Quality Improvement on Decreasing Medication Administration Errors in Nursing Practice

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According to nursing professionals, quality improvement is a thorough plan and method built on research findings to increase the standard and security of patient care. Quality and Safety Education in Nursing (QSEN) is an important movement that aims at guiding nurses in redesigning their care delivery to patients. Like efforts in quality improvement, the overall goal of QSEN is to provide nurses with the knowledge and skills necessary to improve quality and safety in healthcare delivery (Alghamdi et al., 2019). Nurses give the majority of the medication. The most frequently committed MAEs to include the following: incorrect dose, incorrect timing, incorrect medicine, incorrect route, omitting doses, incorrect patient, incomplete paperwork, and technical errors. Medication administration errors are one of the issues facing nurses worldwide. They risk patient safety and reduce the positivity of patient outcomes; hence it is an issue of concern for QI professionals.

Article Summary

Introduction

The most common reasons for preventable patient injury in healthcare systems worldwide are unsafe pharmaceutical practices, most of which take place while taking medicine. This paper introduces the routes of medication errors in hospitals and suggests some quality improvement measures to reduce them. Researchers in Addis Ababa, Ethiopia, conducted a hospital-based cross-sectional study with 298 randomly chosen nurses. Prescription writing, transcribing, auditing, preparation, dispensing, administration, and monitoring are some potential entry points for medication errors to occur in this setting (Wondmieneh et al., 2020). Therefore, it is crucial to learn about MAEs to implement specific interventions and the factors that cause

them. This article aims to be useful for international colleagues investigating the benefits of similar stewardship initiatives in inpatient settings.

Overview

The Joint Commission International recommends continuous improvement to eliminate pharmaceutical mistakes and increase patient safety. In the research paper, the researchers undertake to understand the quality improvement measures in place to decrease medication administration errors (Wondmieneh et al., 2020). Also, the article summarizes the impacts of medical errors, their severity, and their occurrence across different wards and relates them to nurse qualifications.

Quality Improvement

The quality improvement project implemented to reduce hospital medication errors includes all physicians' automated dispensing and multidisciplinary efforts. As suggested by the article, the intervention to reduce medication administration errors by nursing staff can help through multidisciplinary actions. According to the article, physicians, pharmacists, nurses, information engineers, and hospital administrators must work together in a coordinated fashion to ensure the safe delivery of medications. Additionally, the article's findings indicate that automated drug dispensing and proper nurse education with simulation would be essential in reducing MAE rates.

Application to Nursing

Practice

Medication errors are the most frequent kinds of medical errors in hospitals. Experts say that healthcare providers and management must prioritize adequate nurse staffing and reduce the burden on nurses to reduce prescription errors. According to Wondmieneh et al. (2020),

medication errors affect medical practitioners; nurses who participated in MAEs experienced emotional anguish and a lack of confidence in themselves. In addition, statistics show that patient safety is improved, and nurses' performance is enhanced when they are not required to work long shifts while caring for a high volume of patients. Medical facilities may also introduce rules and procedures that compromise drug security and hire more nurses.

Education

Most individuals worldwide will use pharmaceuticals to prevent or treat illness at some point in their lives. However, medications can occasionally result in serious injury, incapacity, and even death if taken improperly. Insufficient training and the absence of a medication administration plan were all found to have a significant correlation with adverse drug responses. Training is required to reduce medication mistakes, given the rapid pace at which novel diseases, treatments, and administration methods are discovered (Wondmieneh et al., 2020). The availability of medication administration guidelines may also enhance the standard of nursing care while decreasing the number of adverse drug reactions.

Research

From the limited literature on the concern, researchers need to prioritize understanding the effects of nursing training on medication errors. Also, the effects of personal stress, burnout and work strain, and domestic stress on the occurrence of errors. According to Alghamdi et al. (2019), the median rate of medication mistakes in pediatric intensive care units was 14.6 per 100 prescription orders. Dosing mistakes were the most often reported error category in both contexts, with prescribing and medication administration errors being the most frequent medication errors. In three investigations of pediatric intensive care units, the report shows that 2.3 per 100 patients were preventable adverse medication (Alghamdi et al., 2019). This research

will form a basis through which forensics and nursing boards could use to propose measures to mitigate the errors.

Conclusion

As with quality improvement initiatives, QSEN's overarching objective is to provide nurses with the know-how to boost healthcare quality and safety. According to Wondmieneh et al. (2020), crucial steps to enhance the standard and safety of medication administration include continuing education on safe medication administration. Therefore, making medication administration guidelines available for nurses, creating a supportive environment for nurses to safely administer medications, and keeping more experienced nurses on staff. Given the seriousness of MAEs, it is essential to have a deeper understanding of these events to devise effective countermeasures and identify their underlying causes. According to experts, health, and management, health care proper nurse staffing lessens the strain on nurses to reduce prescription errors.

References

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