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## Dissemination of Evidence into Practice: Medical Errors

While to err is human, there are other causal factors, which do result in the myriad of medical errors experienced. Accordingly, the Institute of Medicine (IOM) provides that more than 100, 000 deaths are recorded in the USA alone, on an annual basis. This is in addition to a million plus injuries, all of which are attributed to the prevailing rates of mistakes and medical errors. Various measures exist, with regard to preventing and alleviating the resultant negative effects of medical errors. However, there is need for a coordinated effort, towards finding long-lasting and practical solutions to such occurrences. One of the methods towards reducing overall occurrence rates would be to delve on the prevailing scenario of available drugs, surgical interventions and diagnostic tests.
These drugs unfortunately do result in more fatalities than cures, especially due to the prevailing presence of side effects. Additionally, preventable errors do account for massive deaths, with the most recent research revealing that 210, 000 deaths occur because of these errors (Kohn, Corrigan, & Donaldson, 1999). Diagnostic errors, failure of following prescribed guidelines and errors of omission are other core influences on resultant deaths. Methods crucial in evaluating proposed solutions include evidence-based research, with regard to diagnostics and drug prescriptions, and enhancing human capacity and development by way of training. Other methods may include the constant monitoring and testing of equipment present, especially those utilized for high-risk operations and/ or patient cases.
Variables that are crucial in evaluating the project’s outcomes include the medical fraternity’s capacity, the number of specialists present, drugs available, and economic viability of each of the cases brought forth. Tools that would be crucial towards aiding the dissemination of the outcomes would be majorly anchored on various studies and research conducted especially evidence-based projections. The utility of various media, with regard to information dissemination, practical analysis of existing case studies, as well as input from pertinent agencies and organizations involved in the greater medical fraternity (Likic & Maxwell, 2009).
Patient safety, although having received significant attention in recent times, has been incapacitated by the focus on the existing epidemiology of adverse events and errors, as opposed to practical applicability of preventative procedures collaboration (Buetow, Sibbald, Cantrill, & Halliwell, 1997). There is thus the need for key stakeholders in the medical field, to understand not only the prevalence of medical errors and accompanying adverse events, but also preventative procedures present. To aid in this, would be by way of a number of avenues, where key stakeholders engage in constant communication, not only within their given areas of specialty and departments, but also inter-departmental and inter-disciplinary. There should be consistency, with regard to not only departmental meetings/ conferences, but also through inter-departmental collaboration.
Furthermore, through inter-disciplinary interaction, various administrative procedures would be enhanced, especially through journals, conference meetings and contributions, public-private sector collaboration and practical application on both small and large-scale situational contexts (Langford, Landray, Martin, Kendall, & Ferner, 2004). Regarding the dissemination of the project’s outcomes to the greater nursing community, a number of viable options do exist, which are crucial for widespread information intake. Significantly so would be the utility of various medical journals, which are crucial educational tools for these professionals.
During such interactions, nursing professionals can debate and discuss various issues with the aim of positively enhancing both their individual as well as group-entity input. Practical applicability would also be further enhanced by way of utilizing evidence-based research, as well as other pertinent information/ knowledge avenues (Langford et al., 2004).). These steps, if taken into consideration, would significantly reduce the rising cases of medical errors, especially preventative and system-based application of health and medical care.

## References

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