

Evidence based practice and applied nursing research



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Evidence Based Practice and Applied Nursing Research

(UG, C361, XAP1-0219)

Evidence Table

A1. *Quantitative* Article: Duthie, E., Favreau, B., & Ruperto, A. (2015, February 4). Quantitative and Qualitative Analysis of Medication Errors. Retrieved February 8, 2019, from [https://www. ncbi. nlm. nih. gov/books/NBK20445/](https://www.ncbi.nlm.nih.gov/books/NBK20445/).

Background or Introduction

249 New York State hospitals implemented an experimental mandatory adverse event reporting system that examine hospital policy issues and identify useful interventions for future

prevention.

In total, 14 articles were referenced within the publication.

Review of the Literature

The supporting material related to drug facts and comparisons, human errors, incident reporting, medication error prevention, and hospital guidelines.

Methodology

An 11 member panel utilized random error reports received by the New York State Department of Health from the

249 participating
hospitals.

A committee of
multidisciplinary
professionals
spent 24 months
performing a
quantitative
analysis that
examined
several variables
to include:

- where in
the
medication
administrat
ion process
did the
error
occur?
- what
department
s were
involved?
- how often

did the
same error
occur?

- what
medication
s or
medication
class was
involved?

DataAnalysis

A quantitative
analysis of
numeric data
was used to
calculate
statistics
regarding both
fatal and non-
fatal medication
errors received
from the 249
participating in
the tracking
program. This
type of
methodology

allows for greater objectivity when results are reviewed. Also, for purposes of developing new hospital policies and procedures, numerical quantitative data is viewed as credible and more reliable.

Quantitative Conclusions: The medication error tracking received from the 249 pilot hospitals was successful in meeting the program mandates. The data collected from fatal or near-fatal errors was instrumental in improving patient safety. The information compiled will generate educational initiatives to address identified weaknesses. These initiatives will provide knowledge and skills that proactively implement a safer medication administration system.

Quantitative: Protection and Considerations: The researchers indicate the information compiled originated from each hospital's risk management department and there was no need to obtain informed consent. " In quantitative research, ethical standards prevent against such things as the

fabrication or falsifying of data and therefore, promote the pursuit of knowledge and truth which is the primary goal of research.” (Duthie, 2015).

Quantitative: Strengths and Limitations: The data collected provides useful and practical data to the healthcare industry in order to reduce the incidence of medication errors that cause fatal and non-fatal outcomes. An initial lack of compliance from each reporting institute proved to be a problem with data collection. However, the New York Patient Occurrence Reporting and Tracking System (NYPORTS) provided reeducation to the staff of each recruited hospital and cooperation was eventually achieved. It was determined the most common pitfall of medication administration is human error. Even with a careful, updated tracking system, a deficit in knowledge must be remedied by continuing education.

Quantitative: Evidence Application: The expectation of this tracking program is to improve patient outcomes. If implemented, these initiatives will provide healthcare workers the skills and knowledge to proactively prevent medication errors that result in serious harm.

Evidence Table

B1. *Qualitative* Article: Duthie, E., Favreau, B., & Ruperto, A. (2015, February 4). Quantitative and Qualitative Analysis of Medication Errors. Retrieved February 8, 2019, from <https://www.ncbi.nlm.nih>.

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gov/books/NBK20445/.

Background/
Introduction

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Discussion of Methodology An 11 member

panel utilized

random error

reports received

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249 participating

hospitals.

A committee of

multidisciplinary

professionals

spent 24 months

performing a

qualitative

analysis that

included findings

included findings

that related to:

- lessons learned
 - emergent themes
 - corrective counseling or education
- absent of punitive fixes

DataAnalysis

The research panel consisted of multidisciplinary professionals who were experts in medical qualitative analysis. Upon receipt of the medication error reports, the panel categorized the

collected
information using
a coding system.
Another qualitative
approach is the
narrative
analysis. This is
more subjective
and allows a “
point of view”
approach by
asking the
following
questions:

- what is this
about?
- who?,
what?,
where?,
when?
- then what
happened?
- so what?

Qualitative Conclusions: The narrative data used in qualitative analysis appears to be the best source for implementing initiatives that will reduce
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medication errors. The data collected from fatal or near-fatal errors was instrumental in improving patient safety. The information compiled will generate educational initiatives to address identified weaknesses. These initiatives will provide knowledge and skills that proactively implement a safer medication administration system.

Qualitative: Protection and Considerations: Qualitative research is centered around the “do no harm” platform. One aspect of preventing medication errors is imploring the facility to provide staff with continuing education. In addition, there needs to be a clear, detailed policy for disclosure of information to the patient regarding a medication error.

Qualitative: Strengths and Limitations: The data collected provides useful and practical data to the healthcare industry in order to reduce the incidence of medication errors that cause fatal and non-fatal outcomes. An initial lack of compliance from each reporting institute proved to be a problem with data collection. However, the New York Patient Occurrence Reporting and Tracking System (NYPORTS) provided reeducation to the staff of each recruited hospital and cooperation was eventually achieved. It was determined the most common pitfall of medication administration is human error. Even with a careful, updated tracking system, a deficit in knowledge must be remedied by continuing education.

Qualitative: Evidence Application: The expectation of this tracking program is to improve patient outcomes. If implemented, these initiatives will provide healthcare workers the skills and knowledge to proactively prevent medication errors that result in serious harm.

References

- Duthie, E., Favreau, B., & Ruperto, A. (2015, February 4). Quantitative and Qualitative Analysis of Medication Errors. Retrieved February 8, 2019, from [https://www. ncbi. nlm. nih. gov/books/NBK20445/](https://www.ncbi.nlm.nih.gov/books/NBK20445/).