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Applying Library Research Skills

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NHS4000: Developing a Health Care Perspective

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Identified Topic: Medication Errors

Medication errors are a recurrent and persistent problem in the healthcare sector that harms the patient population. Medication administration is a risky nursing skill that contributes to errors, adverse patient outcomes and threatens nurses' career. According to Kavanagh (2017), medication administration takes 40% of the healthcare providers' time, making it vital to identify factors contributing to medication errors. I am interested in the topic because I have realized that some medication errors do not result in an adverse outcome for the patient. However, an error can contribute to the patient's death. Despite the seriousness of the issue, healthcare workers face significant barriers in reporting medication errors. The barriers include employees' view of the error, fear, and attitudes to drug administration (Soydemir et al., 2017). Therefore, medication error training is necessary to help nurses understand the importance of preventing and reporting those errors.

Criteria Used to Search Articles

I searched the articles from online databases like Proquest, EBSCOhost, Google Scholar, and PubMed using key terms like medication administration, medication errors, and medication safety. I selected articles published between 2016 and 2021 for the study. I identified the following four articles to be relevant to my research topic

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

The article underscores the importance of medication errors and the need for healthcare facilities to identify potential issues and the required support system to address them. The author notes that different healthcare providers contribute to medication errors that occur at various stages of medication administration. Thus, focusing on nurses' roles and a collaborative approach is paramount. Healthcare workers should also pay attention to special groups like the elderly because of their multiple prescriptions and medical condition that increases their susceptibility to adverse drug reactions. The author emphasizes that healthcare organizations should consider nurses' knowledge and accountability in addressing medication errors. Accordingly, organizations should embrace a culture of reporting errors, learning from mistakes and near misses, and implementing preventive measures. The strategies will enhance medication governance and contribute to high-quality care and patient safety. The article is credible because of the author's credentials. She is a lecturer at Galway-Mayo Institution Technology's Department of Nursing, Health Sciences, and Social Care. The article is relevant because it provides an in-depth analysis of medication errors and highlights strategies to prevent them.

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://doi.org/10.1097/CNQ.0000000000000188>

According to the article, medication errors are a significant public healthcare issue, especially among critically ill patients. The issue exerts a considerable healthcare burden on both hospitals and patients. Medication errors are related to systems, procedures, healthcare products, and professional practice, including product dispensing, administration, compounding, distributing, nomenclature, packaging, monitoring, use, and education. Although not all medication errors result in adverse consequences,

preventing the errors is necessary to counter adverse drug events. Thus, the authors highlight healthcare providers' need to respect and adhere to the established procedural safeguards and guidelines to enhance effective drug delivery. The article is relevant to the study topic because it discusses medication errors and their impact on patient and healthcare facilities. Additionally, it highlights measures to prevent medication errors. The article is credible because the authors are affiliated with the Medical Sciences Library, College of Nursing, and College of Architecture, Texas A&M University Health Science Center, and Texas A & M University.

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 authors aimed to find nurses' and physicians' barriers to reporting errors. The researchers conducted a descriptive qualitative design study in a training and research hospital with nurses and physicians as study participants. The researchers conducted in-depth interviews with 15 nurses and eight physicians. According to the study findings, nurses and physicians did not report errors they witnessed or experienced because of various barriers. The researchers categorized the barriers into four themes; system barriers, drug administration attitude, fear, and employees' view of error. Thus, the authors highlighted the need to prevent medication errors by identifying barriers that prevent nurses and physicians from reporting errors they witness or experience. The article is credible because of the authors' credentials. For instance, Seren Intepeler works at Dokuz Eylul University, Balçova in the Nursing Management Department. The article is also relevant to the study topic because it provides an in-depth discussion of barriers that prevent nurses and physicians from reporting errors they witness or experience.

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

According to the article, medication errors are prevalent in the healthcare settings and result in adverse consequences. However, medication error encouragement training (MEET) exposes nursing students to potential errors and enhances their understanding of the context of these errors. Thus, the authors conducted a study to determine MEET intervention effects on medication safety confidence among nursing students. The study was quasi-experimental with a control group. The study comprised 97 participants from a university's nursing education department. Forty-seven (47) of the study participants were randomly assigned to the intervention group and 50 to the control group. Both teams received applied training and theoretical training. However, the intervention group received MEET intervention while the control group was subjected to conventional error avoidance training. The researchers measured the subjects' medication administration confidence before and after the intervention. According to the study findings, the intervention group's confidence was higher than their peers in the control group regarding medication administration procedures and safety, including drug preparation, confirmation of drug information, and patient identification.

Therefore, the article concluded that integrating medication error encouragement training into the nursing curricular can prevent medication errors and associated adverse consequences in the healthcare setting. However, further studies should identify the long-term impact of the training program and its generalizability to nursing undergraduates. The article is credible

because the authors are affiliated with Hannam University's Department of Nursing. It is also relevant to the study topic because it highlights the need to introduce medication error encouragement training into nursing schools curricular to prevent the adverse events associated with the public health challenge.

Summary of the Study Findings

According to the study findings, medication errors are a significant public health challenge. They exert a considerable financial burden on healthcare facilities and patients. Despite being preventable, they are increasing at an alarming rate because nurses and physicians do not report errors they witness or experience because of system barriers, fear, and how healthcare workers perceive these errors. However, these errors can be prevented through nurses' training, designing an error reporting system, learning from near misses and errors, and adhering to medication safety procedures and guidelines.

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