Medical mistakes essay

Profession

Introduction:

Nursing is a profession that deals with the taking care of people who are sick or injured. With the vital cases that nurses do seal with at times, like ordering for drugs, subscribing for a patient and administering of the same, they do undergo training to be able to handle such tasks. During their training, they familiarize themselves or get skills that might enable them handle the different cases that might arise when they are practicing their profession in the field. In the process of their medical practice, they do undergo many challenges that affect both their profession and the people to experience the practice ranging from infants to adults.

These challenges range from the handling of procedures to the devises that they use in medications. As a result many blames have aroused that accuse the nurses as the major causes of medical errors in the process of their practices. This article has summarized the causes of these medical errors in this profession, the effect the medical errors to the patients and the solutions that might reduce these errors not forget the nurses take on the issue as major contributors of medical errors in our health sectors. The summery can be categorized as follows: basing the categorized work on the external and internal factors that might lead to medication errors:

SUMMARY 1

Medication Errors: More Basic than a System Issue

The summery is about the related medical errors that occur in health care agencies and their correlation to the nurses' mathematical skills and

competence. The subject was to describe the validity of mathematical skills for medication administration.

Outcome of the research

The level of competence of nurses pertaining to mathematical skills that they use in the practice of their profession was questionable. It was realized that due to the inability of nurses to handle mathematical concepts right from their college training, the same is exhibited when it comes to the application of the same in the field of profession hence leading to medical errors such as errors in the time of administration and dosage amount.

Results:

It was proven that indeed the mathematical skill of most nurses was wanting. This was evident in the way the related institutions that were offering training and the pass scores they put, really made the level of competence and the mathematical applications of these nurses to their related field was not up to standard hence the medical errors experienced. In addition, the aspect of the validity of the examination, they provided a solution. That, due to the disparity of the period of the examination and the actual practicing of the same in the field, there should be a continuous examination of the skills and the mathematical aspects to reduce the medical errors that might occur. Since, it was perceived that the practitioners might forget all these in the field after that long period.

SUMMARY 2

Fat Emulsion Medication Errors and Nursing Services

This research was about the study of medication errors associated with intralipid administration in the neonatal intensive care unit (NICU). It was more specific in its research in that it was concerned with the foremost causes of medical errors in the neonatal intensive care unit.

The subject was to correlate the different aspects or the causes that might lead to medication errors in the administration of fats emulsions, intralipids, intravenous medication and the analysis of the adverse effects to the patients in the neonatal intensive care unit. Some of them as stated in the article include:

Misprogramming of infusion devices

The practicing of nursing encompasses the use of many devises like syringes and pumps. During the manufacture of these devises, the misprogramming of these devises can lead to medical errors in that when it comes to their use like the fusion of medications to patients the nurse will use the labels on these devises in the computation of the subscribed medication to the patient.

Nurses misinterpretation of the modes

The manufactured devises used in the infusion medication have modes that direct the nurses on the amount, time and the rate of infusion when in application. Due to lack of unfamiliarity with these modes, or by not recognizing the terms of measurement and the figures of the same like in the application of decimal points on the devises display panel.

Poor prescribing practices:

Being that nurses are not well skilled or does not adopt the policy of being competent in the field of training, this is likely to be replicated in the real practicing of nursing in that the aspect of prescribing drugs is poor. This comes up when the drugs or generally the medication procedure meant for a patient is applied incorrectly or the drug prescribed is not meant for the purpose of which it is being put into use.

Medication safety training across all phases of the medication use process

The process of administering medication is a long procedure; these phases need a lot of training and safety measures application to ensure safety of not only the patient but also the nurse. The medical errors may arise when undergoing these phases a part from the actual administration of the drugs. Hence, the phases if not handle properly to the final stage/phase of administration to the patient then the course of medical errors is highly expected.

Lack of experience with neonatal equipment

The advancement in technology is of much significance in its adoption but it also has its shortcoming upon its application. The neonatal equipment due to the urge to improve on the services they offer and reduce the level of complication, they adopt or come up with new equipments to use. The application means the abandonment of the once existing; this brings a lot of complication in that the user of these equipments should be knowledgeable on how to utilize/use these equipments. Hence, this might bring confusion

because of the unfamiliarity that comes with these equipments and their application in the medical process that results in many medical errors.

Correct duration of the infusion.

The practicing of the infusion services especially components like lipids need a lot of care when administering them. The medication errors arise from the time that is meant for the infusion, in other words how long is it expected to last. The correctness of time should be administered this is avoid circumstances like that of overdose or under dose that might lead/result in a medication error that might bring about complication to the patient under treatment.

Result:

The result was that the medication error was not only a case of the nurses as the major contributors but there were other factors like the mentioned, that could lead to the same. Moreover, the solutions proposed were:

The aspect of the misprogramming of the infusion devises is an obligation of the manufactures to see that the infusion devises are labeled correctly.

The nurses should also be keen when reading the modes used to aid in prescription of the drugs by looking at things like the decimal points and the like and they should avoid the poor practice of the prescription services like the administration of the correct duration for an infusion.

There should be a continuous training of the usage of the neonatal equipments, this is to avoid the view that the medical errors occur due to the unfamiliarity with the medical equipments.

SUMMARY 3

When the 5 Rights Go Wrong: Medication Errors From the Nursing Perspective

It was about the nurses' perspective or their take on the issue of medical errors and the ultimate causes. The subject was to come up with a concrete evidence to certify the evidences attributed by the other three articles by carrying out a research on the actual people involved in all the practices mentioned.

From the nurses' perspective, they viewed the cause of medical errors from the below mentioned:

Distractions

Nurses upon practicing of their duties, they indulge themselves in many activities, hence, when in the process of administering all these, distraction from colleagues, other patients e. t. c might bring about confusion this result in medical errors because of maybe the inability to recall the process or what he/she was doing.

Workload increase

Many factors can result in the workload. E. g., the ratio of patients to nurses might vary in that the patients can be many as compared to the number of nurses available. This disparity in terms of numbers and the services required, can lead to many medical errors due to confusion that comes about due to the number of cases handled at the same time

Workload can also be imposed by the management who when they want to cut on the cost of expenditure might decide to reduce the number of nurses hence leaving a few in our health centers to perform the duties that was

previously performed by many. This can lead to work load and as an outcome, medical errors might arise from the fact that one person is handling the many cases.

One factor can lead to another. From the above mentioned because that might lead to medical errors, due to the same workload and the time expected of one nurse to deliver medical services to the health center might lead to fatigue. Hence, due to fatigue, the nurse can be confused and this aspect can result to medical errors arising from the state of the nurse.

Ignorance

As stated in the article there is a motto like phrase that nurses recognize themselves with upon the discharge of their duties that is the five R’s. They admitted that medical errors could occur because of a nurse negligence to adhere to the five R’s.

Results:

It was evident that the outcomes of the other researches were valid, they accepted the blame for causes of medical errors, and they recommended that:

The distraction bit could be reduced by, avoiding the reduction of number of nurses due to budgetary purposes to balance the ratio of patient to nurse.

The internal destruction could be controlled by them the like of the destruction from colleague staff. This could also reduce the workload increase if the ratio balance is maintained.

They argued that the negligence could be reduced by every nurse bearing the responsibility by adhering to the five R’s for the safety of the patient.