and safety risks. The responsibility for these errors falls primarily on nurses because nurses are the primary administrators compared to doctors, pharmacists, or other healthcare professionals. Nurses' perspectives can help develop effective prevention strategies to reduce medication errors.

Quality improvement aims to assess and determine needed improvements within specific healthcare settings to improve outcomes. The QSEN quality improvement competencies discuss how skills, attitudes, and knowledge can affect quality improvement in health care settings by designing and testing changes (QSEN Institute, 2020, Table 4). Demonstrating appreciation for continuous quality improvement in the daily work setting and valuing others' roles and contributions shows an attitude supporting the overall concept of quality improvement (QSEN Institute, 2020, Table 4). Regarding skills, nurses can aid in identifying gaps between best practice and current practice and using methods to evaluate the efficiency of changes (QSEN Institute, 2020, Table 4). Knowledge plays a significant role in quality improvement by allowing nursing students and other healthcare professions to recognize the ability to change the care process and affect patient and family outcomes (QSEN Institute, 2020, Table 4).

The topic selected discusses the high occurrence of medication administration errors within the pediatric population. Although there have been multiple attempts to reduce medication errors in the pediatric setting, such as barcoding and providing additional education, effective

and sustainable solutions for these errors have not been resolved (Alomari et al., 2018). Because nurses spend a majority of their shift administering various medications, this puts them at high risk of involvement in medication administration errors (Alomari et al., 2018). There is potential to improve the safety of medication administration with the utilization of designing and testing of changes through quality improvement methods. Overall, there will be better outcomes for our patients, their treatment, and their safety.

Article Summary

Introduction

This study outlines the current workplace culture of medication practice in a pediatric unit. For three consecutive weeks, data collection included four focus groups of participating nurses to explore their adherence to policies and the care they provided. The data reveals that interactions of the work culture, regulatory environment, management policies and procedures, and physical environment influence medication safety. In addition, these factors affect a nurse's compliance with policies and guidelines (Alomari et al., 2018). The sole purpose of this study is to explore nurses' perceptions of the factors influencing the medication process (Alomari et al., 2018). Considering nurses' knowledge, attitudes, and skills when creating preventative strategies combines the purpose of this article and quality improvement.

Overview

Finding strategies to reduce the number of medication errors and provide safe care in pediatric units goes hand in hand with the idea of quality improvement. Regarding the attitude aspect of QSEN competencies, the research article heavily focuses on the value of nurses' perspectives and contributions to outcomes in the healthcare system. The researchers recognize

that nurses are at the highest risk for making medication errors, which fall back on their knowledge and skills (Alomari et al., 2018). The article addresses that a nurse's job performance can be affected by high patient acuity, interruptions, and lack of resources (Alomari et al., 2018). Considering nursing skills are impacted by these factors ties in with the idea of quality improvement by using quality measures to understand performance (QSEN Institute, 2020, Table 4).

Quality Improvement

The utilization of quality improvement efforts could benefit pediatric care settings and other high-stress nursing jobs (Alomari et al., 2018). Using bedside nurses as a resource during pre-implementation would be a great start. Engaging bedside nurses as essential participants, considering their perspectives, and allowing them to share ideas on reducing medication errors can guide the process towards success. During the pre-implementation stage, financial resources also need to be considered. During the intra-stage, the utilization of educational resources would be beneficial. Retraining nurses and other healthcare professionals on medication policies and guidelines can aid in reducing medication administration errors as it reinforces and updates the skills and knowledge of each healthcare worker (Alomari et al., 2018). In the post-implementation stage, evaluation of the changes will ensure improvement has occurred. Resources such as employee surveys, interviews, and patient satisfaction surveys can aid in noticing the success of quality improvement efforts.

The suggested change would improve patient satisfaction by increasing their safety and level of care. Nurse satisfaction would increase by decreasing the stress and workload of nurses. If nurses receive updated, frequent training, a sustainable patient load, and a less hectic work environment, they are at less risk of performing medication administration errors (Alomari et al.,

2018). With a decrease in medication errors, institutions will benefit financially by reducing liabilities and wasting medications or other medical products. Patient and nurse safety will increase due to the reduction of medication administration errors, proper documentation of missed doses, and reporting of all errors (Alomari et al., 2018).

Application to Nursing

Practice

Regarding medication administration, several practices are in place to avoid errors. The best nursing practice for this issue is following the rights of safe medication administration (Holman et al., 2019). The top five rights include the right patient, the right time, the right route, the correct dose, and the proper medication (Holman et al., 2019). By verifying the name and date of birth of patients, nurses are practicing the right of the correct patient and preventing potential medication errors. The joint commission requires two patient identifiers: the patient's name, birth date, ID card, or telephone number are acceptable methods (Holman et al., 2019).

Regarding the proper medication, nurses perform three checks before administering it to the patient. Correctly interpreting medication orders and verifying completeness and clarity will reduce potential errors (Holman et al., 2019). The prescribed medication will need to be the correct dose and given at the scheduled time to maintain consistent therapeutic blood levels (Holman et al., 2019). It is important to remember that all patient has the right to education on each medication, its purpose, how to take it, and informed that they have the right to refuse it (Holman et al., 2019).

Education

Proper education can guide nurses in minimizing the occurrence of medication errors. The current guidelines for educating staff on patient care regarding medication errors are like the current best nursing practices. Education on managing medications must be ongoing because the field is continuously changing.

During nursing school, it is a requirement for student nurses to complete a pharmacology course, as well as other courses that cover a multitude of medications in depth. In the workforce, nurses can continue their education on medication through eLearning services, case study seminars, and continuing education courses in pharmacology (Alomari et al., 2018). As a nurse, it is an expectation and standard to follow the five medication administration rights taught in nursing school to keep patients safe and avoid complications (Holman et al., 2019).

Research

Medication errors are still occurring frequently in everyday healthcare settings. Further research on how to continuously improve these numbers is crucial. Research in the clinical setting should prioritize studying the reasoning behind these errors, how often they occur, and if more involvement of patients with their medication regimen could reduce these errors. Follow-up on these studies would be necessary.

Conclusion

In conclusion, knowledge, skills, and attitudes contribute to quality improvement in health care settings. As the article stresses, including nurses and their perspectives in quality improvement methods will allow for growth, identifying gaps between best practice and current practice, and improving patient outcomes (Alomari et al., 2018). Quality improvement focuses on improving care to be more safe, effective, timely, and patient-centered (QSEN Institute, 2020,

Table 4). Regarding medication administration, there is potential to improve safety and reduce errors by designing and testing changes through quality improvement methods.

References

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