

RELEARNING SERIES

MEDICATION ERRORS

The Nursing Experience

Donna E. Wynn, PhD, RN

RN

Medication Errors The Nursing Experience

**Shellie M. Bumgarner, Gardner-Webb
University. School of Nursing**

Medication Errors The Nursing Experience:

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
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The Impact of Formal Nursing Education and Nursing Experience on Medication Errors Made by Nurses in the Hospital Setting Shellie M. Bumgarner, Gardner-Webb University. School of Nursing, 2008 The occurrence of medication errors is a problem that is common to health care systems worldwide There has been countless research performed to try to determine the cause of medication errors It has been found that shifts worked pharmacy involvement miscommunication and multiple other elements contribute to the occurrence of medication errors The primary person involved in medication administration is the nurse This study was performed at a western North Carolina hospital examining recorded medication errors from January 1st 2007 through December 31st 2007 Using a retrospective descriptive correlation design n 293 the study determined that a significant correlation exists between the level of education Diploma Associate Bachelor and Master degree in nursing and years of experience of nurses to medication errors among nurses in the hospital setting

Medication Errors Michael Richard Cohen, 2007 In the second expanded edition of the acclaimed *Medication Errors* 1999 Michael R Cohen brings together some 30 experts from pharmacy medicine nursing and risk management to provide the best most current thinking about medication errors Their contributions make this the most comprehensive authoritative examination in print of the causes of medication errors and strategies to prevent them *Medication Errors* provides the health care community acute care long term care ambulatory care the pharmaceutical industry regulatory affairs and academia with practical guidance to make patients who take or receive medications safer Key Features Numerous insights into the causes of medication errors including drug names drug packaging and labeling and error prone abbreviations and dose expressions In depth analyses of prescribing errors dispensing errors drug administration errors and errors related to drug delivery devices using examples of actual errors for illustration Detailed discussions of specialty areas fraught with risk cancer chemotherapy pediatric and neonatal patients and immunologic drugs A comprehensive chapter on high alert medications those drugs most frequently involved in harmful events with precautions that should be taken to avoid such mishaps Dozens of tables and figures throughout plus a color plate section capturing key information concisely

Building Innovative Nurse Leaders at the Point of Care, An Issue of Nursing Clinics Kelly A. Wolgast, 2020-02-06 Together with Consulting Editor Dr Stephen Krau Dr Kelly Wolgast has put together a unique issue that discusses nursing leadership Expert authors have contributed clinical review articles on the following topics Sustainability Strategies and Nursing Building Skills in Policy Advocacy and Media to Promote Population Health Integrating Technology Innovation Into Practice Leading Change in Nurse Bedside Shift Reporting Decision making at the Bedside Making Good Use

of Your Limited Time Nursing Model of Care in Behavioral Health Mentor Relationships to Build Individual Leader Skills
Sepsis Management in the ED Importance of GIS Mapping and Disaster Preparedness Nurse Characteristics and Effects on
Quality Interprofessional Models of Care Magnet and the Direct Care Nurse and Home Health Nursing Satisfaction and
Retention Readers will come away with the information they need to create a successful environment for nurses that
ultimately results in improving patient outcomes **Human Reliability And Error In Medical System B S**

Dhillon,2003-09-05 Human reliability and error have become a very important issue in health care owing to the vast number
of associated deaths each year For example according to the findings of the Institute of Medicine in 1999 around 100000
Americans die each year because of human error This makes human error in health care the eighth leading cause of deaths
in the US Moreover the total annual national cost of the medical errors is estimated at between 17 billion and 37 6 billion
There are very few books on this subject and none of them covers it at a significant depth The need for a book presenting the
basics of human reliability human factors and comprehensive information on error in medical systems is essential This book
meets that need **Annual Review of Nursing Research, Volume 24, 2006** Joyce J. Fitzpatrick,2006-08-14 Designated a

Doody s Core Title Supporting the urgent need for new patient safety guidelines and practices Focus on Patient Safety
provides the most current and authoritative research and review to help decision makers develop new and much needed
standards and practices in nursing With contributions from experts in the field this new up to date reference focuses on key
disciplines and topics that are critical to patient safety today including Patient safety indicators Medication errors Falls and
injury prevention Hospital acquired infections Patient safety in acute care units in hospitals Medications in the perioperative
environment Home visit programs for the elderly Nursing homes Informatics issues Organizational climate and culture
factors From new and emerging issues in patient safety to a review of research methods and measurement this new 24th
volume in the Annual Review of Nursing Research ARNR series continues to provide the highest standards of content and
authoritative review of research for students researchers and clinicians **Nursing Outcomes** Diane Doran,2010-10-22

Nursing Outcomes State of the Science is an invaluable resource for nurse researchers scholars and health care
professionals committed to effective quality nursing care as evidenced by nursing sensitive outcomes measurement This text
concentrates on outcome indicators which focus on how patients and their conditions are affected by their interaction with
nursing staff Each chapter includes a concept analysis of the outcome concept then defining characteristics are identified
and a conceptual definition is proposed Factors that influence the outcome concept are discussed as well as the
consequences for clients health and well being The strength of the evidence is reviewed concerning the sensitivity of the
outcome concept to nursing structure variables and nursing processes interventions The author offers a comprehensive
synthesis of the literature critically reviews the quality of the evidence and provides direction for the selection of outcome
variables and approaches to measurement Awarded 5 Stars from Doody s Review Service Medical Errors and Medical

Narcissism John D. Banja, 2004 Using the concept of medical narcissism the author examines both the psychological and biological factors involved when a physician decides not to disclose when a medical error has occurred

Just Culture Professor Sidney Dekker, 2012-10-01 Building on the success of the 2007 original Dekker revises enhances and expands his view of just culture for this second edition additionally tackling the key issue of how justice is created inside organizations The goal remains the same to create an environment where learning and accountability are fairly and constructively balanced The First Edition of Sidney Dekker's Just Culture brought accident accountability and criminalization to a broader audience It made people question perhaps for the first time the nature of personal culpability when organizational accidents occur Having raised this awareness the author then discovered that while many organizations saw the fairness and value of creating a just culture they really struggled when it came to developing it What should they do How should they and their managers respond to incidents errors failures that happen on their watch In this Second Edition Dekker expands his view of just culture additionally tackling the key issue of how justice is created inside organizations The new book is structured quite differently Chapter One asks what is the right thing to do the basic moral question underpinning the issue Ensuing chapters demonstrate how determining the right thing really depends on one's viewpoint and that there is not one true story but several This naturally leads into the key issue of how justice is established inside organizations and the practical efforts needed to sustain it The following chapters place just culture and criminalization in a societal context Finally the author reflects upon why we tend to blame individual people for systemic failures when in fact we bear collective responsibility The changes to the text allow the author to explain the core elements of a just culture which he delineated so successfully in the First Edition and to explain how his original ideas have evolved Dekker also introduces new material on ethics and on caring for the second victim the professional at the centre of the incident Consequently we have a natural evolution of the author's ideas Those familiar with the earlier book and those for whom a just culture is still an aspiration will find much wisdom and practical advice here

Research Handbook on Patient Safety and the Law John Tingle, Caterina Milo, Gladys Msiska, Ross Millar, 2023-12-11 Despite recurring efforts a gap exists across a variety of contexts between the protection of patients safety in theory and in practice This timely Research Handbook highlights these critical issues and suggests both legal and policy changes are necessary to better protect patients safety

The Nursing Experience: Trends, Challenges, and Transitions Lucille A. Joel, Lucie Young Kelly, 2002 This text is intended for use with associate degrees and covers the material needed for the Introduction to Nursing Course Attention is given to the changing role of nurses and the differences between the staff nurse and the nurse specialist

Patient Safety B.S. Dhillon, 2011-11-08 With unintended harm during hospital care costing billions of dollars to the world economy not to mention millions of deaths each year it's no wonder the issue is equally front and center in the minds of healthcare providers and the public Although the issue has been tackled in journal articles and conference proceedings there are very few books on the topic And none consider how methods and

techniques developed in the area of engineering can handle safety and human error related problems Until now Written by an expert with vast know how in engineering management design reliability safety and quality Patient Safety An Engineering Approach brings together the pertinent information scattered throughout books and journals eliminating the need to consult many different and diverse sources to find what you need B S Dhillon draws on his real world experience to demonstrate how to handle patient safety related problems using engineering techniques and backs this up with references for further reading at the end of each chapter He sets the stage with introductory chapters on mathematical patient safety and human factors concepts essential to understanding materials presented in subsequent chapters Dhillon s clear concise discussion of the topics presents the information in such a way that no previous knowledge is required to understand the contents yet he does not present it at a merely rudimentary level He brings a fresh approach and engineering perspective to the issues giving you a new tool kit for performing patient safety related analysis designing better medical systems devices and handling patient safety related problems from an engineering perspective *Advances in Usability and User Experience* Tareq

Ahram, Christianne Falcão, 2019-06-12 This book focuses on emerging issues in usability interface design human computer interaction user experience and assistive technology It highlights research aimed at understanding human interaction with products services and systems and focuses on finding effective approaches for improving user experience It also discusses key issues in designing and providing assistive devices and services to individuals with disabilities or impairment to assist mobility communication positioning environmental control and daily living The book covers modelling as well as innovative design concepts with a special emphasis on user centered design and design for specific populations particularly the elderly Virtual reality digital environments heuristic evaluation and forms of device interface feedback of e g visual and haptic are also among the topics covered Based on the both the AHFE 2019 Conference on Usability User Experience and the AHFE 2019 Conference on Human Factors and Assistive Technology held on July 24 28 2019 Washington D C USA this book reports on cutting edge findings research methods and user centred evaluation approaches *The Nursing Experience: Trends, Challenges, and Transitions, Fifth Edition* Lucille A. Joel, 2006-01-03 One of the Most Widely Used Texts in Nursing Education

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 Risk Management Handbook for Health Care Organizations, 3 Volume Set, 2011-01-06 Continuing its superiority in the health care risk management field this sixth edition of The Risk Management Handbook for Health Care Organizations is written by the key practitioners and consultant in the field It contains more practical chapters and health care examples and additional material on methods and techniques of risk reduction and management It also revises the structure of the previous edition and focuses on operational and organizational structure rather than risk areas and functions The three volumes are written using a practical and user friendly approach Medical Mistakes United States. Congress. Senate. Committee on Appropriations. Subcommittee on Departments of Labor, Health and Human Services, Education, and Related Agencies, United States. Congress. Senate. Committee on Health, Education, Labor, and Pensions, United States. Congress. Senate. Committee on Veterans' Affairs, 2001 **Patient Safety and Quality: sect.IV: Working conditions and environment** Ronda Hughes, 2008 **Keeping Patients Safe** Institute of Medicine, Board on Health Care Services, Committee on the Work Environment for Nurses and Patient Safety, 2004-03-27 Building on the revolutionary Institute of Medicine reports *To Err is Human* and *Crossing the Quality Chasm* **Keeping Patients Safe** lays out guidelines for improving patient safety by changing nurses working conditions and demands Licensed nurses and unlicensed nursing assistants are critical participants in our national effort to protect patients from health care errors The nature of the activities nurses typically perform monitoring patients educating home caretakers performing treatments and rescuing patients who are in crisis provides an indispensable resource in detecting and remedying error producing defects in the U S health care system During the past two decades substantial changes have been made in the organization and delivery of health care and consequently in the job description and work environment of nurses As patients are increasingly cared for as outpatients nurses in hospitals and nursing homes deal with greater severity of illness Problems in management practices employee deployment work and workspace design and the basic safety culture of health care organizations place patients at further risk This newest edition in the groundbreaking Institute of Medicine *Quality Chasm* series discusses the key aspects of the work environment for nurses and reviews the potential improvements in working conditions that are likely to have an impact on patient safety Pharmacology and the Nursing Process Linda Lane Lilley, PhD, RN, Shelly Rainforth Collins, PharmD, Julie S. Snyder, MSN, RN-BC, 2015-12-15 Let this outstanding pharmacology text help you learn how to administer drugs safely and effectively Now in its eighth edition *Pharmacology and the Nursing Process* continues to deliver the perfect amount of pharmacology prioritization and nursing process information to today's nursing students Centering on its unique key drug approach this text focuses only on the drug information you need to safely administer drugs The text also continues

to emphasize the nursing process and prioritization covering the most essential assessments nursing diagnoses interventions and evaluations you need to practice effectively New to this edition is even more coverage of QSEN competencies simpler language and a wealth of reader friendly features and innovative learning aids Along with its integrated NCLEX preparation and insightful learning strategies you won't find a more complete pharmacology text on the market NEW Additional QSEN coverage incorporates more QSEN information throughout the text Applicable QSEN competencies added to text case study titles Collaboration and teamwork content added to selected case studies Addition of new Safety What Went Wrong case studies Explanation of QSEN initiatives as it relates to safety and quality of patient care is included in the Medication Errors chapter NEW Improved readability is aided by more friendly direct address language shorter sentences simplified language where appropriate and much more An extensive Photo Atlas of Drug Administration features more than 100 step by step illustrations depicting key steps in drug administration for various routes of drug administration UNIQUE QSEN focus highlights those aspects of the book such as boxes tips case studies and other content that correlate with the QSEN competencies Popular key drug approach focuses on the need to know content for safe clinical practice and uses a streamlined approach to drug indications emphasizing only the most common or serious adverse effects Integrated NCLEX Examination preparation includes seven NCLEX Examination review questions in every chapter with at least one alternate format item per chapter Thorough application of the nursing process is addressed in each chapter to help readers learn how to prioritize nursing care to focus on the most essential assessments nursing diagnosis interventions and evaluation outcome criteria Colorful and consistent learner friendly format utilizes a variety of tables and practical body systems organization to help readers integrate pharmacology content with what they are learning in medical surgical and adult health nursing courses Focus on prioritization includes prioritized nursing diagnoses along with corresponding prioritization of goals and outcomes helping readers learn to connect nursing diagnoses to goals and outcomes Large collection of reader friendly learning aids includes approachable text elements such as Cartoon illustrated learning strategies covering study time management and test taking tips related to studying pharmacology Drug profiles highlighting specific information on commonly used agents Case studies that help bring patients to life and promote critical thinking skills Dosages tables providing instant access to dosages routes and indications for individual drugs Key points summarizing key pharmacology and nursing content in each chapter Critical thinking and prioritization questions encourage readers to think on a deeper level More than 250 full color photos and illustrations show how drugs work in the body and how to administer medications safely and effectively NEW Updated learning strategies include strategies for incorporating technology and active learning NEW Exclamation point icon identifies ISMP high alert drugs NEW Diamond icons indicate key drugs in the Dosage tables

The Enigmatic Realm of **Medication Errors The Nursing Experience**: Unleashing the Language is Inner Magic

In a fast-paced digital era where connections and knowledge intertwine, the enigmatic realm of language reveals its inherent magic. Its capacity to stir emotions, ignite contemplation, and catalyze profound transformations is nothing in short supply of extraordinary. Within the captivating pages of **Medication Errors The Nursing Experience** a literary masterpiece penned with a renowned author, readers set about a transformative journey, unlocking the secrets and untapped potential embedded within each word. In this evaluation, we shall explore the book's core themes, assess its distinct writing style, and delve into its lasting impact on the hearts and minds of people who partake in its reading experience.

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