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**Analyzing a Current Health Care Problem or Issue**

Capella University

NHS4000: Developing a Health Care Perspective

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## Describing the Healthcare Problem of Issue

The healthcare issue is medication error. The annual cost of tackling medication error is approximately $6billion and $ 29 billion annually (Foster et al., 2018). Although student nurses and other health professionals take an oath not to harm their patients, medication error remains a significant public health challenge that undermines patient safety. Various reasons prevent healthcare providers from reporting these errors. In their study, Soydemir et al. (2017) found that fear prevented healthcare professionals from reporting medication errors. Nurses and physicians prefer not to report the errors they witness or commit for fear of being condemned or blamed. Also, hospital administration does not offer nurses and physicians adequate support when reporting errors, thus, diminishing their likelihood of reporting the error. Other barriers to error reporting include a lack of an error reporting system or complicated reporting systems that are difficult to use or lacks functionality. In summary, medication errors are preventable, but individual and organizational factors undermine reporting these errors.

## Possible Causes of Medication Errors

Various factors contribute to medication errors. They include exposure to illegal prescription, insufficient medication knowledge, incorrect calculations, staffing levels, workloads, interruptions, distractions, and drug rounds. According to Kavanagh (2017), illegal prescriptions contribute to medication errors because they undermine safe prescription policies. Although computer-based systems minimize medication errors, not all healthcare settings have implemented them. The author further argues that busy environments and heavy workload cause distraction and fatigue. As a result, healthcare providers neglect the 5 rights (right medication, right patient right dose, right route, right time), specifically due to interruptions. Nurses are

responsible for administering medication and should have the pertinent knowledge base regarding prescriptions, including possible interactions, dosage side effects, and action. However, deficient knowledge regarding the drug being administered increases medication error (Kavanagh, 2017). Similarly, many nurses feel anxious when administering medication because of their poor drug-calculation skills. Any discrepancy in drug calculations contributes to medication errors. Addressing these factors is necessary to prevent medication errors and enhance the patient's safety.

## Review of Articles

**Kavanagh, C. (2017). Medication governance: preventing errors and promoting patient safety. *British Journal of Nursing*, *26*(3), 159-165.**

The author's credentials suggest that the article is credible. For instance, the author is lecturer at Galway-Mayo Institution Technology's Department of Nursing, Health Sciences, and Social Care. The author provides significant insights into medication errors and measures that healthcare providers can implement to prevent these errors. Thus, the article is relevant based on the issue under discussion.

**Foster, M. J., Gary, J. C., & Sooryanarayana, S. M. (2018). Direct Observation of Medication Errors in Critical Care Setting. *Critical care nursing quarterly*, *41*(1), 76-92. https:/10.1097/CNQ.0000000000000188**

The article is appropriate because it provides an analysis of medication errors and their adverse consequences. However, it also offers various strategies that healthcare organizations and providers can implement to prevent medication errors. Thus, the article is relevant because it primarily focuses on medication errors and prevention measures.

The article is authoritative because the authors are affiliated with credible organizations like Texas A & M University and the Medical Sciences Library.

**Soydemir, D., Seren Intepeler, S., & Mert, H. (2017). Barriers to medical error reporting for physicians and nurses.** ***Western Journal of Nursing Research*****,** ***39*****(10), 1348-1363. https:/10.1177/0193945916671934**

The article is relevant to the health problem because it focuses on the barriers that prevent physicians and nurses from reporting medication errors. Similarly, the authors' credentials suggest that the source is credible because Seren Interpeler works in the Nursing Management Department at Dokuz Eylul University, Balcova.

**Kim, K., & Lee, I. (2020). Medication error encouragement training: A quasi-experimental study.** ***Nurse Education Today*****,** ***84*****, 1-6**

The article argues that considering medication error encouragement training as a nursing course can help prevent medications and related consequences on patients and healthcare facilities. The article authors' affiliation with Hannam University's Department of Nursing makes the article credible and authoritative.

## Analyzing Medication Error

As a nurse professional, I should be careful when administering medication because it is the most frequent activity. Medication administration accounts for about 40% of my work. It is a complex multistep and multidisciplinary process because of the diversification of medical devices, medication routes, and the severity of the patient's illness. These attributes contribute to medication errors, patient harm, or inappropriate prescription. The error can occur at any phase of administering, including the administration, delivery, preparation, verification, or prescription. However, medication errors are preventable, and I should consider training to enhance my

medication management process and perform accurate and correct drug administration. The resultant effect is enhanced patient safety and reduced threats from legal lawsuits that may undermine the facility's reputation.

**The Context of Medication Errors**

The "Five Rights" model approach to medication education concentrates on nurses' compliance with the correct drug administration process. However, Kim and Lee (2020) argue that the five rights fail to quip individuals with the competence required to administer medication in the clinical setting. The authors also claim that the five rights approach is narrow and fails to teach skills needed by healthcare professionals to cope with errors they witness or experience in their work setting. Therefore, nurses and allied healthcare professionals should be trained to enhance safety drug administration. The training allows nurses to reflect, experience, and observe the error. Additionally, the training focuses on the causes and repercussions of medication errors and approaches to prevent them. Therefore, nurses' training will address factors that contribute to medication errors.

**People Affected by Medication Errors**

The most affected patients by medication errors are those in the acute care setting. They include the neonatal, pediatric, and adult populations. The acute care setting's patient characteristics, environment, and medications are different from those in other departments or units. For instance, nurses in the critical care setting administer four or more drugs. Medication administration is through infusions or weight-based boluses that mandate accurate calculations (Foster et al., 2018). Any miscalculation results in medication errors and adverse events.

## Possible Solutions for Medication Errors

Various solutions can prevent medication errors in hospital settings. For instance, organizations should develop a culture of safety and support for those who report errors. The culture assures staff that the error-reporting system will facilitate learning from mistakes and help develops strategies to prevent those errors from occurring. Additionally, leaders should embrace a blame-free culture where employees do not fear reprisals and learn from their mistakes. Furthermore, creating a non-punitive, free, and open environment empowers healthcare providers to report near misses and adverse events. Also, healthcare facilities should audit their medication management practices regularly. The audit outcomes will guide the design of procedures and policies, training and education for those involved in medication management. Additionally, integrating error avoidance and patient safety into the undergraduate nursing cause is paramount. The course will ensure graduate nurses understand the importance of safe administration, have in-depth pharmacological knowledge, apply pharmacology principles, learn and practice medication calculations and administration before transitioning into the nursing profession

## Implementing the Solution

Implementing a safe and supportive culture requires the collaboration of healthcare workers and the administration. The safety culture will enhance patient's safety, prevent healthcare workers and hospitals from legal lawsuits, enhance workers' confidence and retention, and promote productivity and positive work behavior. However, the safety culture effectiveness may be undermined by individual and organizational factors. For instance, healthcare workers' lack of creativity, staff incompetence in clinical decision-making and judgment, inadequate

moral and professional competence, and lack of pharmacological knowledge may thwart the safety culture's effectiveness. These limitations suggest that a combination of interventions is necessary to prevent medication errors because failure to address the issue results in negative repercussions. For instance, medication errors can result in death or patient injury, job dismissal, disciplinary action, criminal and civil charges. Therefore, addressing medication errors is vital to avoid adverse consequences.

**Ethical Implications If the Potential Solution Were to be implemented**

According to the ethical principle of self-determination and autonomy, healthcare providers should inform patients if a medication error occurs. Therefore, even if the organization requires healthcare providers to report medication errors, they should inform patients about the errors regardless of the consequences. According to the principle of nonmaleficence and beneficence, healthcare workers should avoid harm. Instead, they should focus on the patient's best interest (Sorrell, 2017). Therefore, healthcare providers should take necessary actions to minimize adverse consequences caused by medication errors.

In conclusion, medication errors are a significant healthcare challenge caused by individual and organizational factors. However, staff training, designing a safe corporate culture, and supporting staff prevent medication errors. Otherwise, medication errors can result in adverse consequences like criminal or civil lawsuits, patient's death or injury, job dismissal and disciplinary actions. Therefore, healthcare workers and hospital administrators should collaborate to design a policy that minimizes medication errors.

## References


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