

Medication Errors

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Introduction

Medication errors are very common and have life-altering consequences. According to Cheragi et al. (2013), medication errors cause an increase in mortality, hospitalization duration, medical expenses, and safety hazards for the patient and their family. Although not completely unavoidable, a great deal can be done to reduce the number of medication errors in healthcare. It is vital to identify the source of medication errors and continuously strive to understand how to avoid them.

Medication Error Sources

There are many reasons for medication errors. According to Tzeng et al. (2013), errors take place during all stages of medication administration. One of the main reasons for medication errors is a lack of communication between healthcare workers. For example, medication orders can be confused when drug abbreviations are used or when handwritten prescriptions are misinterpreted (Aldhafeeri & Alamatrouk, 2019). According to Zacher et al. (2018), this is especially an issue when there are many drugs that look or sound the same, such as bupropion XL and bupropion SR. Obviously, a lack of communication can be detrimental and can easily lead to medication errors.

Another reason for medication errors is deficient pharmacological knowledge. According to Cheragi et al. (2013), wrong dosage and infusion rates are very common medication errors. Being aware of common drugs used and their dosages is extremely important to not commit medication errors. Also, not knowing the correct route of administration or the difference between two similarly written drugs have serious consequences, which can be averted by being more pharmacologically conscientious and knowledgeable (Tzeng et al., 2013).

Medication errors can also occur due to nurse fatigue. According to Ferris (2015), physical and mental fatigue that come from long hours are harmful to patients as well as the nurse. A study was done to see how work hours affected medication error occurrence and when nurses worked 12.5 hours or more, the risk of making a mistake almost doubled (Ferris, 2015). In addition, fatigue decreases a nurse's ability to notice slight changes due to a medication reaction (Aldhafeeri & Alamatrouk, 2019). Although many nurses may not have the choice to not work overtime, there are many negative repercussions.

Another reason why medication errors occur is due to not following protocols and taking action without proper authorization. According to Aldhafeeri & Alamatrouk (2019), a nurse's attitude of carelessness can be destructive as they choose to not be extremely careful to avoid medication errors. Nurses can show this carelessness by administering medication without proper permission and then by pressuring other nurses to do the same, leading to an unsafe cycle (Aldhafeeri & Alamatrouk, 2019). Not being thorough and not respecting authority increases the number of medication errors.

Not reporting medication errors can lead to more medication errors. Even though some medication errors are minor, they should always be reported and need more supervision (Cheragi et al. 2013). According to Cheragi et al. (2013), reporting medication errors is a moral obligation and can help reduce the number of medication errors in the future as they are evaluated and understood better. No one likes making mistakes and admitting to them, but not doing so worsens the chances of ever reducing the number of medication errors.

How to Avoid Medication Errors

While medication errors are impossible to completely eliminate, there are many important steps that can be taken to reduce the number of medication errors significantly.

According to Aldhafeeri & Alamatrouk (2019), an integrative collaboration and better communication between all healthcare workers will greatly decrease the number of medication errors that occur. For example, misunderstandings that occur because of handwriting and stated prescriptions can be avoided by using a computerized physician order entry (Aldhafeeri & Alamatrouk, 2019). As healthcare workers are more unified and methods to improve communication are used, the number of medication errors will decrease.

Additionally, medication errors can diminish as nurses become more knowledgeable. According to Aldhafeeri & Alamatrouk (2019), providing education courses, especially on new medications, can help avoid medication errors. Also, requiring nurses to update their knowledge on medication and making sure they have sufficient pharmacological knowledge would help in reducing medication errors (Cheragi et al. 2013). When nurses have a sound knowledge on medication and constantly increase that knowledge, they will commit fewer medication errors.

Another way to decrease medication errors is to avoid nurse fatigue as much as possible. According to Ferris (2015), nurses should not choose work over-time. Nurses should also not become complacent and be more situationally aware and awake to possible medication errors that can take place (Ferris, 2015). Although getting tired is inevitable, as measures are taken to avoid fatigue nurses will be more alert and mindful of possible medication errors.

Being thorough and following rules is essential to avoiding medication errors. According to Aldhafeeri & Alamatrouk (2019), it is crucial for the nurse to work as a team member. If a nurse is not asking for authorization from a physician to administer medication, they are not working as a team member for the patient's well-being. Also, being attentive by double-checking the dosage, name, and form would reduce medication errors significantly (Tzeng et al., 2013). As nurses simply respect authority and remain aware of medication, errors will decrease.

Reporting errors would undoubtedly reduce medication errors. According to Tzeng et al. (2013), reporting medication errors should be encouraged so that the error can be addressed and avoided in the future. Cheragi et al. (2013) suggests that managers should not look down upon errors and use the opportunity to understand better the causes of medication errors and incorporate new policies and prevent them. When reporting errors is encouraged, nurses will won't be as scared to report them and medication errors can be better handled and avoided.

Avoiding Making Medication Errors

There are many ways a nurse can take accountability to avoid making medication errors. According to Ferris (2015), complacency and carelessness easily lead to medication errors. One way that a nurse can take accountability is to constantly update their knowledge of medication to be more confident and accurate in their practice. Aldhafeeri & Alamatrouk (2019) suggest having a pharmacist available in the unit to provide education sessions specifically to help nurses become more knowledgeable on medications. A nurse can also take accountability by being meticulous such as double-checking prescriptions and saying the name of the drug back to the doctor if stated verbally. A nurse's willingness to take accountability and carefulness will definitely help them to avoid making medication errors.

Conclusion

One out of every ten patients experience a medication error (Tzeng et al., 2013). This alarming number can be reduced significantly. Most medication errors can be avoided by being precise, knowledgeable, and working with others to ensure patient safety and wellness. Overall, a nurse has the greatest impact on medication error occurrence and it's up to each nurse to make the decision to make the conscientious effort to reduce medication errors.

References

- Aldhafeeri, N. A., & Alamatrouk, R. (2019). Shaping the future of nursing practice by reducing medication error. *Pennsylvania Nurse*, 74(1), 14–19.
- Cheragi, M. A., Manoocheri, H., Mohammadnejad, E., & Ehsani, S. R. (2013). Types and causes of medication errors from nurse's viewpoint. *Iranian Journal of Nursing and Midwifery Research*, 18(3), 228–231.
- Ferris, J. (2015). Nursing fatigue: an evidence-based practice review for oncology nurses. *Clinical Journal of Oncology Nursing*, 19(6), 662–664.
<https://doi.org/10.1188/15.cjon.662-664>
- Tzeng, H.-M., Yin, C.-Y., & Schneider, T. E. (2013). Medication error-related issues in nursing practice. *MEDSURG Nursing*, 22(1), 13–50.
- Zacher, J. M., Cunningham, F. E., Zhao, X., Burk, M. L., Moore, V. R., Good, C. B., ... Aspinall, S. L. (2018). Detection of potential look-alike/sound-alike medication errors using Veterans Affairs administrative databases. *American Journal of Health-System Pharmacy*, 75(19), 1460–1466. <https://doi.org/10.2146/ajhp170703>