

The Impact of Medication Errors on Patients and Healthcare Organizations

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ABSTRACT

Error in medical treatment is worse and can cause several damages which may be permanent or temporary or even cause death. In this paper a detailed study is made based on the medical error and mistakes made by human or system and noted in health care centers. These problems can be solved by maintaining regular records and giving skilled programs to staff and maintain system regularly.

KEYWORDS: medication error, skilled program,

INTRODUCTION

In hospital settings, medication errors refer to treatment process failures that cause or exhibit the potential to cause patient harm (Mixon, Myers & Leak et al., 2014). Whereas the medication errors could arise from plain human error or systemic issues, they can lead to severe physical injury; translating into patient deaths in some cases. It is also notable the mistakes, which are preventable, could lead to severe emotional, psychological, and financial stress to the healthcare organizations and providers (Slight, Howard, Ghaleb, Barber, Franklin and Avery, 2013). The aim of this paper is to present some of the negative consequences with which medication errors are associated, giving insights from the perspectives of hospitals, healthcare providers, and patients. Indeed, some studies show that medication errors pose negative effects on patients and their loved ones, relatives, or families. For instance, Westbrook, Woods, Rob, Dunsmuir and Day (2010) stated that the range of medication errors' consequences could stretch from effects that

are likely to go unnoticed to death. Also, Wittich, Burkle and Lanier (2014) documented that medication errors could cause new conditions; whether permanent or temporary. The study by Mixon, Myers and Leak et al. (2014) suggested that some of the new conditions with which medication errors are associated include skin disfigurement, rashes, and itching. Whereas it may be uncommon, patient errors have been associated with death, as well as severe patient injury. In the study by Slight, Howard, Ghaleb, Barber, Franklin and Avery (2013), findings demonstrated that the loss of a family's loved one (due to medication errors) tends to be a devastating outcome; with the situation compounded by their knowledge that such causes of death are preventable. Hence, it can be inferred that medication errors cause psychological and emotional problems to the patients' families, besides the problems of severe injury and death of the patients themselves (Westbrook, Woods, Rob, Dunsmuir and Day, 2010).

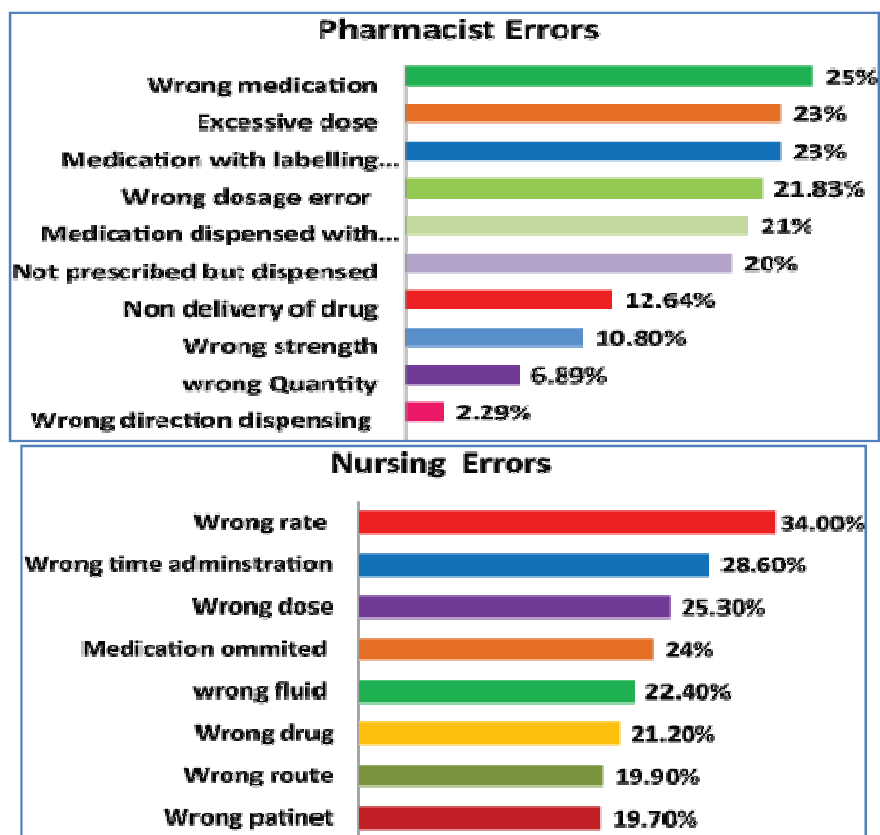


Figure 1: Recent trends in Medication errors

Source: Wittich, Burkle and Lanier (2014)

The impact of medication errors on health care providers has also been examined. In one of such investigations, Wittich, Burkle and Lanier (2014) observed that in situations, where nurses or doctors inadvertently experience a near-miss or give wrong medications to patients, they are likely to suffer from self-doubt, guilt, and shame. Hence, health care providers become second victims. One of the secondary effects of this syndrome, which has been observed to be life-threatening, includes suicide; including situations such as those in which the providers overdose fragile babies with about ten times the expected amount of calcium chloride (Mixon, Myers & Leak et al., 2014). Given that only 3% of health care providers are likely to inform patients and their families about medication errors (Slight, Howard, Ghaleb, Barber, Franklin and Avery, 2013), many studies contend that system changes and reviews end up being prevented (Westbrook, Woods, Rob, Dunsmuir and Day, 2010). Should the affected patients and families pursue lawsuits against the providers in relation to their perceived negligence, Wittich, Burkle and Lanier (2014) stated that additional effects include probabilities of license revocation, as well as stalled progress in healthcare professional career advancement. Also, medication

errors have been documented to affect hospitals. According to Mixon, Myers and Leak et al. (2014), hospitals in which medication errors are reported are likely to incur settlement costs. For the staff with whom the errors are associated, Slight, Howard, Ghaleb, Barber, Franklin and Avery (2013) stated further that there is likely to be lost productivity, as well as an increase in the cost of unplanned patient treatment – and prolonged hospitalization. Furthermore, the process of settlement, litigation, investigation, and dealing with errors could prove time-consuming, especially due to the need for the hospital's management team to ensure that policies through which future errors could be minimized are investigated and modified (Westbrook, Woods, Rob, Dunsmuir and Day, 2010). Should there be cumulative medication errors, a study by Wittich, Burkle and Lanier (2014) revealed the hospital's re-accreditation and reputation are likely to be affected negatively. In conclusion, several strategies are worth embracing – in relation to the prevention of medication errors in health care settings. Some of these strategies include the development of robust error reporting systems and a culture of safety (at the organization level), conducting regular re-skilling

activities via seminars and conferences, and the reporting of near-miss to the reporting supervisors.

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