**Enhancing Quality and Safety**

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Nurses play a fundamental role in promoting overall human health. Essentially, they are tasked to improve human health through such aspects as the provision of safe and, at the same time, quality patient care. Nurses are, in most cases, directly involved in disseminating drugs to patients as well as spending most of their time providing other important medical services. Therefore, nurses are the leading perpetrators of medication errors. According to Gholipour et al. (2016), medication errors have become hindrances to the nursing goal of quality and safe patient care. Recent studies have affirmed that medication errors are the most common medical errors in the healthcare setting. By definition, medication errors are preventable events over the treatment process that have the highest likelihood or potential to cause patient harm while the medication is in control of the care providers, patient, or even consumer (Gholipour et al., 2016). A typical example of medication errors is when the care provider administers the wrong drug concentration using an incorrect method of administration.

Factors Leading to Medication Errors

Gholipour et al. (2016) posit that medication errors have become a nursing care problem across the globe following their adverse impacts on the patient, care providers, and healthcare institutions at large. Some of the undesirable consequences emanating from medication errors include heightened mortality rate, increased length of hospital stay, negative patient experience, severe injury, compromised patient safety, just to mention a few. Persistent medication errors have been proven to pose a risk of negligence lawsuits as well as the termination of practice licenses for the care providers involved. Given that medication error is ranked as a quality issue, it significantly affects the financial position of healthcare institutions. As such, it has been evident from the recent linking of the insurance reimbursement to patient outcomes and satisfaction by the Center of Medicare Services. Even though some medication errors might not necessarily be harmful to patients, recent studies have shown that 30% of patients affected by medication errors either succumb to the complications caused or suffer a disability (Gholipour et al., 2016). More often, medication errors are associated with issues emanating from nursing knowledge, healthcare products, professional practice, and hospital systems.

The recent advancement in technology, medical tools, procedures, and a wide range of drugs has streamlined care delivery but at the same time heightened medication errors. Regardless of their therapeutic impacts, each of these advancements has unique instructions. The new and unfamiliar instructions are somewhat overwhelming to nurses, leading to poor understanding of what is expected of them, and consequently resulting in medication errors. The other common source of medication errors is nurse stress and burnout. As such, it is mainly attributed to the shortage of nursing staff, which forces the few available nurses to have long working shifts as well as increased workload. According to Gorgich et al. (2016), stress and burnout heighten medication errors because they reduce nurse concentration and accuracy. Unreliable and unreadable orders issued by doctors to nurses and pharmacists, especially the written ones, increase the risk of medication errors due to illegible handwriting.

Hospitals in an unconducive environment such as noisy areas compromise effective communication between care providers, especially during prescription and assessment. The other common factors that make the care environment unconducive for the nurses include congestion, lack of specialization, especially regarding segregation of departments, ventilation, and poor lighting, which impairs health and physical fitness and thereby compromising the health and physical fitness accuracy of care providers. An ineffective system for reporting errors in healthcare organizations is one of the most significant barriers for the investigation of the major cause of medication errors. As such, it makes it quite difficult to come up with mitigation measures.

The presence or rather availability of the faulty error reporting that fails to protect nurse anonymity while at the same time instilling strict disciplinary measures for the medication errors perpetrators discourages nurses from self-reporting errors. The lack of a sound internal communication system in a healthcare setting prevents consultation and collaboration among the care providers and increases sharing of inaccurate data. Moreover, it enhances poor relationships, especially between nurses and their seniors, thereby compromising collaboration and consultations. Other aspects that heighten medication errors include inadequate monitoring as well as supervision of medical procedures and wrong labeling of drugs.

Evidence-Based and Best Practice Solutions

Different versions of strategies have been established to mitigate the risk of medication errors. To begin with, it is equally significant to provide nurses with such resources as library materials since such will enable them to access medical studies as well as subjecting them to continuous training on evidence-based practice. As such, it will ensure nurses are adequately informed about the available drugs and medicines as well as their administration procedures. Designing conducive and favorable work schedules, hiring adequate nursing staff, and providing nurses with stress management alongside time management programs can best help to reduce burnout and stress. Moreover, such interventions can energize nurses and enable them to stay focused in their quest to provide accurate and quality care. According to Gorgich et al. (2016), technology can be utilized in the healthcare setting to eradicate medication errors. For instance, implementing state-of-the-art systems such as automated prescription and electronic health systems can facilitate sharing of patient information between care providers, especially during collaborative care. Such a system also eradicates the handwritten prescription, which has posed the risk of medication errors for decades. The other intervention is specializing services in healthcare setting into departments since such ensures care providers only operate in their areas of specialty and thereby doing away with such issues as hospital congestion. Still, it ensures patients receive quality time during the treatment process. Hospitals should also consider implementing an anonymous error reporting system alongside al-inclusive policies that guarantee disciplinary actions shall not accompany self-reporting errors. According to Gorgich et al. (2016), self-reporting enhances investigations and easy identification of the major factors contributing to medication errors. An effective internal communication system should also be implemented as it might help eradicate the hierarchical challenges or barriers among care providers and, consequently, enhance information sharing (Asensi-Vincente et al., 2018).

How Nurses can help Coordinate Care to Increase Patient Safety with Medication Administration and Reduce Costs

Mitigating medication errors reduces the overall cost of healthcare as a result of improved patient satisfaction, reduced length of hospital stay, and improved care outcomes. The primary role of nurses in care coordination includes organizing patient care activities as well as disseminating and sharing data among all the parties involved in patient care. In order to effectively eradicate medication errors, nursing staff should communicate with patients since such would enable them to identify their specific healthcare needs and preferences accurately. They should as well strive to communicate their findings to the physicians involved in inpatient care in a timely manner. According to Murray (2017), timely communication helps in ensuring the information is incorporated into care planning and consequently promoting accurate, safe, and quality care. Some of the mechanisms or rather strategies nursing staff can use to eradicate medication errors include patient-centered care, frequent monitoring of patients to record their progress, providing patients and their families with discharge education, and communicating any changes in the treatment plan to other care providers.

Stakeholders with whom Nurses would coordinate to Drive Safety Enhancements with Medication Administration

In order to effectively prevent the risk of medication errors, nurses can consult and collaborate with different stakeholders. Patients alongside their families are significant when it comes to the provision of essential insights into the patient needs that have to be incorporated into the treatment plan. Nurses can also coordinate and collaborate with colleague nurses to compare perspectives on effective patient care, which will help them make accurate decisions. They can coordinate with physicians among other specialists in healthcare settings so as to aggregate their instructions and adequately organize them for safe incorporation into patient care. It is also possible for the nurses to coordinate with different organizational leaders so that they may approve the budget for the state-of-the-art tools and systems.

References

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