

Research critique research paper sample

[Business](#), [Management](#)



Stetina, Pamela - Groves, Michael - Pafford, Leslie. (2005). Managing medication errors - a qualitative study. *MEDSURG Nursing*, 14 (3). 174-178.

The purpose of the study was to examine the management of medication errors by practicing nurses by exploring the ways which the nurses describe medication errors, how they make decisions concerning the reporting of medication errors, and finally, how their day-to-day practices is affected by medication errors. The research submitted that, 44, 000 to 98, 000 individuals people die every year in hospitals as a result of preventable medical errors. Medication errors results to increased in-patient costs increased lengths of stay, patient disability, and worst of all, death. The study suggested that, medication errors could occur at any point of the medication process, including prescription, transcription, and dispensing or drug administration. It also suggested that, error-supporting systems rely on voluntary self-reporting in order to collect statistics of the number of cases of medication errors in hospitals. The research questions in the study were:

- What were the causes of medication errors?
- Do practical nurses report medication errors to hospital management?
- What influences a practical nurse to report or not to report medication errors to the hospital management?

These research questions were congruent with the goals of the research because they were directly related to the research problem. However, the research question did not include some part of the research problem, that is, did not include the area that shows how medication errors affect practical nurses in their daily activities.

The survey was distributed to cover both part-time and full-time practical

nurses who administered the medication in hospitals. Among the participants, 69.1% returned the survey. The participating practical nurses were asked to grade 10 perceived causes of medication errors. From the results, it was found that the top three perceived causes of medication errors to be from a failure to compare the medical administration record with the patient identification band, nurse's extreme tiredness, and the prescriber's illegible hand writing which stood at 35.7%, 24.6% and 12.3% respectively. In addition, 43 nurses from six clinics were examined to study incidents of giving wrong doses to the patients. Different drugs that were administered wrongly were also examined. The drugs examined were aspirin, furosemide (Lasix) among others. The process of investigating individual drugs on the idea of looking into the issue of practical nurses giving a wrong dose to the patient was unnecessary. Examining the frequency of giving the wrong doses to the patient would have been the best alternative. The study in addition did not show the duration in which the study was carried.

In the investigation on the possible barriers to the reporting of medication errors by practical nurses, 1,382 nurses in 24 acute care hospitals in Iowa participated via a 16-item Likert study. The study identified several possible barriers. The barriers were the fear of the consequences of reporting, negative response by the administration and complex efforts that accompany the procedure of reporting. However, if the nurses were willing to report medication errors to the administrators, the likeliness of the nurses' not reporting errors incidence caused by others varied. In reporting errors caused by a physician, pharmacists or other nurses, practical nurses would never report this incidence in the proportion of 19%, 14% and 9%

respectively. The study was well conducted; the researchers used older data, from a study conducted in the year 1996. However, some data was obtained from a 2003 study that in this case might not be suitable for a qualitative study.

The study targeted nurses who were currently working in the clinics in Southeast and Southern Texas. Medical experience of the nurse ranged from six months to 34 years in service. A variety of clinical settings was included. This is exemplified by participant's included medical-surgical nurses, labor and delivery nurses, and emergency nursing, school and faculty nurses. Direct interviewing was conducted, and general themes were described after the analysis of the data. The study would have targeted the most experienced practical nurses only, who have worked for more than two years.

In the findings of the research, the study pointed out three themes: time, context and system reliance. In the case of time, the participants identified five elements that could be used in the process of medication administration in order to eliminate medication errors. Usually, the violation of these elements will lead to medication error. Most nurses agreed that administering medication to a patient at the right time is not that critical as compared to other elements (patient, dose, drug, and route). In a matter of context, it was found to be the most challenging part of the nurse's role. It is challenging because, in some instances, the nurse has to use her personal judgment to make a decision. For example, to stop administering certain drug to a patient because the patient was responding to it negatively. In addition, the nurse can administer the drug late, because an emergency

preceded the medication administration process. System reliance is not advisable, as the automated medication; dispensing machines, (AMDMS) could not be able to detect errors made when filling medication dispensers. The study captured all areas that were required to establish how medication errors arise. However, it did not provide the administrator's response when it comes to reporting medication errors.

The study has significant merit, and the methods used were sufficient. The study did not, however, cover the aspect area of how medication errors affect nurse's daily activities. The power of the study necessitates improvement to incorporate a larger sample size. In some instances, the number of interviewed nurses was not provided and this makes it hard to determine if the sample was sufficiently large enough to produce reliable results. When these corrections are considered, the study will be more meaningful.

References

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