Free medication errors essay sample

Health & Medicine, Drugs

Implementation Plan for Nurses in Addressing

Implementation Plan for Nurses in

Addressing Medication Errors

The problem with medication errors has been around for many years and is considered a serious healthcare concern in the US which may be responsible for the death or injury of a patient. While preventing medication errors may be simple, bringing it to public light has helped accomplish some improvements. Despite several countermeasures to alleviate the rampant problem, complete eradication of medication errors still remains a big challenge.

Medication errors have come to public attention upon the release of the report done by the Institute of Medicine (IOM) in 1999 entitled To Err is Human: Building a Safer Health System. When this report was published, only then did the people truly realize the risk they are in when it comes to taking the wrong type or dose of medicine. Medication errors are a strong cause of death in the United States, with more people dying from such unfortunate phenomenon compared to motor vehicular accidents or even diseases such as cancer or AIDS.

Being the professional who administers the drug, nurses are usually the ones accounted for most medication errors since they are at the receiving end of the order. This proposal is to help minimize nurse-related medication error. A crucial step to the process is to detect the error and then follows the methods of detecting and eliminating errors such as careful review of charts and use of information technology advancements when monitoring and carrying out physicians’ orders.

The lack of knowledge of different drugs is also a problem that results in medication errors. Some drugs may not be so commonly used particularly those that are intended for special illnesses. This could lead to administering an unfamiliar drug to a patient. Nurses should be able to study or research more about the drug, in order to be equipped with drug knowledge such as contraindications, drug interactions, and common side effects. Working closely with the pharmacist can help in widening the knowledge on different medications.

Fatigued nurses, overworked nurses, and a shortage of nurses can be factors that contribute to medication errors. Excessive workload, lack of comprehensive drug information, staffing problems, and erroneous or illegible handwriting from physicians can pose as real challenges for nurses who only want to make sure their patients receive the right medication, at the right amount, route of administration, and time.

Details on Proposed Solution

Measures taken to address medication errors are focused on ensuring patient safety. The first step is to identify errors anywhere on the multi-step process of giving medication. To achieve this step, verification from different parties involved in the medication-administration process is critical. Communication is an essential component in minimizing medication errors and should be continuously fostered all throughout. Even the slightest unclear piece of instruction should be brought into attention by asking the doctor, transcriber, or pharmacist.

Reporting medication errors is also a crucial step to minimize the problem. Unfortunately, most cases of medication errors go unreported by nurses for

various reasons. Nurses fear for losing their job or harming the patient as opposed to the real meaning of their job. Failure to report on medication errors may also be due to the fear of reactions coming from colleagues. Whatever the reason may be, concealing these problems will only lead to a more flawed health care system. Medical institutions should encourage their staff nurses to report medication errors at all times.

The use of information technology should be promoted throughout hospital institutions. The use of computerized data should also be encouraged to minimize medication orders coming from illegible doctor’s handwriting. Computerized data is not only limited to the physician’s orders, but also on medication charts or nurse’s charts and even drug labels.

Continuing education can also improve the competency of the staff. This is especially true for nurses who are responsible for administering medications. Keeping nurses updated with the latest medical information or drug knowledge helps them become more familiar of different drugs and their uses. Investing in seminars regarding updates on the latest in the medical field is also a tremendous help.

Rationale of the Proposed Solution

The growing number of cases of medication errors is already a major threat in the country’s health care system. It is only necessary for health care professionals to be vigilant about the drugs they are giving out. Nurses are on the front-line of drug administration since they are the ones to receive the final order in order to be given to a patient. However, the proposed solutions to minimize medication errors should not only address nurses, but also all medical professionals involved in the multistep process of drug

administration.

Saving lives can be stressful and the stress brought about by the job can take a toll on the mental capacity of a person leading to memory lapses or slips. To err is indeed human, but saving lives requires careful attention despite the stressful nature of the job. Superior nurses should always look out for their subordinates and constantly communicate with them in order to instill in their minds that errors can mean the death of a patient.

It is also necessary to invest in modern technology to help minimize these errors. Although using systems for computerized data can be an added expense to the medical institution, it should be implemented for patient safety as the sole reason.

Literature Review

According to the article, Medication Errors: Don’t Let Them Happen to You, written by Pamela Anderson MS, RN, APN-BC, CCRN (2010), medication errors can happen anytime in any setting. Most of these errors go undetected and nurses are usually held responsible since they are always the ones to administer the drugs. Modern technology has indeed helped minimize

errors but the use of such technology should still be promoted further. The article also states that communication is an important tool to eradicate these errors since most of them stem from miscommunication.

Taking measures to avoid medication errors will only deem to be futile if hospital staff is not vigilant enough. Although modern technology may be available to ease errors, it may seem pointless if the professional operating this technology is not knowledgeable enough or is not observant enough to

catch or detect errors. Vigilance and proper use of modernized systems can definitely decrease the case of medication errors.

Description of Implementation

The first step towards implementation plan for reducing medication errors by nurses is to keep a vigilant mind at all times. Vigilance will result in early detection of errors, thereby preventing errors to progress through the end-stage of the drug administration process. This plan will also involve constant communication among professionals involved in the process of drug administration.

The next phase is for medical institutions to keep their medications in an organized manner while being stored. This is particularly true especially for drugs that have like-sounding names or drugs that are packaged almost the same as others. The proper labeling of drugs also plays an important role since there are several drugs that can look confusing. To prevent this error, organizing medicine cabinets or storage areas is a must.

Medical institutions should consider investing on modern technology when it comes to patient data to include medication orders and patient demographics. The use of modern technology can be a more convenient approach to minimizing medication errors.

Resources Required for Implementation

Reducing medication errors involves different resources. While nurses are in focus with this project, different medical professionals are involved as resources as well. First, medication

orders come from physicians and these orders should be legible enough. If

the use of computerized orders is implemented, this technology should help lessen the problem.

Transcribers should be responsible enough to detecting errors in the orders. It could be that the error is a mismatch of brand names and generic names or that the requested dose does not exist. Transcribers for the orders should also be vigilant about erroneous prescriptions carried out.

The pharmacist is an important person in the multi-step process as he or she will be responsible in dispensing out the right medications. The pharmacist, being a drug expert, should also be knowledgeable enough about different drugs and how they are supposed to be used.

Finally, nurses are the last professionals to receive the order before medication is distributed to a patient. The role of the nurse is critical in this case. If there are errors in the previous steps, a nurse can still give the medication mistakenly unless he or she is well-equipped with the knowledge of what is supposed to be right. The best way for a nurse to avoid mistakes is to know more about the drugs that are being administered to the patient.

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