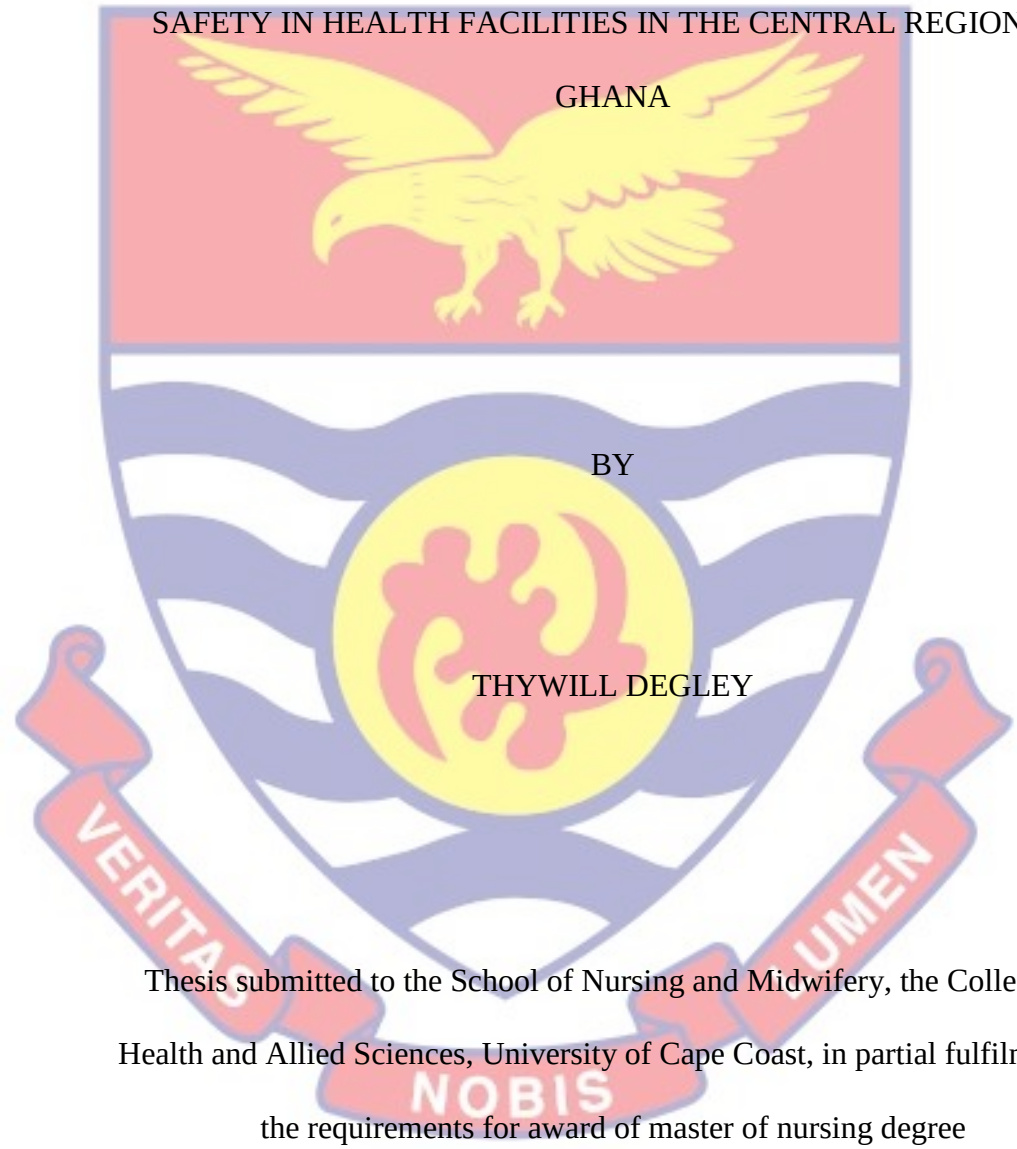
UNIVERSITY OF CAPE COAST

NURSES VIEW ON DRUG ADMINISTRATION ERROR AND PATIENT SAFETY IN HEALTH FACILITIES IN THE CENTRAL REGION OF GHANA



BY

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MAY 2016

DECLARATION

Candidate's Declaration

I hereby, declare that this dissertation is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature: ..... Date .....

Name: Thywill Amenuveve Degley

Supervisors' Declaration

I hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature: ..... Date .....

Name: Professor Janet Gross

Co-Supervisor's Signature: ..... Date .....

Name: Dr. Peter Mate Siakwa

ABSTRACT

Drug administration is a core responsibility of nurses. Medication error occurring during the drug administration process can be attributed to varied effects on patients' safety, ranging from the errors going undetected to prolonged hospital stays, discomfort and death. It is relevant to identify the extent of drug administration error in the district hospitals in the Central region of Ghana. A quantitative, cross-sectional study was conducted among nurses nursing patients admitted to selected district hospital in the Central Region of Ghana. Primary data was gathered from 168 nurses using a pre-tested questionnaire and a review of incident books on the wards. Logistic regression was done to assess possible factors contributing to drug administration error. The majority of the respondents (61.9%) were below 29 years and had worked between one and four years (72.2%). Most common types of error committed include pre-administration error (mean=2.67) and administration technique error (mean=2.67).The majority of these errors occur during the night shift (65%). Lack of understanding of medication jargons (mean = 3.89), "feeling uncomfortable to wake patient up' (mean = 3.78) and nurses eagerness to go home (mean = 3.67) were the most predisposing factors to drug administration error. Increasing internal environment constraints corresponds with increasing drug administration error commitment by a factor of 0.228. Lack of emphasis placed on medication error as a measure of quality of care and non-existence of channels for reporting drug administration error were the main barriers to reporting drug administration error.

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DEDICATION

I dedicate this work to my children and all nurses.

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LIST OF ABBREVIATIONS

ADE	Adverse drug events
ADR	Adverse Drug Reaction
AHRQ	Agency for Healthcare Research and Quality
CHPS	Community-based health's planning and services
CIHI	Canadian Institute for Health Information
CMIRPS	Canadian Medication Incident Reporting and Prevention System
CRAR	Central Regional Annual Report
DAE	Drug Administration Error
FDA	Food and Drug Administration
GFFR	Ghana Fact and Figure Report
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HCP	Health Care Provider
HRD-GHS	Human Resource Division –Ghana Health Service Report
IOM	Institute of Medication
ISMP	Institute for Safe Medication Practices
KQI	Key Quality Indicator
MAE	Medication Administration Error
ME	Medication Error
MIR	Medical Incident Report
NCCMERP	National Coordinating Council for Medication Error Reporting and Prevention
NHIS	National Health Insurance Scheme

NMC	Nursing and Midwifery Council
PS	Patient Safety
US	United States
WHO	World Health Organization