Medication Administration and Documentation Errors

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BACKGROUND

Medication Administration and Documentation Errors

- Safe medication administration and its documentation was a critical issue in patient safety. The leading cause of avoidable patient harm in the health care system in the United States was unsafe medication practice (Wondmieneh et al., 2020).
- Medication errors have been frequently identified in the areas of wrong patient, wrong dose, wrong time, wrong route, wrong reason, wrong medication, wrong documentation, and patient opposition (XXX Hospital, 2021).
- Medication errors were one of the most common type of medical errors in the United States (Zhou et al., 2018).
- A needs assessment was performed before the pre-test survey was offered to participants at XXX Hospital.
- Data showed there was a need for improvement and clarification in the medication administration process.
- Deficits were identified in; proper patient identification, order of medication administration, and understanding of hospital policy over medication administration and documentation (XXX Hospital, 2021)
- Improper patient identification was a common reason errors occur
- Use of the 7 rights of administration is one way to prevent errors

PURPOSE

- The purpose of this project was to evaluate the effectiveness of an educational offering aimed at improving nursing knowledge regarding medication administration and documentation errors at XXX Hospital.

OBJECTIVES

- Identify the rights of medication administration at XXX Hospital
- Identify where to locate XXX Hospital policy
- Identify means of proper patient identification for medication administration

THEORETICAL FRAMEWORKS

Hammond's Cognitive Continuation Theory

- Interpersonal learning and interpersonal conflict are key points in human psychology and decision making (Dhami & Mumpower, 2018).
- Nurses have an opportunity to combine interpersonal skills and intuition to provide safe patient care (Dhami & Mumpower, 2018).
- In order to provide safe patient care, the nurse must be able to use knowledge about medication administration to prevent making errors (Harris, 2021).

ADKAR Change Management Model

- Awareness of the need to change
- Desire to participate in and support the change
- Knowledge on how to change
- Ability to implement required skills and behaviors
- Reinforcement to sustain the change (Sharma, 2019)
- In this project, nurses were taught medication administration rights, need for change, and how to adopt safer practice methods.

METHODS

The Educational Offering

- A 5-question pre-test survey, presentation, and the same 5-question post-test survey were emailed to 24 nurses at XXX Hospital to complete within 2 weeks.
- Nine of the 24 nurses emailed participated in both surveys and presentation.
- Pre-test survey on Survey Monkey was used before presentation to assess knowledge about medication administration and documentation.
- 3-minute PowerPoint Presentation with voiceover focused on rights of medication administration, common medication errors, proper patient identification, hospital policy, and proper order of medication administration.
- Objectives discussed during presentation.
- Post-test survey on Survey Monkey with the same questions as pre-test survey was conducted to assess learning from the educational offering and taken immediately after presentation.

EVALUATION

- Pre-test survey to identify knowledge base over medication administration process, hospital policy, rights of medication administration, proper patient identification, and medication administration errors.
- Post-test survey to identify the effectiveness of educational offering over medication administration and documentation errors.
- Nurses on Unit 1 and Unit 2 at XXX Hospital were emailed with request to participate in surveys and prerecorded presentation.
  - 9 of 24 nurses participated in educational offering.

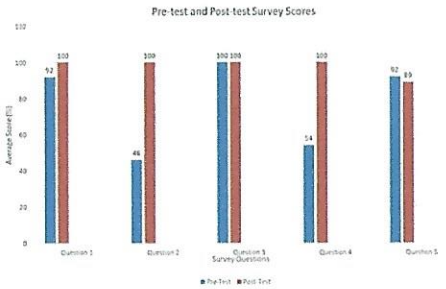
Table 1. Pre-test and post-test questions

Question	Pre-test Average Score	Post-test Average Score
1. What are the rights to medication administration at XXX Hospital?	92%	100%
2. Which of the following are reasons medication errors occur?	46%	100%
3. Where can an XXX Hospital employee access hospital policy?	100%	100%
4. T/F Patients must have their wristbands on to receive medications on all units.	54%	100%
5. In what order should medication administration occur?	92%	89%

OUTCOMES

- Nine nurses completed the pre-test and post-test surveys
- Average scores on questions 1, 2, and 4 increased to 100% on the post-test survey.
- Average score for question 3 remained at 100%
- Average score on question 5 decreased from 92% to 89%.
  - Decrease could have been due to moving through answers too quickly, and the test was designed to change order of answers each time the test was taken.

Table 2. Pre-test and post-test survey scores



CONCLUSION

- Data showed there was a need for improvement and clarification in the medication administration process.
- Deficits identified included proper patient identification, the order of medication administration, and understanding of hospital policy over medication administration and documentation.
- The outcomes of the survey showed general improvement in the understanding of XXX Hospital's policy over safe medication administration and timely documentation.
- Reduce medication error and improve patient care safety.
- Additional rights of medication administration will increase proper patient identification and reduce medication error.
- The information gathered and the educational offering could be used in other settings that involve medication administration since the information is based on updates in hospital policy not specific to any one area of practice.

IMPLICATIONS

- The findings support the need to provide up-to-date education to nurses about hospital policies and how to locate them when questions arise.
- The added rights to medication administration of "right documentation" and "right reason" should reduce medication errors in the health care setting.
- Continue quarterly evaluations for medication errors.
- Medication process education for all registered nurses.
- Accurate and timely documentation will improve patient care.

RECOMMENDATIONS

- Continued research on evaluating educational offering effectiveness
- Review proper documentation
  - Larger participant groups
  - More diversity in participant groups
- Further research to assess the need for more education to nurses over hospital policy locally and nationwide.
- Reinforce knowledge on hospital policy over proper medication administration and documentation quarterly.
- With proper support from the leadership and management teams, the educational offering could be used as a foundation for retraining nurses on the hospital policy and improving safe patient care.

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