

Medication Errors in the Neonatal Intensive Care Units: Quality Improvement

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Quality improvement is a fundamental aspect of nursing and is essential in healthcare. Quality improvement is vital in the nursing and healthcare community as it addresses skills, attitudes, and knowledge in clinical practice (QSEN Institute, 2020). Healthcare personnel must follow these guidelines to ensure the well-being and potential impacts on client outcomes. Team members are responsible and have a significant effect on the performance of the workplace and are held accountable for quality improvement. Regarding skills, quality improvement comes into effect to ensure healthcare personnel are following the current standard to ensure the best practice. Quality improvement aligns with attitude as team members must contribute and value outcomes in the care setting to ensure best practices (QSEN Institute, 2020). Appreciating the value and maintaining appropriate attitudes improve the quality of care a client may receive (QSEN Institute, 2020). Knowledge is essential as healthcare team members have the impact of suggesting different methods to improve current practices (QSEN Institute, 2020).

Quality improvement affects everyone in healthcare and affects positive client outcomes. The article discussed in this paper is a qualitative article regarding medication errors in the neonatal intensive care unit (NICU) and how nurses can improve and recognize medication safety in neonates (Rishoej et al., 2018). The study looks at the discussion of physicians and nurses on how practices currently prevent medication errors in the NICU and how to become better at preventing medication errors. This article seeks to define the knowledge gap and attitudes of healthcare workers to improve the safety of medication errors in neonates.

Article Summary

The article by Rishoej et al. (2018) discusses preventing medication errors in the NICU. This study uses focused interviews to ask doctors and nurses questions regarding the current and future practices to prevent medication errors in the NICU (Rishoej et al., 2018). Through the participant interviews, researchers found that medication errors still occur in the NICU, and current practices to reduce medication errors are in effect (Rishoej et al., 2018). It also outlines how to improve and change current practices to facilitate a better reduction of medication errors in the NICU setting. The occurrence of medication errors in the NICU and prevention can be amended through quality improvement to improve medication safety in neonates.

Introduction

This study uses a qualitative approach to gather data from participants on gathering knowledge on how to prevent medication errors in neonates better. The study found that current medication safety practices should be enhanced and the need for new interventions to have a better outcome of reduced medical errors in the NICU (Rishoej et al., 2018). The findings from the article can be associated with quality improvement as this can reduce medication errors and improve results in neonates.

Overview

This article has great potential to affect hospitals and improve NICUs as this research can help improve outcomes in reducing medication errors. Rishoej et al. (2018) use the qualitative approach by interviewing the participants who can fulfill the QSEN competencies outlook of

attitude as it values and acknowledges that quality improvement is essential in the NICU as it can improve the outcomes of reducing medical errors amongst neonates. The article highlights existing practices and discusses future prevention ideas based on the data gathered from the participants' structured interviews. Asking participants questions on practices utilized in the NICU and future recommendations to reduce medical errors in neonates aligns with the QSEN Institute (2020) competency of quality improvement regarding knowledge. Having the participants give input and describe ways to reduce medication error aligns with approaches to changing processes in care in the NICU (QSEN Institute, 2020). This article evaluates the effectiveness of current practices and involvement in reducing medication errors by utilizing a table to see, on average, the total of medication errors made in three different NICUs at different hospitals (Rishoej et al., 2018). This information falls in the QSEN Institute's (2020) competency of quality improvement regarding skill, as this method can seek information about care outcomes with these strategies in place to help reduce medical errors. The data from participants helped the researchers of this article to conclude that utilizing quality improvement can address the complex challenges of improving medication safety in the NICU (Rishoej et al., 2018).

Quality Improvement

The article focuses on prevention and methods to reduce medication errors in neonates. Rishoej et al. (2018) took participants' responses from structured interviews to correlate ideas to improve current practices and suggestions for improving medication safety in neonates. In the pre-implementation stage of identifying barriers, this article identifies nursing skills, clear communication, hospital pharmacy services, and checking medication need to be improved to reduce medication errors (Rishoej et al., 2018). As quality improvement progresses onto the intra-implementation stage, nurses can improve on double-checking medication, effective

communication with the provider, and continuous education and training provided by hospitals is an effective way to improve medication safety in neonates (Rishoej et al., 2018). In the post-implementation stage, hospitals should follow up with competency checks among providers and nurses. Hospitals should evaluate staff to ensure nurses meet the standards to provide neonates with the best care and safe medication administration (Rishoej et al., 2018). These follow-ups would aid in the QSEN competency of quality improvement in attitudes and skills as they demonstrate how hospitals would effectively evaluate the changes made among nurses (QSEN Institute, 2020). Having hospitals take part in this ensures they are meeting the standards and valuing the staff's contribution in changes to improving medication errors (QSEN Institute, 2020). Reducing medical errors in the NICU would save hospitals money by placing effective measures to reduce medication errors. Patient satisfaction and safety would improve significantly as more complex precautions would be in place to reduce medication errors. Nursing satisfaction and safety would be improved as nurses have the proper education and guidelines to help prevent these errors and reduce the risk of lawsuits against the hospital and nurses for medication errors.

Application to Nursing

Here add in a summary of the information learned to the application to practice. Follow the MEAL paragraph formatting and use Grammarly.com. Be sure to cover all aspects within the rubric. Be sure to use double space and to tab over for your first line of a new paragraph.

Practice

Paragraph goes here discussing the application to practice. Review the rubric for full requirements. Follow the MEAL paragraph formatting and use Grammarly.com.

Education

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Conclusion

Write a conclusion here in your overall paper. Review the rubric for full requirements. Follow the MEAL paragraph formatting and use Grammarly.com.

References

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https://qsen.org/competencies/pre-licensure-ksas/#quality_improvement

Rishoej, R. M., Lai Nielsen, H., Strzelec, S. M., Fritsdal Refer, J., Allermann Beck, S., Gramstrup, H. M., Thybo Christesen, H., Juel Kjeldsen, L., Hallas, J., & Almarsdóttir, A. B. (2018). Qualitative exploration of practices to prevent medication errors in neonatal intensive care units: A Focus Group Study. *Therapeutic Advances in Drug Safety*, 9(7), 343–353. <https://doi.org/10.1177/2042098618771541>