

شبكة المعلومات الجامعية







شبكة المعلومات الجامعية التوثيق الالكتروني والميكروفيلم



شبكة المعلومات الجامعية

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ASSESSMENT OF MEDICATION SAFETY MEASURES USED IN EVERY DAY PRACTICE IN PEDIATRIC CRITICAL CARE UNITS AT PEDIATRIC CAIRO UNIVERSITY HOSPITAL

N V.

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The candidate

Assessment of Medication Safety Measures Used in Every Day Practice in Pediatric Critical Care Units at Pediatric Cairo University Hospital

Abstract

By

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Medications are of a great benefit to patient's lives for relieving pain or curing illness. Medications may be very dangerous if improperly used, moreover medications' safety is one of the highest priorities of nursing practice, a matter of considerable concern for all health team members. Medication errors produce a variety of problems for patients ranging from minor discomfort to substantial morbidity that may prolong hospitalization or lead to death and risk of litigation. Therefore, the aim of this study was to assess the medication safety measures used in every day practice. The study was conducted at the Pediatric Cairo University Hospital. All critical care units of the hospital were included in the study. A convenient sample consisting of all staff nurses who are giving direct care and working three shifts were recruited. The tool used a socio demographic data sheet, and a "Medication Safety Measures Evaluation Tool for Nurses" to assess safety of medication in every day practice. It contains 10 domains with a total of (91) items representing safe medication use. The result of the study indicated the unsafe use of medication safety measures. all items of the Medication Safety Measures Evaluation tool showed statistically significant differences between staff nurses and the head nurses' responses except for the Staff competency and education. The study recommended that safety measures for safe medication practice should be applied in the hospital, and an educational program for all hospital and medical staff in medication recording and administration process especially for nurses to develop and maintain pediatric medications knowledge base.

Key words: patient safety, medication error, medication safety.

Signed Chairperson of thesis

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LIST OF ABBREVIATIONS

ADEs : Adverse Drug Events

BCMAs : Barcode Medication Administration

CDSS : Clinical Decision Support System

CPOE : Computerized Physician Order Entry

eMARs : Electronic Medication Administration Records

FDA : Food and Drug Administration

ISMP : Institute of Safe Medication Practices

IT : Information Technology

JCAHO : Joint Commission on Accreditation of Healthcare

Organization

MARs : Medication Administration Records

MERS : Medication Error Reporting System

NCCMERP : National Coordinating Council for Medication Error

Reporting and Prevention

OSHA : Occupational Safety and Health Administration

WHO : World Health Organization

CHAPTER I

Introduction

Safety is a key component of quality within any health care organization (Kohn, Corrigan & Donaldson, 1999; and WHO, 2005), and currently considered as an international priority in health care, as it is widely accepted that the quality of health care provision, in term of reducing errors and other forms of unnecessary patient harm, needs to be improved significantly (Heatlie, 2003). Patient safety is defined as the freedom from accidental injuries during the course of medical care and encompasses the activities aimed to avoid, prevent or mitigate adverse outcomes which may result from health care (Pines, 2006).

Each health care organization can support patient safety, and improve the quality of care treatment and services by implementing a well planned medication management system. Such a system reduces practice variation errors and misuse, monitors medication management process as regards efficiency, quality and safety, standardizes equipment and process across the organization to improve medication management system, uses evidence based good practices to develop medication management process, and manages critical process associated with medication management to promote safe medication use throughout the organization (Leape, Rogers & Hanna, 2006).

Providing drug treatment in the hospital setting requires that a series of actions be performed by several members of the health care team such as the physician, the unit clerk, the hospital pharmacist and the nurse as numerous medications lack formal licensing, indications and dosing guidelines for pediatric (Food and Drug Administration, 2007).