Applying Library Research Medication Errors

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Modern healthcare practices need high leveled skills, especially relating to nursing services. In case of lacking such skills, various adverse impacts may occur. The most severe and fatal impacts of deficient skills are Medication errors. Undoubtedly, Medication errors are severe and harmful but are avoidable. During my personal healthcare experience spanning over twenty years, I witness several times that medication errors can be avoided. These errors are not intentional in nature, but they should not be taken lightly. These errors can be reduced by strictly following the policies formulated by hospital authorities. However, regarding my personal experience of nursing practice, I formulate medical treatment plans and also administer medicine to patients. According to my observations, the US population mostly takes prescribed medication instead of counter drugs, or dietary supplements.

However, the prescribed medications have become problematic for both the healthcare industry and insurance companies. While working and performing duties as a case coordinator in an insurance company, I had to interact with patients in a variety of situations. Electronic authorization from the system is usually needed to report diagnoses and medical care. So, confusion in such cases may arise because the diagnosis of the patients depends upon the medication and the number of doses. It is pertinent to mention that the dose of the same medicine may differ from disease to disease. For example, Ozempic is the main drug used to treat diabetic patients as well as for weight loss purposes. To rectify such confusion, the healthcare industry mainly needs immense awareness of the patient community. Such awareness may revolve around the monitoring of problems, medication know-how, and prescription strategy of experts. Resultantly, such integrated action plans ensure patients' safety and effectively prevent medication errors. In addition, due to the heavy workload in the hospitals, the doctors, nurses, and paramedical staff may make medication errors. Such massive workload erupts severe issues among which miscommunication regarding doses is fatal. So, the policies and strategies revolving around patient safety have become an immense need of time in healthcare practices.

Identifying Academic Peer-Reviewed Journal Articles

Healthcare topic i.e., Medication Errors needs enormous and colossal research to find peer-reviewed scholarly articles and databases. For that purpose, I explored multiple resources including Capella Library's search engine, Summon and Google Scholar, etc. In this context, to find the most appropriate sources, various keywords or search tags proved very obliging and supportive. These mainly included 'medication errors', 'reducing medication errors', 'impacts of medication errors', and 'nullifying medication errors', etc.

Annotated Bibliography

Dirik, H. F., Samur, M., Seren Intepeler, S., & Hewison, A. (2019). Nurses' identification and reporting of medication errors. *Journal of clinical nursing*, *28*(5-6), 931-938.

The article mentioned above explores various dimensions and explains medication errors concerning nursing practice. The authors emphasize the significance of reporting medication errors in healthcare units and the various ways adopted by nurses to report these errors. Moreover, the research also indicates the fatal impacts of not reporting medication errors and their detrimental impacts on the healthcare industry. Most of the nurses are able to identify such errors but they are reluctant to report them due to several reasons. One such hindrance is the fear of consequences. For the research purpose, about one hundred and thirty-five nurses and participants were included in the population to study prescribed dimensions. However, according to the objectives of the study, about eighteen sample cases were proven main targets to identify medication errors. The significant basis is the assumptions about the occurrence of errors and how fast the nurses report them (Dirik et al., 2019).

Gates, P. J., Baysari, M. T., Mumford, V., Raban, M. Z., & Westbrook, J. I. (2019). Standardising the classification of harm associated with medication errors: The Harm Associated with Medication Error Classification (HAMEC). *Drug safety*, *42*(8), 931-939.

The authors in this article explain harm classification mainly associated with medication errors. Medication errors contribute to various severe harms and the article reported these by comparing various cases, especially regarding the medicine administration steps. There are several classes of harm related to medication errors that lead to detrimental impacts. Such harm may result from inconsistency in using tools to identify the harms concerning medication errors. However, the new tool 'Harm Associated with Medication Error Classification (HAMEC)' is associated with harm classification concerning both clinical and research points of view (Gates et al., 2019).

Mulac, A., Taxis, K., Hagesaether, E., & Granas, A. G. (2021). Severe and fatal medication errors in hospitals: findings from the Norwegian Incident Reporting

System. *European Journal of Hospital Pharmacy*, *28*(e1), e56-e61.

The cited research article analyses severe and fatal medication errors reported through Norway's incident-reporting system. The goal of reducing severe avoidable medication-related harm by 50% over five years came from the World Health Organization's global (Mulac et al., 2021) *Medication Without Harm* challenge, launched in 2017; it was not a finding of the Norwegian study or a verified 2022 result. The study points out two main aspects of medication errors based on available data; one aspect concerns errors that occur at the administration stage, while the second concerns incorrect dosage. Furthermore, the research article highlights patient-safety measures such as computerized prescribing and order entry, electronic medication administration and electronic record keeping.

Learnings from the Research

The facts collected and described above are based on deep research regarding medication errors through Summon and peer-reviewed articles. It improvised my approach towards medication errors by enhancing fact-based knowledge grounded on a practical approach. Meanwhile, various reasons for medication errors, respective harmful impacts, strategies to diminish risks, and comprehensive planning to avoid medication errors in the healthcare field are the main learning outcomes.

References

Dirik, H. F., Samur, M., Seren Intepeler, S., & Hewison, A. (2019). Nurses' identification and reporting of medication errors. *Journal of clinical nursing*, *28*(5-6), 931-938.

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