

# Hospital Administration Thesis On Medication Errors Pdf

**Cyndie Koopsen, Daniel Farb, Caroline Young**

Medication Errors Michael Richard Cohen, 2007 In this expanded 600+ page edition, Dr. Cohen brings together some 30 experts from pharmacy, medicine, nursing, and risk management to provide the most current thinking about the causes of medication errors and strategies to prevent them.

**Medication Safety in Hospitals** Nithushi Rajitha Samaranayake, 2017-01-26 This dissertation, Medication Safety in Hospitals: Medication Errors and Interventions to Improve the Medication Use Process by Nithushi Rajitha, Samaranayake, was obtained from The University of Hong Kong (Pokfulam, Hong Kong) and is being sold pursuant to Creative Commons: Attribution 3.0 Hong Kong License. The content of this dissertation has not been altered in any way. We have altered the formatting in order to facilitate the ease of printing and reading of the dissertation. All rights not granted by the above license are retained by the author. Abstract: Medication errors are an unnecessary threat to patient safety. The aim of this study was to assess the epidemiology of medication errors and to assess the effectiveness of interventions intended to avoid medication errors in a tertiary-care hospital in Hong Kong. The epidemiology of medication errors included the study of the pattern of interception of medication errors and the study of technology-related medication errors using medication incidents reported during years 2006-2010. 34.1% of all medication errors that were reported in the study hospital were not intercepted and 92.4% of all drug administration errors reached the patient. 17.1% of all reported medication errors were technology-related and, most were due to human interaction with technology. The effects of a bar-code assisted medication administration (BCMA) system when used without the support of computerised prescribing (stand-alone), on its users and the dispensing process was studied using direct observations, questionnaires (Likert scale) and interviews. It was found that this system increased the number of dispensing steps from 5 to 8 and dispensing time by 1.9 times. Potential dispensing errors also increased (PAvoiding the use of inappropriate abbreviations in prescriptions will help to reduce medication errors. Therefore the effectiveness of a 'Do Not Use' list (a list of error-prone abbreviations used in the study hospital) and attitudes of health care professionals on using abbreviations in prescriptions was studied using prescription review and questionnaires respectively. The use of abbreviations included in the 'Do Not Use' list decreased significantly (PThe use of abbreviations in

prescriptions and attitudes of pharmacists in the study hospital was compared with a different medical system to determine the appropriateness of developing a universal error-prone abbreviation list. It was found that the types and frequencies of using inappropriate abbreviations vary among different medical systems. In conclusion, additional interventions such as technological interventions are needed to minimise drug administration errors, but proper planning and careful monitoring are needed to avoid unintended errors when using technologies. Implementing a stand-alone BCMA system aimed at reducing drug administration errors may affect the dispensing process. Therefore effects of a technology on all related processes need to be considered before implementation, and monitored after implementation. The introduction of a 'Do Not Use' list is effective in reducing inappropriate abbreviations in prescriptions and most health care professionals agree that avoiding inappropriate abbreviations may help to reduce medication errors. However, formul

To Err Is Human Institute of Medicine, Committee on Quality of Health Care in America, 2000-03-01 Experts estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDS—three causes that receive far more public attention. Indeed, more people die annually from medication errors than from workplace injuries. Add the financial cost to the human tragedy, and medical error easily rises to the top ranks of urgent, widespread public problems. *To Err Is Human* breaks the silence that has surrounded medical errors and their consequence—but not by pointing fingers at caring health care professionals who make honest mistakes. After all, to err is human. Instead, this book sets forth a national agenda—with state and local implications—for reducing medical errors and improving patient safety through the design of a safer health system. This volume reveals the often startling statistics of medical error and the disparity between the incidence of error and public perception of it, given many patients' expectations that the medical profession always performs perfectly. A careful examination is made of how the surrounding forces of legislation, regulation, and market activity influence the quality of care provided by health care organizations and then looks at their handling of medical mistakes. Using a detailed case study, the book reviews the current understanding of why these mistakes happen. A key theme is that legitimate liability concerns discourage reporting of errors—which begs the question, How can we learn from our mistakes? Balancing regulatory versus market-based initiatives and public versus private efforts, the Institute of Medicine presents wide-ranging recommendations for improving patient safety, in the areas of leadership, improved data collection and analysis, and development of effective systems at the level of direct patient care. *To Err Is Human* asserts that the problem is not bad people in health care—it is that good people are working in bad systems that need to be made safer. Comprehensive and straightforward, this book offers a clear prescription for raising the level of patient safety in American health care. It also explains how patients themselves can influence the quality of care that they receive once they check into the hospital. This book will be vitally important to federal, state, and local health policy makers and regulators, health professional licensing officials, hospital

administrators, medical educators and students, health caregivers, health journalists, patient advocates—as well as patients themselves. First in a series of publications from the Quality of Health Care in America, a project initiated by the Institute of Medicine

**Preventing Medication Errors** Institute of Medicine, Board on Health Care Services, Committee on Identifying and Preventing Medication Errors, 2007-01-11 In 1996 the Institute of Medicine launched the Quality Chasm Series, a series of reports focused on assessing and improving the nation's quality of health care. Preventing Medication Errors is the newest volume in the series. Responding to the key messages in earlier volumes of the series—To Err Is Human (2000), Crossing the Quality Chasm (2001), and Patient Safety (2004)—this book sets forth an agenda for improving the safety of medication use. It begins by providing an overview of the system for drug development, regulation, distribution, and use. Preventing Medication Errors also examines the peer-reviewed literature on the incidence and the cost of medication errors and the effectiveness of error prevention strategies. Presenting data that will foster the reduction of medication errors, the book provides action agendas detailing the measures needed to improve the safety of medication use in both the short- and long-term. Patients, primary health care providers, health care organizations, purchasers of group health care, legislators, and those affiliated with providing medications and medication-related products and services will benefit from this guide to reducing medication errors.

**Use of Technology to Reduce the Occurrence of Medication Errors in a U.S. Hospital** Setika Narang, 2013 Abstract: Hospitals, health care systems, and employees all aim to provide the safest and highest quality of care possible, but the number of medication errors continues to increase each year. Multiple technologies are available that provide a valuable tool for improving the safety of medication administration, such as electronic Medication Administration Reports, bar-code-assisted medication administration (BCMA), and computerized physician order entry (CPOE). The purpose of this project was to determine the effectiveness of BCMA and CPOE technology in a U.S. hospital. Data were collected for 9 months from the quality control department of the organization. Pre- and post-BCMA and CPOE data analysis was conducted to evaluate the trend in medication error rates. There was a statistically significant decrease in the errors recorded after the successful implementation of the technology.

**Medication Errors** Robert Paul Trautman, 1960

**A Spoonful of Sugar** Audit Commission for Local Authorities and the National Health Service in England and Wales, 2001

**Safety in Medication Use** Mary Patricia Tully, Bryony Dean Franklin, 2015-08-18 An estimated 1 in 20 patients are admitted to the hospital due to problems with their medication and 1 in 100 hospitalized patients are harmed due to medication errors during their stay. The prescribing of medications is the most common health care intervention and

medication safety is relevant to all health care professionals and patients, in all

**Medication Errors** Neil M. Davis, Michael Richard Cohen, 1981

**Advances in Patient Safety** Kerm Henriksen, 2005 v. 1. Research findings -- v. 2. Concepts and methodology -- v. 3. Implementation issues -- v. 4. Programs, tools and products.

*UCL Hospitals Injectable Medicines Administration Guide* University College London Hospitals, 2010-10-18 I would definitely recommend this book to all staff with an interest and involvement in intravenous drug therapy. —The Pharmaceutical Journal There is no doubt that nurses will find this small book useful. It should be available for consultation in any clinical area where drugs are administered to patients by the injectable routes. —Journal of Clinical Nursing The safe administration of injectable medicines is key to patient safety. The NPSA recognises the use of injectable medicines is a high risk activity and recommends written information about injectables to be available at the point of preparation. The UCL Hospitals Injectable Medicines Administration Guide is a practical, accessible guide covering many important aspects of administering medicines by injection. It provides clear, concise information on the preparation and administration of over 245 injectable medicines for adults, paediatrics and neonates. It is an essential resource for nurses and other healthcare professionals: it provides the key information and advice needed for the safe and effective administration of injectable medicines. The Guide's introductory section provides a concise yet comprehensive overview of injectable therapy, including the risks and benefits of IV administration, infusion devices, and pharmaceutical aspects of injectable therapy. For each drug the alphabetically tabulated monographs provide: A practical method of preparation and administration via the IV, IM and SC routes, with risk reduction in mind at every step Expert advice from the team of specialist pharmacists at UCLH to ensure safe and pragmatic use of each medicine Monitoring advice for the management of reactions that may occur during administration Y-site and syringe driver compatibility data Minimum infusion volume data for fluid restricted patients Extravasation warnings, pH, sodium content, displacement values, stability and flush data New to this edition: 40 new monographs including recently marketed, unlicensed, rarely used and specialist medicines Detailed advice for the administration of high risk medicines such as heparin, with access to UCLH's medicine related guidelines at [www.wiley.com/go/UCLH](http://www.wiley.com/go/UCLH) A colour-coded NPSA risk assessment for every mode of administration for every medicine, to highlight the safest method of administration A user guide and tutorial to give new readers confidence in using and understanding the Guide Revised chapters on administration methods and devices, aseptic non-touch technique, and latex allergy Fully revised and expanded Y-site compatibility section Spiral binding to allow the book to be left open at the relevant page The Guide is also available electronically at [www.uclhguide.com](http://www.uclhguide.com).

*Medication Errors* Cyndie Koopsen, Daniel Farb, Caroline Young, 2004-10 Medication Errors is an authoritative, compelling, well-written book/CD course loaded with questions, interactivity, and videos that will leave the reader with a

comprehensive view of medication errors and what to do about them. This course is for everyone in the healthcare field. Upon completion of this course, you will be able to do the following: 1. Discuss the contribution of the current health care system to the increase in medical and medication errors, 2. Describe the scope of the problem, 3. Identify the key messages in the 2000 U.S. Institute of Medicine report, 4. Describe the major causes of medication errors. 5. Describe four types of medication errors, 6. Explain the role of the incident report and its analysis in determining the causes of medication errors, 7. List the four stages of drug ordering and delivery and describe the unique issues related to each stage, 8. Describe the guidelines for preventing errors during each of the four stages (prescribing, transcribing, dispensing, and administration), 9. Identify and explain possible solutions to the problem of medication errors, including advances in technology, standardized bar codes, the use of ward-based clinical pharmacists, and patient education, 10. Explain the impact of cultural diversity on medication safety. The manual accompanying the CD provides a summary of the major points of the CD in a handy format. Estimated time: 6 hours. 297 pages in the CD, 44 in the book. You must have Internet Explorer 4.0 or higher running on your computer. Supported operating systems are Windows 95, 98, 98 SE, ME, 2000, or XP. The CD is licensed to play once on any Windows computer; the borrower may purchase the program after that. One library reference activation is included in the price.

**Medication Errors** Robert Naylor, 2024-08-23 Adverse events in patients caused by medical management are a serious and grossly underreported public health problem. One patient in ten entering hospital will suffer an adverse event of impairment, disability or death. This book is a major comprehensive examination of the incidence and causes of adverse events. Using data obtained from hospitals within the United Kingdom, United States and other developed countries, it examines the risk factors leading to errors, the human and financial costs, and the scope to reduce errors. In particular, it focuses on the need for a critical reappraisal of undergraduate teaching and clinical tuition. All healthcare professionals throughout primary and secondary care, including clinicians, managers and policy makers, and patient and carer groups, can benefit from reading this book. It identifies possible solutions and how adverse events and medication errors can be reduced, resulting in improved patient care.

Preventing Medication Errors and Improving Drug Therapy Outcomes Charles D. Hepler, Richard Segal, 2003-02-25 Read this book in order to learn: Why medicines often fail to produce the desired result and how such failures can be avoided How to think about drug product safety and effectiveness How the main participants in a medications use system can improve outcomes and how professional and personal values, attitudes, and ethical reasoning fit into

**Medication Errors** Zane Robinson Wolf, 1994 This book features accounts of nurses' experiences with medication errors, practical approaches and advice regarding errors, and suggestions for risk reduction as well as possible solutions to problems. PRODUCT NOW DESIGNATED AS A 'KIP' (KEEP IN PRINT) EDITION AS OF 9/20/00 & WILL BE REPRINTED

BASED UPON CUSTOMER NEED/ DEMAND.

A Study of the Prescribing, Dispensing and Administration of Medicines with Reference to Medication Errors in the Armed Forces Hospital, Kuwait Fahad M. Al-Hameli, 2010 Introduction: Medication errors are a major cause of illness and hospitalization of patients throughout the world. This study examines the situation regarding medication errors in the Armed Forces Hospital, Kuwait since no literature exists of any such studies for this country. Several types of potential errors were studied by physicians, nurses and pharmacists. Their attitudes to the commission of errors and possible consequences were surveyed using questionnaires. Additionally, patient medical records were reviewed for possible errors arising from such actions such as the co-administration of interacting drugs. Methods: This study included direct observations of physicians during the prescribing process, pharmacists while they dispensed medications and nurses as they distributed and administered drugs to patients. Data were collected and compiled on Microsoft Excel spreadsheet and analyses were performed using SPSS. Where applicable, results were reported as counts and/ or percentages of error rates. Nurses, pharmacists and physicians survey questionnaires: From the 200 staff sent questionnaires a total of 149 respondents comprising nurses (52.3%), physicians (32.2%) and pharmacists (16.1%) returned the questionnaires a total response rate of 74.5%. All responses were analyzed and compared item-by-item to see if there were any significant differences between the three groups for each questionnaire item. All three groups were most in agreement about their perception of hospital administration as making patient safety a top priority with regard to communicating with staff and taking action when medication errors were reported (all means 3.0 and  $p > 0.05$ ). Pharmacists were most assured of administration support when an error was reported whereas nurses were least likely to see the administration as being supportive (p

**Making Healthcare Safe** Lucian L. Leape, 2021-05-28 This unique and engaging open access title provides a compelling and ground-breaking account of the patient safety movement in the United States, told from the perspective of one of its most prominent leaders, and arguably the movement's founder, Lucian L. Leape, MD. Covering the growth of the field from the late 1980s to 2015, Dr. Leape details the developments, actors, organizations, research, and policy-making activities that marked the evolution and major advances of patient safety in this time span. In addition, and perhaps most importantly, this book not only comprehensively details how and why human and systems errors too often occur in the process of providing health care, it also promotes an in-depth understanding of the principles and practices of patient safety, including how they were influenced by today's modern safety sciences and systems theory and design. Indeed, the book emphasizes how the growing awareness of systems-design thinking and the self-education and commitment to improving patient safety, by not only Dr. Leape but a wide range of other clinicians and health executives from both the private and public sectors, all converged to drive forward the patient safety movement in the US. Making Healthcare Safe is divided into four parts: I. In the Beginning describes the research and theory that defined patient safety and the early initiatives to enhance it. II.

Institutional Responses tells the stories of the efforts of the major organizations that began to apply the new concepts and make patient safety a reality. Most of these stories have not been previously told, so this account becomes their histories as well. III. Getting to Work provides in-depth analyses of four key issues that cut across disciplinary lines impacting patient safety which required special attention. IV. Creating a Culture of Safety looks to the future, marshalling the best thinking about what it will take to achieve the safe care we all deserve. Captivatingly written with an “insider’s” tone and a major contribution to the clinical literature, this title will be of immense value to health care professionals, to students in a range of academic disciplines, to medical trainees, to health administrators, to policymakers and even to lay readers with an interest in patient safety and in the critical quest to create safe care.

**Exploring the Relationship Between Reporting Medication Errors and Nurse Fear of Retribution** Emily J. Hanna, Gardner-Webb University. School of Nursing, 2014 Studies have shown that medication administration errors are a critical issue in healthcare and more importantly preventing this type of error depends on precise reporting. Analysis of medication errors can lead to healthcare system improvement and reduced risk if the errors are detected, reported, and used to formulate improved patient care practices and systems. Nurses are the front line of defense to intercept and report errors. Through a review of the literature, it has been determined that nurse possibly fear blame and punishment when a medication administration error (MAE) occurs; therefore, the purpose of this Master of Science in Nursing thesis was to examine whether nurses avoid reporting MAEs due to perceived fears of retribution. A quantitative cross-section correlative design was used to implement the study. The Medication Administration Error Reporting Survey was utilized as the survey instrument. The study was comprised of registered nurses working on various inpatient units. The subjects were recruited through convenience sampling, with 48 participants being used for the study. The data were analyzed by calculating means and standard deviations for individual items and for subscales, and correlational analyses were conducted to determine if an association exists between perceived reporting barriers and perceived frequency of reporting. The study identified that the primary perceived barriers to reporting MAEs were fear-related. Nurses indicated that additional barriers to reporting are due to not receiving positive feedback for passing medications correctly and that nurses may not think that the error is important enough to be reported. Also identified in this study, is the fact that nurses perceive that medication errors are underreported; although no correlation was found to exist between perceived reporting barriers and nurses' perceptions of the frequency of medication error reporting.

*High Performance in Hospital Management* Edda Weimann, Peter Weimann, 2017-05-10 This book provides a broad overview of what is needed to run hospitals and other health care facilities effectively and efficiently. All of the skills and tools required to achieve this aim are elucidated in the book, including business engineering and change management, strategic planning and the Balanced Scorecard, project management, integrative innovation management, social and ethical

aspects of human resource management, communication and conflict management, staff development and leadership. The guidance offered is exceptional and applicable in both developed and developing countries. Furthermore, the relevant theoretical background is outlined and instructive case reports are included. Each chapter finishes with a summary and five reflective questions. Excellence can only be achieved when health care professionals show in addition to their medical skills a high level of managerial competence. High performance in Hospital Management assists managers of health care providers as well as doctors and nurses to engage in the successful management of a health care facility.

**Nurses' Perceptions of and Experiences with Medication Errors** Mary Jo Maurer, 2010 The purpose of this study was to explore the relationship between nurse characteristics and medication errors. The study examined nurses' perceptions of factors which contribute to medication errors; barriers to reporting and factors that increase the reporting of medication errors; whether medication errors should be reported to the patient, family or an outside agency; and, medication administration technology for reducing medication errors. A survey was mailed to a random sample of 800 registered nurses (RN) from across the United States who were members of the American Nurses Association. A response rate of 49% was achieved using a three-wave mailing. The primary causes of medication errors identified were interruptions during medication pass, short RN staffing, nurses caring for high acuity patients, nurses working more than 12 hours in one shift, and nurses' knowledge of medications dispensed. Approximately one-fourth of nurses reported they had made at least one error that had resulted in some type of harm to a patient in the past 12 months, while approximately 60% of nurses reported making one or more medication errors that did not cause harm to a patient. Rank ordering identified three major barriers to reporting medication errors: fear of consequences that may result if a medication error is reported, fear of blame if something happens to the patient due to a medication error, and fear of a reprimand if they reported a medication error had been made. Nurses perceived that medication administration technologies would decrease medication errors in their hospital. The majority of nurses overwhelmingly agreed that medication errors should be communicated to patients or families, as well as hospitals being responsible for communicating their error rates to the public. Results of this study have serious implications for individual staff nurses, nurse administrators, as well as hospital administration and hospital systems in terms of error reduction and patient safety.

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