

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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Thesis submitted to the School of Nursing and Midwifery, the College of  
Health and Allied Sciences, University of Cape Coast, in partial fulfilment of  
the requirements for award of master of nursing degree

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.

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## ABSTRACT

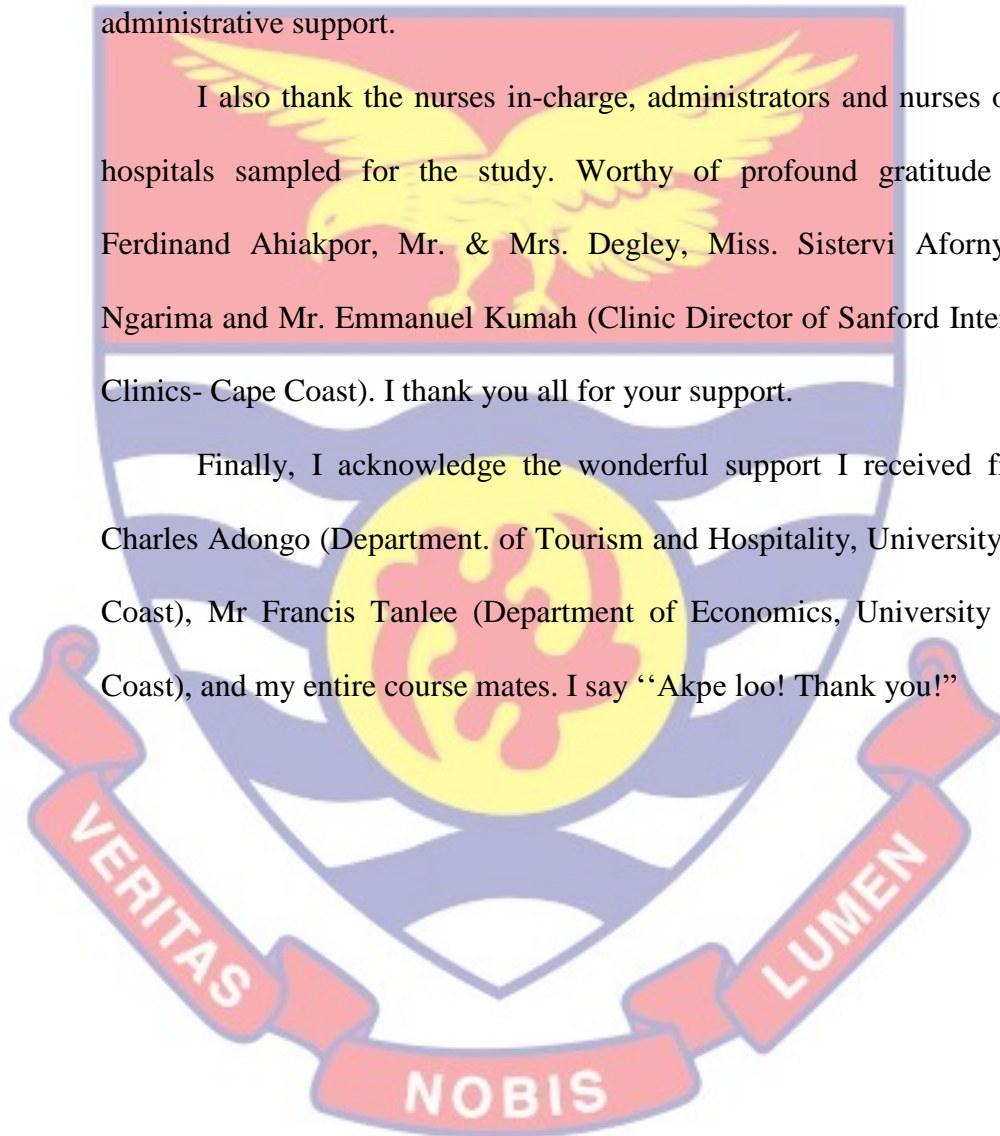
Drug administration is a core responsibility of nurses. Medication error occurring during the drug administration process can be attributed to varied effects on patients' safety, ranging from the errors going undetected to prolonged hospital stays, discomfort and death. It is relevant to identify the 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.

## ACKNOWLEDGEMENTS

I express my heart-felt gratitude to my supervisors, Prof Janet Gross and Dr. Mate Siakwa for their time, tireless guidance, concrete suggestions and patience. To all lecturers and faculty members of the School of Nursing and Midwifery, University of Cape Coast, I say thank you for the administrative support.

I also thank the nurses in-charge, administrators and nurses of all the hospitals sampled for the study. Worthy of profound gratitude are Dr. Ferdinand Ahiakpor, Mr. & Mrs. Degley, Miss. Sistervi Afornyo, Alex Ngarima and Mr. Emmanuel Kumah (Clinic Director of Sanford International Clinics- Cape Coast). I thank you all for your support.

Finally, I acknowledge the wonderful support I received from Mr. Charles Adongo (Department. of Tourism and Hospitality, University of Cape Coast), Mr Francis Tanlee (Department of Economics, University of Cape Coast), and my entire course mates. I say “Akpe loo! Thank you!”



## DEDICATION

I dedicate this work to my children and all nurses.



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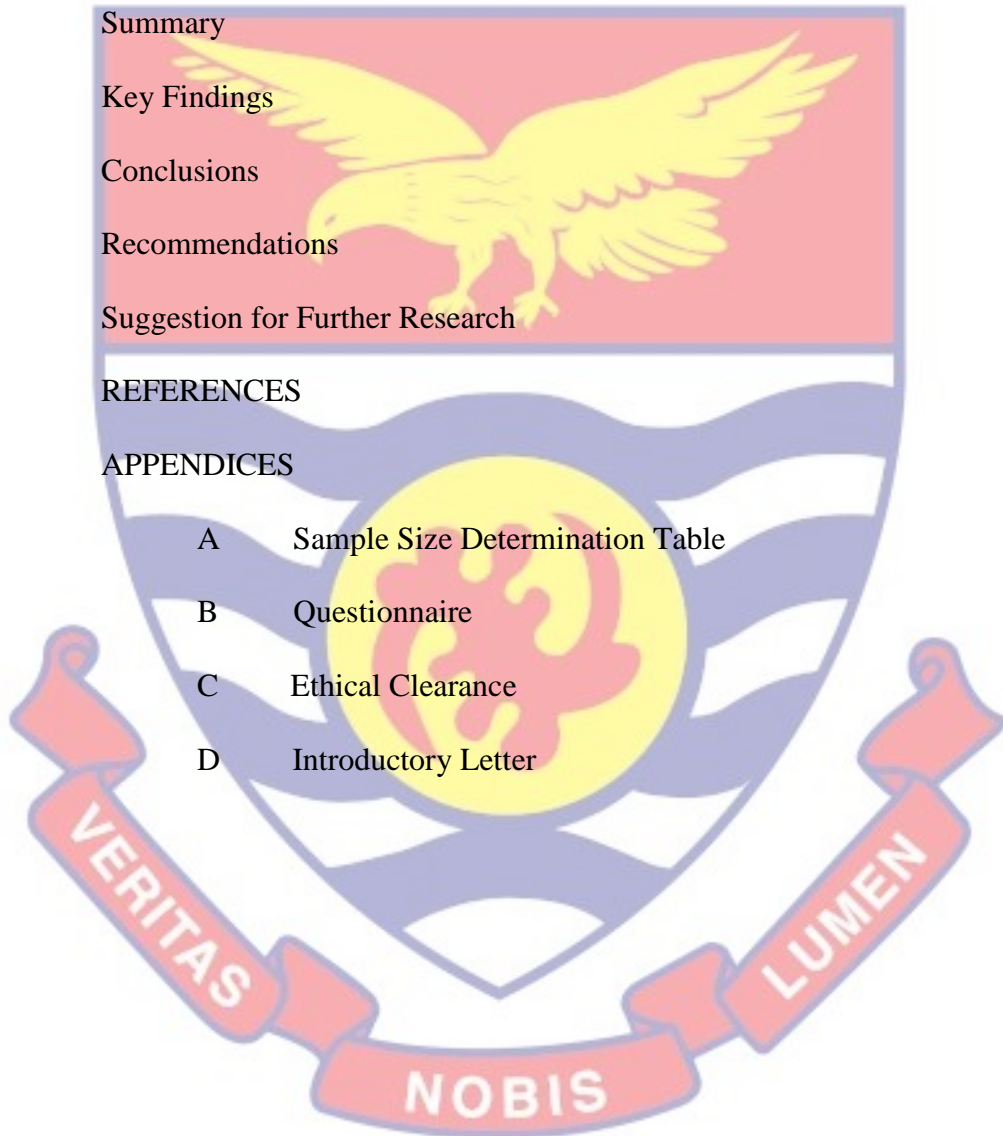
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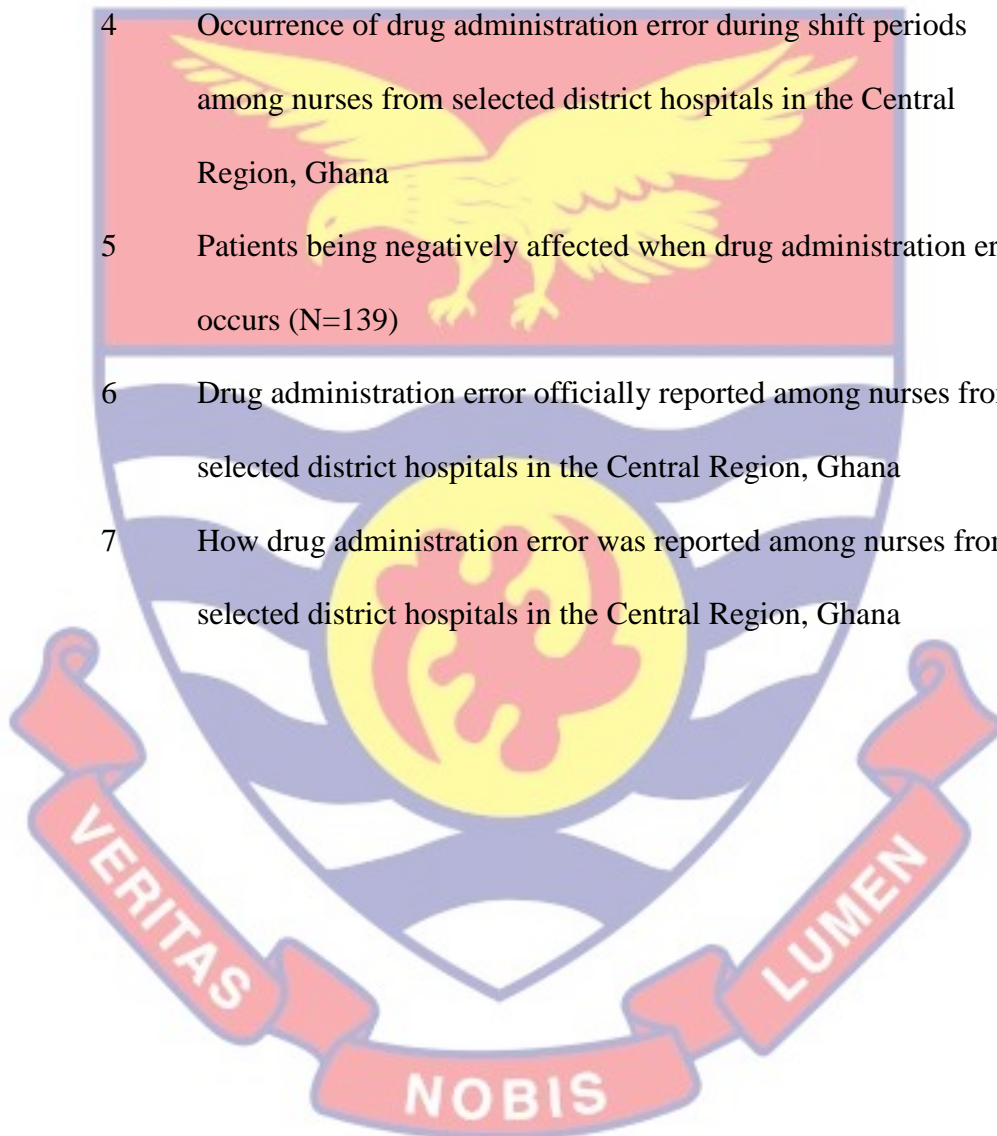
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## LIST OF ABBREVIATIONS



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

