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Perceptions on Medication Administration Errors (MAEs) Among Nurses at the Philippine Orthopedic Center (POC)

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Background: Medication administration errors (MAEs) is a serious public health threat that causes patient injury, death, and results to expensive health care. It can have severe consequences for patients and affect nurses more than the other members of the multidisciplinary team. The nurses' participation is very visible in the medication equation, thus, may predispose them in committing medication-linked errors considering the chaotic, fast-paced, complex, unpredictable, and stressful circumstances they are working on.

Objective: The primary goal of this study was to identify the nurses' perceptions on the occurrence of Medication Administration Errors (MAEs) and barriers to reporting using the Medication Administration Error (MAE) Reporting Survey.

Methods: A quantitative, descriptive study with cross-sectional research design was conducted. Descriptive statistical analysis was done using Stata 12. Quantitative variables were described by the mean, standard deviation (SD), frequency, and percentage.

Results: The overall response rate from 240 respondents was 79.17%. The most frequent reason for MAEs according to the nurses was physicians' medication orders are not legible (4.67 ± 1.21), unit staffing levels are inadequate (4.63 ± 1.45), and physicians' medication orders are not clear (4.48 ± 1.20), respectively. The most frequent reason for unreported MAEs was when med errors occur, nursing administration focuses on the individual rather than looking at the systems as a potential cause of the error (4.95 ± 4.33), nurses could be blamed if something happens to the patient as a result of the medication error (4.29 ± 1.48), and no positive feedback is given for passing medications correctly (4.22 ± 1.50), respectively. The highest prevalent non-IV related MAEs included wrong time of administration ($M = 3.02 \pm 2.37$), medication administered after the order to discontinue has been written ($M = 2.60 \pm 2.11$), and medication is omitted ($M = 2.48 \pm 1.97$), all with 0-20% of reported non-IV MAEs. The highest prevalent IV related MAEs included wrong time of administration ($M = 2.76 \pm 2.29$), medication administered after the order to discontinue has been written ($M = 2.45 \pm 2.01$), and medication is omitted ($M = 2.28 \pm 1.95$). More than half ($n = 95$, $\% = 54.29$) of the respondents stated that 0-20% of all types of medication errors, including IV and non-IV medication errors are actually reported.

Conclusions: The results of this study provided information about the factors nurses perceive as contributing to MAEs, reasons why medication errors were not reported, extent of error reporting in the institution, and possible preventive measures. The findings supported the notion that nurses perceive low percentages of MAEs reporting. MAEs rates are misleading since these low reported rates are affected by the nurses' attitudes toward the reporting system. Physicians who write the prescription, pharmacists who dispense it, and the nurses who receive the medicine and administer it to the patients all play an important role in preventing MAEs.

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