Reduction of Medication Errors in Nursing: Quality Improvement

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Quality improvement is used daily in healthcare to obtain the best patient care. It helps to "continuously improve the quality and safety of health care systems" (Quality and Safety Education for Nurses [QSEN], 2020, Table 4). Without continuous quality improvement, the healthcare system would have a poor future. When combined with healthcare workers' knowledge, skills, and attitudes, it can lead to quality improvement on the topic of interest. Knowledge can help provide valuable information and discussion; skills will offer the ability to conduct hands-on tasks and measurements to help with research; a positive attitude can help portray the appreciation of self and others in the research process (QSEN, 2020). This quality improvement paper is focused on the process of reducing medication errors in the nursing field. This is a very significant topic to discuss due to the large amount of mistakes made and the possible damage these errors can cause (Wondmieneh et al., 2020).

Article Summary

Medications are administered in hospitals all around the world throughout the day. Although medications can help a patient tremendously, they can also harm a patient if they are not carefully and correctly administered (Wondmieneh et al., 2020). This article conducted a study of randomly selected nurses to complete a survey questioning whether they have ever caused a medication error (Wondmieneh et al., 2020). The survey then would ask why the error was caused if the individual answered yes. Multiple factors can relate to a nurse causing a medication error, such as multitasking with numerous patients and tasks (Wondmieneh et al., 2020). There are preventions that nurses and healthcare facilities can take to help prevent a medication administration error.

Introduction

The article focuses on errors made in the nursing field when administering medication. The purpose of this article is to describe the number of nurses who make medication errors and the reasoning behind the errors (Wondmieneh et al., 2020). The researcher of this study wanted to find out the reasoning behind the medication errors and ways to prevent nurses from making these errors (Wondmieneh et al., 2020). Many of the patients who have received a medication error have faced difficulties with their health (Wondmieneh et al., 2020). Therefore, it is crucial to help reduce the amount of medication errors that are made.

Overview

This research article relates perfectly to the selected nursing practice topic. The topic of this paper is to reduce medication administration errors in nursing, and this research article shows the reasoning behind the mistakes from the perspective of nurses. The five leading causes of medication errors found were "lack of adequate training, unavailability of a guideline for medication administration, inadequate work experience, interruption during medication administration, and night shift duty" (Wondmieneh et al., 2020, par. 3). If nurses read this article, it will provide them with the knowledge of what is causing these errors to help prevent and reduce the number of mistakes made. Quality improvement will allow the nurses to improve the care they are giving to the patient. If the nurse is cautious about administering medication, it will help reduce medication errors. All the variables that were causing the errors could have been prevented somehow. If these errors are fixed, it will help improve the patient's health.

Quality Improvement

The quality improvement effort can be implemented in a hospital. During the pre-implementation stage, the facility must approve the research study. After the study is approved,

goals will be set, and a plan will be developed and prepared. The study committee can set a goal for maximum errors made in a month after the quality improvement effort begins. During the intra-implementation stage, the individuals involved in the study will try to prevent all medication errors as possible. This would be the month after the pre-implementation stage to reach the goal number. Lastly, the post-implementation stage is when the study is evaluated. After the month, the committee will go back and look at the study to analyze the results. The number of medication errors will be counted. If the goal is reached, the prevention plan of reducing medication errors is successful.

Reducing the number of medication errors in a hospital facility will positively change the impact on the institution and everyone involved in the care. According to Wondmieneh et al. (2020) in paragraph 8, “Medication errors are undoubtedly costly to patients, families, employers, hospitals, healthcare providers, and insurance companies.” Fewer errors will financially help everyone involved. It will also improve patient satisfaction and safety. Medication errors can harm a patient; therefore, with reduction, the patient’s health will not be affected. Fewer medication errors can also help to improve nurse satisfaction. Without making an error, the nurse is left without any guilt, trouble from the facility, and lawsuits from the patient.

Application to Nursing

The application to nursing consists of three components. These three parts are practice, education, and research. The practice process helps the nurses or health care members understand the changes that must be implemented. The goal is for the practice to fix the concern. The education process informs the nurses of the knowledge they need to help change the issue. The education process always continues throughout the application of nursing. It is essential to

make sure the information is the most recent. The last part of the nursing application is research. After the study is completed, it is important to see if the goal of reducing the number of medication errors was reached. If the goal was not achieved, then further research should be done.

Practice

Reducing medication errors is essential for the health of patients and nurses. These mistakes can harm the patients physically and the nurses mentally (Wondmieneh et al., 2020). The key to reducing the number of medication errors is to have the nurses make implementations while working. Some of these interventions could be to identify the patient, have another nurse check the medication dose, identify any allergies the patient may have, and check the drug handbook. The facility can also make interventions such as decreasing nurse workloads to avoid errors (Wondmieneh et al., 2020). If these interventions are done correctly, it can help lower the amount of medication errors made.

Education

Continuous education is critical to reduce medication errors. All healthcare workers should be updated with the most recent knowledge to help fix the concern of errors. With new, continuous education, nurses can find more interventions that can be implemented to help with the increase of safety when administering medications. Education can also provide nurses and others with communication about any changes that need to be made. One way of educating nurses is by e-learning (Rouleau et al., 2019). According to Rouleau et al. (2019), in paragraph 6, e-learning “is a means by which learners can be provided with enhanced or transformed educational experiences.” Without proper education, the study will not be successful, and errors will continue to be made.

Research

The reason for this study was to reduce the amount of medication errors that are made in the health field. Nurses need to implement all the necessary interventions to lower the numbers. After the study is complete, it is essential to go back and review the results. If the numbers have stayed the same within the study period, further research will need to be done.

Conclusion

The goal of quality improvement is to reduce the number of medication errors that occur within the health field. Quality and Safety Education for Nurses helps nurses improve patient care by assessing their knowledge, skills, and attitude. Medication errors are often made in healthcare (Wondmieneh et al., 2020). These errors can cause extreme harm to a patient and possible mortality (Wondmieneh et al., 2020). Implementing new practices and educating healthcare professionals can improve the number of errors. The importance of this article is to reduce the amount of medication errors to help with the safety and health of patients and nurses.

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