

**Medication Error through Nursing: Literature Review**

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The provision of and improvement of human health is nurses' primary professional objective. One of the most frequent health-threatening errors impacting patient care is medication error—such errors as a widespread issue that raises death rates, hospital stays, and associated expenditures. Error detection makes those mistakes known, which promotes a safe culture. Voluntary reporting is the main factor in understanding the magnitude and effects of pharmaceutical mistakes (QSEN Institute, 2020, Table 5). In order to better the quality of healthcare services, service providers and program implementers must inform about the proportion of medication errors that nurses report and the associated reasons. The techniques used to identify error causes and assign blame and accountability for pharmaceutical errors in the interest of patient safety when describing the medication errors (QSEN Institute, 2020, Table 5).

### **Proportion of medication error reporting and associated factors among nurses: A cross-sectional study**

The purpose of this study was to determine how frequently medication errors are written up per nursing staff and to investigate the connections between the various barriers, including sociodemographic factors, organizational factors, social factors, and nursing attitudes. In therapeutic settings, incident reporting provides more accurate information about incidents and can identify preventable events.

### **Key Points**

In this article, medication errors disclose, and safe practices are by effective reporting and active treatment of errors. Any avoidable circumstance resulting in improper drug use or patient

damage refers to a medication error. Mohammed Hassen, Tesfaye Demeke, Abebaw Jember, and corresponding authors Mignote Hailu and Anteneh Messele did a quantitative cross-sectional study at an institution contributing 397 nurses. Bivariate and multivariate logistic regression models were to be fit to determine the variables linked to the percentage of medication error reporting among nurses.

To summarize descriptive statistics, cross-tabulations and frequencies use, and tables to display the data. The factors linked to reporting medication errors using binary logistic regression. The likelihood of getting a p-value result equal to or more extreme than what was is used in this example as the P value under the presumption that there is no influence or difference. The p-value, odds ratio, and 95 percent confidence interval continue to use to determine whether there was a statistically significant correlation between the variables.

This study showed a statistically significant difference in the proportion of male and female nurses reporting medication errors. This study indicated that a substantial percentage of nurses reported drug errors. Experience with medication errors, having committed a medication error, participants' sex, and marital status were all substantially correlated.

### **Assumptions**

The assumption for the view of the article on why the authors chose to write this was to improve voluntary reporting of medication errors. Systems for reporting have the potential to perform two crucial tasks. They might demand performance from providers, or conversely, they can disseminate knowledge that enhances safety. Though conceptually compatible, it may be challenging to fulfill both goals simultaneously in practice. Additionally, medication errors nurses should report, and nurses' should stop barriers to reporting medication errors. Nurses must take this into account to increase medication safety.

**Deficit/Conclusion**

This student accepts the author's line of reasoning in providing safer, higher-quality care. Sustained and cooperative efforts must value to lessen medical errors' frequency and severity. Identifying errors, acknowledging mistakes, addressing harmful circumstances, and reporting system improvements are all essential components of error-reporting procedures that aim to increase safety. When system improvements are congruent with error patterns, the more real errors and near misses nurses report, the more dependable a healthcare organization or system may be from a safety standpoint. The ability of medical practitioners to give their patients safe care may improve learning more about drug errors. If these measures do not implement through nursing, there will not be enhanced patient safety.

**The Mindful Path to Nursing Accuracy: A Quasi-Experimental Study on Minimizing Medication Administration Errors: Literature Review**

This study aims to eliminate drug errors, a crucial component of achieving error-free health care. This goal does not make attainable in the United States. Despite their best efforts, nurses may make mistakes due to staffing shortages, excessive workloads, distractions, exhaustion, and insufficient training. Alarming frequent medication mishaps in healthcare facilities have raised concerns across the country. This study aimed to reduce or maybe eliminate medication errors by incorporating mindfulness thinking training into the existing system protocol. This quantitative, quasi-experimental study sought to ascertain if educating nurses in mindfulness thinking, based on the Dossey Integral Theory, altered the incidence and seriousness of medicine administration errors.

**Key Points**

This article study looked at how often and how severe medication administration errors occur and whether using mindfulness thinking could reduce those numbers. The subjects in the test group received a comprehensive, holistic nursing philosophy through mindfulness thinking training. This article did not provide information on their p-value. One hundred thirty-two nurses in total consented to take part in the trial. Due to attrition, only 111 nurses finished the research. Before gathering data, the research proposal was reviewed and approved by an academic institutional review board. Participants' identities and the identity of the healthcare system are kept private. The control group received no training in attentive thinking. They instead got a recently released article on the influence of new technologies in nursing care (Ekkens & Gordon, 2021).

When the control group had finished reading the paper, they were instructed to email the researcher. Each participant in the control group discussed a novel developing technology. The two groups' participants were arbitrarily chosen and allocated. Before starting the treatment, compare the two groups because they had equivalent educational backgrounds, medical credentials, and work histories (Ekkens & Gordon, 2021). Any noticeable variations following the intervention were strong indicators that the intervention was the source of those differences—the self-reported frequency and intensity of MAEs observation in both groups for three months.

### **Assumptions**

The purpose of the author's assumptions is going to help an improvement in care. Deactivation of the autopilot button is a prerequisite for developing mindful thinking skills. This experience will provide awareness of the present moment and a mindful compass. A naturally occurring quality that differs from person to person is mindfulness. Mindful thinking is one of

the more effective methods for reducing nurse anxiety in the clinical context. According to cognitive psychologists, most people frequently use mental shortcuts resulting in cognitive biases. The Dunning-Kruger effect, also known as an exaggerated self-perception of cognitive abilities, is a cognitive bias that nursing students must be aware of to properly prepare for assessments of decision-making ability, reading comprehension, and error-recognition skills. Nursing students must also be careful not to overestimate their knowledge and skills when performing nursing duties.

### **Deficit/Conclusion**

This student agrees with the author's argument. Nurses may pay more attention to their daily responsibilities, be present with patients at the moment, and make fewer costly mistakes thanks to mindfulness-based training. Nursing staff can benefit from mindfulness-based training by learning to handle clinical stress better. By taking better care of themselves, paying more attention to patients and families, showing more empathy, and enjoying greater work satisfaction, serenity, and reduced incidental overtime. If nurses fail to accept these mindful-based courses, we will find out there will be a decrease in care, and nurses and patients will be in harm's way.

### **Medication Administration Errors and Associated Factors Among Nurses**

Experiencing and distributing medication errors, the patient could suffer adverse effects due to medication errors. It is the main factor that undermines public confidence in the healthcare system, prompts remedial therapy, extends hospital stays for patients, incurs additional costs, and sometimes even results in fatalities. In Ethiopia's referral hospitals, this study sought to evaluate medication administration error (MAE) and its contributing factors among nurses.

## **Key Points**

This article uses a straightforward random sample technique to choose 422 study participants for the institution-based, cross-sectional study design (Tsegaye et al., 2020). A semi-structured, pretested, self-administered questionnaire and observational checklist use to collect the data. The acquired data examines using descriptive and analytical statistics and binary logistic regression to determine the factors linked to medicine administration errors. *Statistical significance* is a P-value of 0.05 or lower (Tsegaye et al., 2020).

There were 414 participants, with a response rate of 98.1%, and 54.3% of those individuals were female. The bulk of them (83.8 percent) had a BSc in nursing, and their ages range was 28 to 34 (Tsegaye et al., 2020). The median age was 30. In this study, there was a 57.7% prevalence of MAE, and 30.4% of those individuals survived more than three times. The three most often occurring pharmaceutical administration mistakes are administering at the incorrect time (38.6%), the incorrect assessment (27.5%), and the incorrect evaluation (26.1%) (Tsegaye et al., 2020). The questionnaire and the observational checklist pretest on 21 nurses working at Finoteselam General Hospital before two weeks of actual data collection. Specific prescriptions were then to manufactured as a result. The nurses know they are being looked at while giving their patients medicine to reduce prejudice. Additionally, supervisors and data collectors received a one-day orientation and training on the data collection process (Tsegaye et al., 2020).

## **Assumptions**

The author's assumption is to emphasize the failure to follow any of the medication rights of the patient. The right patient, the right medication, the right time, the right dose, the right route, the right education and advice, the right to refuse, the right assessment, the right evaluation and response, and the documentation—can result in errors in the administration of medication. The

primary cause of various injuries and other harms in the health care system worldwide, pharmaceutical errors account for around 10% of all preventable injuries for hospitalized patients.

### **Deficit/Conclusion**

This student agrees with the author because this student believes in the rights of the patient. In this study, medication administration errors were prevalent. The most frequent error was giving medication at the incorrect time, followed by incorrect assessment and evaluation. Medication administration errors significantly correlate with a lack of training, the absence of guidelines for medication administration, interruptions during medication administration, poor communication when faced with issues, and a failure to adhere to the ten rights of medication administration. In order to reduce issues brought on by a medical administration error, stakeholders, including the regional health bureau, hospital administrators, and nurse professionals, should work together and share responsibility.

### **Conclusion**

Changing the healthcare system makes it possible to reduce errors by making it harder for practitioners to make mistakes and more straightforward for them to make the right ones. The system and culture need to be changed so that reporting errors result in system improvement rather than individual punishment. In contrast, individuals must be held accountable for mistakes that are directly due to them. When the system continuously focuses on continuous quality improvement and preventing the repetition of the same error, the greatest good for the most number of patients is attained. Nurses must update their knowledge of new medications and broaden their pharmacologic understanding. Continued medication competency is required. Continuing medication education keeps nurses informed about the safe use of new medications,

including the correct indications and dosages. How to administer the medication, what it does, how it interacts with other medications, what side effects could occur, how to monitor patients, how to teach patients, and how to document.

Describe strategies for modifying medication-care procedures across all facilities. In return will minimize medication errors for both patients and nurses (QSEN Institute, 2020, Table 4). Nurses can also make sure they are paying attention to every medication that they administer, and nurses can also take moments or breaks to make sure they can collect their thoughts before administering any medication. Medication errors are among the most critical factors that endanger hospital patient safety. Doctors, pharmacists, and nurses can administer medications to patients safely by adhering to preventative strategies.

## References

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