Reduction in Medication Errors and Adverse Events : Quality Improvement

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Safety and effective treatment are ideals of the healthcare system that nurses strive for in order to provide the best care to their patients. Quality improvement is a goal of healthcare that is guided by data analysis with the intent to facilitate the advancement of safety and efficiency in nursing practice. The progress towards this objective is attained through the awareness of changing information as it pertains to the healthcare setting to make alterations in care processes (QSEN Institute, 2020). The evaluation of previous information allows for a reduction in errors for future approaches to care along with better outcomes. There are certain areas that require further review and education to help improve safety for clients, one of which is medication administration because of the high potential for errors and adverse effects.

Medication errors remain a prominent issue in nursing care. It is the nurse's responsibility to make sure that they are giving the correct medication at the right time with an accurate dosage to the proper patient. A study was performed to examine the factors contributing to medication administration errors, specifically in an ICU setting. The reason that this is the focus of the study is that patients that are admitted into an ICU tend to have more severe conditions that could result in greater consequences. The article discusses how it analyzed the types of drugs and drug interactions involved the most in medication errors. Preparation of insulin, administration of heparin, dilution of noradrenaline, and infusion speed of potassium chloride were the most common problems. The average patient was prescribed nearly 14 medications, and there were instances where the transcribed prescriptions were incorrectly documented, which could cause issues with drug interactions. Drug management relating to high-risk medications and the routes of administration were also reviewed to find that about three out of four medication errors were given intravenously, with NG tubes also being a high-risk route (Gracia et al., 2019). The article relates to the QSEN competency concerning quality control because it prioritizes finding the

underlying causes of a significant problem within the nursing profession. The research does so by gathering data and forming a conclusion on quality improvement to ensure the safety of clinical practice to protect patients. Data supports that the quality of care processes is affected by knowledge of the medications and how they are being administered, so they are using this information with the purpose of designing a better system. Nurses at the facility of the study were questioned on whether they participated in continuing education on pharmacology, and 25% claimed that they did not, while the other 75% claimed they took training courses (Gracia et al., 2019). Because of this, it is worth implementing more resources into education about drugs, what constitutes a medication error, and how to properly report one to respond accordingly to a patient. Another noteworthy source of errors that should be addressed according to the study is the documentation of prescriptions that used abbreviations that were unclear or were missing important information, such as the dosage that delayed administration (Gracia et al., 2019). Incorporating quality improvement changes to the education that nurses receive so they can be mindful of errors and the responsibility of reporting them would help to improve patient safety. The resources in place for documentation may also need changes in facilities such as the one in this study to prevent errors. Service organization was a cause for concern with high nurse-to-patient ratios, inadequate access to information, and the level of training for new nurses were mentioned in the qualitative portion of the mixed study (Gracia et al., 2019). Nurse satisfaction is an aspect that should be addressed to decrease stressful environments that could contribute to medication errors.

References

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