Evidence-based practice of Medicine Safety Administration

[Authors Name]

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 **Research Topic: Evidence-based practice of Medicine Safety Administration**

**Reason for choosing this topic**

Administration of medicine to patients is a major responsibility of nurses therefore, nurses should possess required skills, knowledge and competency to administer medicines to patients. I choose this topic because nurses are usually involved in dispensing, preparation and administration of medicine. By implementing evidence-based practice in the administration of medicine death associated with medicine error, medicine related complications and health cost can be reduced. This, in turn, will lead to improving patient outcome. Wrong administration of medicine can lead to serious consequences, such as serious harm, lengthy stay at a hospital, or even death. Medicine error usually occurs due to the wrong administration of medicines (wrong dose, wrong time and wrong administration).

**How it will support my practice**

The method I have chosen to collect information regarding safe medication administration by nurses is by conducting a literature review to gather relevant information on my topic. This topic will help me to learn and implement effective strategies on the safe administration of medicine in my practice. Secondly, knowledge about barriers in the safe administration of medicine will help me to overcome them in my practice. Thirdly this topic will help me to know about the reason for not reporting errors that are associated with the administration of medicine and will also help me to report error during my practice. This in turn lead to the identification of recurring problems associated with medicines.

**Objectives**

* To identify the effective strategies that can be used to prevent error associated with the administration of medicines
* To determine the different infection control practices in medicine administration
* To determine the factors associated with the errors in medicine administration.
* To identify the reason for poor reporting of medicine administration error by nurses

**Article 1:**

 **Source**

 (ABA, 2007)

**Relevance to objective 1 and 2**

Nurses play an important role in preparing, administration monitoring and evaluating the response to medicines. They also have a responsibility to educate patients about medicines. This article is relevant to my topic as it provided a proper guideline which is necessary for safe medication administration. This article clearly defined the nurse's role in the administration of medicine that is needed to obtain safe patient outcomes. This article also recognizes the value of the competencies of nurses in avoiding medicine error and in safe medication administration.

The strategies which are given in this article include the practice of safe administration of medicines. For the safe medication administration, nurses should possess appropriate knowledge on medication safety as well the appropriate practices to avoid medication errors. Nurses should assess suitability of medicine based on the health status of the patient. They should have information about the medicine dose, side effect, route and adverse effect. They should know how to do accurate dose calculation and prepare medicine correctly. In this article double-checking is evidenced as a method to recognize actual errors and to prevent serious error in the administration of medicines such as route medication error and intravenous preparation instead of oral. This strategy will help the nurses to identify any error on time before administering to the patients. Before administering medicine to patient nurses should consult physicians about any kind of patients’ allergies and should also check the prescription details (timing, dose, frequency, strength and route). Nurses should also check the prescription for its clarity, patient identity and authorized signatures. If possible, medication chart can be used to avoid any kind of error in the administration of medicine.

Control and prevention of infection transmission are very important in the administration of medicines. To ensure the safety of the patient infection control practices should be implemented such as hand hygiene which can be maintained by washing hand before and after patient contact, proper handling of sharps and waste, use of aseptic methods during the formulation and administration of IV medication, safe injection practice like e single-use syringes, infusion supplies and needles.

**How this information is useful**

This information is useful in many ways such as by knowing different strategies in the safe administration of medicines health care cost associated with the error in medicine administration will reduce. Implementation of different strategies will help in the prevention of serious errors in medicine which in turn will improve the safety of patients. By implementing these strategies infection transmission will be prevented.

**Implementation safe medicine administration strategies in my practice**

As humans we all make errors. There are many types of medication administration errors and different strategies to avoid them. However, I believe that it is possible to prevent their occurrence by proper monitoring, identification and reporting. By keeping in my mind that I have a great responsibility to dispense and administer medicines. I will follow each guideline regarding the safe administration of medications. First, I will adhere to all the right of medicine (right dose, right time, right route, right patient, and right documentation) to avoid any type of error in administering of medicines. I will always update my knowledge regarding medicine side effects, dose and interaction. I will check all prescription orders for their clarity and appropriateness before administering to the patient. Before prescribing medicines to patients, I will review prescription and confirm the patient name, time of the dose and route of administration. I will always ask my patients regarding any allergies they have. I will respond to telephone and verbal prescription order only if circumstances allow me. I will always educate my patients about taking medicines. Before administering medicines to patients, I will verify the medicine order, name of the patient, name of medicine, pharmacy labels, medicine dosage and strength and route of administration. While preparing medicine I will always try to be vigilant by avoiding distractions. I will collaborate with pharmacists to ensure that all medicines are stored at their place.

**Article #2**

**Source**

 (Hammoudi, Ismaile, & Abu Yahya, 2018)

**Relevance to objective 3**

The most common threat to a patient's safety is poor medication administration errors. It is a responsibility of the nurses to provide the best quality care and patient safety. There are different barriers which prevent the nurses to adhere to the guidelines of drug administration such as failure to implement evidence-based practice, poor support, lack of communication among different team members and a working environment that is not supportive. Other than this poor knowledge about the patient allergies, difficulty in reading prescription order, confusion in medicines which have similar names.

**How this information is useful**

This information is useful in several ways by knowing the different factors that are associated with errors in the administration of medicines, strategies can be formulated which will remove all these barriers.

**How I will overcome these barriers in my practice**

Evidence has confirmed that most of the error in the administration of medicines is due to their packages. As when medicines are removed from their package it can be confused easily with other medicines. Therefore, in my practice, I will try my best to label all the medicines properly to increase safe medication administration. I will try to establish effective communication with physicians and pharmacists because evidence has shown that most of the errors in the administration of medicine occur due to poor communication. I will try to maintain proper information on all medicines and will adhere to the guidelines of medicine administration. I will report all errors which I will found during my practice and this will further help in the identification of recurring problems associated with the administration of medicines.

**Article # 3**

**Source**

 (Koohestani & Baghcheghi, 2009)

**Relevancy to objective 4**

This article discusses the barriers for not reporting errors that are associated with the administration of medicines. Fear and administrative barrier were found to be the major reason for not reporting medication error. Other reasons for not reporting errors include being incompetent, negative attitude of patient, decrease knowledge, forensic problems, a threat to the job, criticism from other professionals, not serious to be reported and time-consuming.

**How this information is useful**

In light of the above findings’ steps can be taken to increase the reporting of errors by nurses in health care settings.

**Reporting of errors in my practice**

I will try to overcome all these barriers and will report all errors that I will discover during my practice. I will report even those error which are not serious as I believe that all errors should be reported to decrease mortality and morbidity associated with the wrong administration of medicines.

**Discussion**

Globally safety of the patient is a major concern in a healthcare setting. Errors in the administration of medicine are very common which result in negative consequences on the health of the patient and also increase the economic burden. The first article discusses the different strategies that can be used to prevent errors in the administration of medicines. Secondly, it also discusses the infection control practice that can be used by nurses in the administration of medicine. In contrast, the second article discusses the different barriers which prevent the nurses to adhere to the guidelines of drug administration. These barriers can be removed by implementing proper strategies and by adhering to the guidelines of safe administration of medicines as discussed under the first article. Although by implementing effective strategies most of the errors in medicine administration can be removed as nurses are also humans and mistakes can also occur from them. In that case, errors should be reported to the concerned authority. The third article discusses all the reason for underreporting of medicine administration related error.

**Most rigorous and relevant resource**

The most rigorous and relevant resource to me was the third article as it appropriately answers the questions regarding reasons of underreporting of errors that are associated with the administration of medicines.

**Most reliable and current resource**

The most reliable and current resource for me was article 1. It provides a thorough and strong discussion about the most effective strategies in detail that can be easily implemented in any health care setting and used to prevent errors in the administration of medicines.

**Most useful resource**

 The most useful resource to me were all three articles as my objectives are covered in all three articles.

**Areas which require further research**

The first area which requires further research and evaluation are barriers associated with underreporting of errors in the administration of medicine. Qualitative studies should be conducted to know more in detail the reasons why nurses do not report errors associated with the administration of medicines. Secondly, further research is needed to identify factors which cause errors in medicines.

**Conclusion**

In this article evidence-based practice in the safe administration of medicines was seen. Three articles were chosen based on the relevance priority of objectives. The first article focusses on the main objective of effective strategies in the safe administration of medicine, the second article discusses the barriers in the safe administration of medicine and third article focus on the reason why errors in medicine are not reported by nurses. Further research is needed to identify the barriers in underreporting of errors in medication administration and factors associated with the medicine administration errors.

**References**

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