Barriers to Reporting Medication Administration Errors among Nurses in Services Hospital Lahore

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Abstract: According to the report of Institute of Medicine (IOM) that about 7,000 of death are occur annual because of the medication error which is going worse day by day. The effect of medication error is not good for patient health. It reduces the efficiency of health care system. It is also evident from the report of IOM that about 1.5 million of people are injured because of the medication administration error and annual expense for treating those patient take more than 3.5 billion Dollars annually which is a great expense. This all happen just because of the medication administration error. To assess the barriers to which minimize reporting medication administration error among nurses in Services hospital Lahore. This study was carried out by using a cross sectional descriptive study design in Services Hospital Lahore. Data was taken from the staff nurses and the total sample size was 222. Response from the participants was taken through simple random sampling techniques.Spss21 version used for descriptive analysis and applied chi square and one sample t-test. The results after study show 35% of the staff nurses were agree that they didn't recognize an error occurred properly while 16% were disagree. 41% of staff nurses were agree that while reporting an medication error then the colleagues will be think that they are incompetent while 38% of the nurses were disagree to this statement. 68% of staff nurses were agree that it is very important for a Hospital to have proper medication error reporting system while 20% were disagree, 62% of staff Nurses were agree that the response of hospital administration doesn't match with the severity of case while 24% disagree. The barriers which play a vital role in underreporting of medication error is the fear of staff nurses form the hospital management and the response of hospital administration.
Keywords: Medication Administration Error, Barriers, Nurse

INTRODUCTION

Hospitals are built for the care of sick and it's the responsibility of the staff and management to prevent, reduce and eliminate the hazardous environment and situation in the health care facility, the most critical and crucial situation for patient is that when he/she received wrong medicine or through wrong route.

Medication administration error can be defined as the administering wrong medication to the patient, selecting wrong patient or giving medication through wrong route. The most common is administering extra dose or giving or unable to follow the time framework for specific medicine and for specific patient, it may occur when Nurses doesn't know about their patient or about his medicine [1].

Medication administration error are occurred more frequently in health care settings and it can be preventable if follow the standard rules and guidelines. The errors may be occur due to the wrong prescription of medicine or dispensing of medicine inaccurately and the most prominent is giving medication to the patient through wrong route. The errors occur due to the inability of health care provider or ignorance of the standard operating procedure rules. Nurses have directly contact with patient and have responsibility to administer medication to the patient because of this nurses are most likely to involve in medication administration error [2].

The main concern of hospital administration is to give quality care to patient and for which they need the cooperation of all staff. The hospital credibility depends on provision of quality care to patient and the quality of care is the main indicator of any hospital [3].

It is portrayed from many studies that one third of adverse drug reaction occurs because of the medication error which can be prevented by effective knowledge and skills [4].

Medication administration errors can be happened at any stage of treatment but the most common is during prescription of medicine by the

doctor or by the administration of medication by the staff nurse [5].

The most appropriate step after occurring medication error is to inform the hospital administration and to document it via this patient could be prevented from serious harm or injury and the problem can be manage as soon as possible. Meanwhile hiding the error may lead to serious consequences and may lead to the death of patient which may be intolerable for the patient family and hospital administration. Informing the error to management will help the hospital to sort out the problem in a very good way, identify the problem area and enabling the staff to prevent further error [6].

Several reasons are contributing in underreporting of medication error in which the most prominent is the fear of disciplinary action against the staff nurse by the management or to fire from job, teasing by the colleagues to prove the staff is incompetent and malpractice, fear of being blamed for any serious condition of the patient and also fear from the patient attendant to take action against staff and take revenge [7].

In health care setting medication error may cause dissatisfaction and mistrust of the patient on organization and staff and may lead to stress, ethical and legal issue in sever situation. Patient attendant may violate in hospital and a serious situation can be happened [8].

Medication error is harmful for all patients but having a very significant and severs threat for children. Children are the more vulnerable group for medication error and its adverse reaction that's all are because of the weight-based drug dosing; for children it's necessary to calculate drug dose, which is a time consuming activity that's why they are more vulnerable instead of adult for medication error. Children need special attention and special drug calculation to reduce medication error in children [9].

A study which was conducted by Mcleod et al. [10] stated that the risk for medication administration error is five time more likely to occur in intravenous medication then other medication like oral, rectal, intradermal, sublingual etc. It is very mandatory that strictly double cheeked the route and dose of drugs while administering medication, Intravenous medicine is a direct contact with blood stream and mishandling or any negligence can cause life threating situation for the patient.

A study which was carried out by Watts and Parsons [11] stated that most of the medication error occur because of the incorrect calculating of dose, nurses either given very high dose of medicine to patient or sometime administered very low dose by which patient didn't respond properly to the medicine and no progress occur in patient treatment. Watts find out that overdosing is more predominant then lower dosing and the response of the patient to overdosing is very severe which cause serious complications.

Leufer conducted a study in 2013 [12] stated that many factors are contributing in medication error including intrinsic and extrinsic factor; Intrinsic factor like Knowledge and performance are the great contributor factor in medication error, it is evident from his study that knowledge play a vital role in preventing medication error. Some nurses had lack of knowledge about the proper dose and route of administration. The extrinsic factor like overconfidence also play an important role in medication error. Some nurses are overconfidence about their work and didn't focus on prescription and dosage that's why an error occur.

Medication error is the most common cause of injury to patient in hospital, it is more severe immunocompromised patients and the staff nurses need to give an extraordinary care and focus on immunosuppressive patients. To treat the injury of patients which occur because of the incorrect and wrong medication required a huge amount of expenses. All around the globe injury from medication error drain an extensively economical resources which cause the hospital to loss of resources and credibility [13].

The medication error incidence is higher in developing countries is compared to developed countries. A study which was carried out by Rentero in 2014 [29] stated that the ratio of medication error is higher in developing countries because of the unavailability of necessary facilities and they didn't have competent staff in most of the hospitals. The underreporting of medication error is higher because of the lack of knowledge about the consequences of medication error. Therefore it is more important to evaluate the barriers to reporting medication administration error among nurses.

Purpose of the Study
The purpose of this study is to assess the barrier in reporting medication administration error among nurses.

Significance
In everyday nursing care there is a lot of medication error occurred which are not reporting properly due to multiple reasons. This study will help in identifying some of the main barriers which play a vital role in underreporting of medication error. This study will help the hospital administration to build systematic and effective strategies to prevent medication administration error and also help the staff nurses to

know about their perception of underreporting medication error. The reporting of medication error will help the organization to develop measures to reduce the error therefore, cost effective health can be deliver to public.

Problem statement

The most critical and crucial situation for patient is that when he\she received wrong medication or through wrong route. Providing safe medication administration is the primary and basic right of every patient to be treated safely without providing any harm to the patient by the negligence or incompetency of staff. The Institute of Medicine (IOM) issued a report, *To Err is Human* [30]: *Building a Safer Health System*. This is mentioned in the report of IOM that about 7,000 of death are occur annual because of the medication error which is going worse day by day. The effect of medication error is not good for patient, nurses, doctors and the health care system it reduce the efficiency of health care system.

It is also evident from the report of IOM that about 1.5 million of people are injured because of the medication administration error and annual expense for treating those patient take more than 3.5 billion dollar annually which is a great expense. This all happen just because of the medication administration error.

Now a days it's a very great concern for the stake holders of health care system that how to prevent medication error and reduce the death rate and the expenses [30].

Research questions

What are the Barriers which minimize reporting medication administration error?

Dependent Variable

The dependent Variable of this study will be "Reporting of medication Error"

Independent Variable

The independent variable will be the barriers which play role in underreporting of medication error

Related Theory

The Theory which may be applied for this study and to support this study in a theoretical and Logical way is the "**Theory of planned behavior**" **TPB.** This theory was presented by Ajzen's in [13].

In this study I am going to find out the perceived barriers which may play the role in underreporting of medication error, The TPB is theory which clearly stated about the behavior modification and the intention by which any of the act occur and it is widely used in the medical field to assess and know

about the various behavioral changes which may occur in the health care professions [14].

This theory was used by [15]. In his study and find out that this theory play a vital role in the identification of behavior and moral norms by which the identification of intentions is easy it is reveled from his study that it is the important predictor of nurses intention towards making their clinical decisions.

In my study this theory will play a vital role in the identification of perceived barriers among nurses because when nurses' report or neither report the medication error these both are the clinical decisions and this theory support the intention and behavior.

Conceptual definition
Medication Error

Any preventable event that may cause the handling and administrating of medication in an inappropriate way which may cause serious health problem to patient and may lead to severe consequences even the prevention of this are the responsibility of health care delivery person [4].

Barrier

Any situation or obstacles which prevent normal movements or being hurdle in doing something [16].

Nurse

The definition of a nurse is someone who cares for sick, old or young people, or someone who provides medical assistance [17].

Operational definitions
Medication error

Any case will be considered as an error which is notify by the staff nurse or having evidence of medication error, medication error may be considered as an extra dose or giving medicine through wrong route or to give medicine to wrong patient.

Barriers

All the situation and hurdles will be considered as a barrier by which the staff nurses are afraid to report an error or in which they feel hesitation to do it.

Nurse

All the nurses of services hospital will be considered having degree of diploma nursing or BSN who are directly involved in patient.

LITERATURE REVIEW

A huge amount of medication error were seen in many health care setting which may cause a very serious health problem to patients and can lead to a very

severe consequences to minimize occurrence of medication error [18].

A study which was conducted by [18] in Lowa,s acute care hospital stated that the reason of underreporting medication error can be divided into several subunit in which the most prominent is administrative response, disagreement over an error, reporting error and fear. These all are the reasons by which nurses can't report medication error incidence to high management. This is portrayed from this study that about 78% of staff nurse didn't report medication error because of the reason of fear of administrative response and fear of losing job, to be proved incompetent by the supervisor also play a great role in underreporting of medication error, while 12% of staff nurses only reported medication error and the remaining 78% were not take it serious to be reported.

Another study which was conducted by [19] to recognize the perception of barriers to report medication administration error among Taiwanese nurses. It is revealed form his study that the perception of 60% staff nurses towards reporting medication was the fear of being blame, unskillfulness, and the fear of serious consequences after reporting an error. 68% of staff nurses believed that they didn't report medication error because of the response of administration and management which include: no positive feedback after reporting an error even lead to negative response and feedback, the nurse may be focused by everyone after reporting error. 39% of staff nurses were agreed that face-saving and power of hierarchy have also a very great contribution in underreporting of medication among nurses.

Another study which was conducted by Mohammad Nejad, E., *et al*. [20]. stated that many barriers were contributing in underreporting of medication error the main one he found was that 54% of staff nurses believe that this is not significant to report an medication error and have no worth to report an error if it occurred which lead to missing valuable information and by this hiding of information the administrations were failed to take preventive measure.

A study which was conducted by Almutary in 2012 [21] in Saudi Arabia it is reveled from his study that most of the staff nurses which was making 63% of his study were found extreme barriers in reporting medication administration error while 37% of staff nurses were agree that didn't face or found any barrier when reporting medication administration error.

A study was conducted by Unver et al. [20] in Turkey to find out the perception of staff nurses regarding the underreporting of medication administration error. It is portrayed from his study that

about 45% of nurses were reported medication error to their supervisor while the 50% of staff nurses didn't report it and the remaining 5% didn't take is significantly.

Another study which was carried out by Elnitsky in 2009 [23], is revealed from his study that medication error is the most threat able condition for patient and patient may suffer from very serious consequences. Its portrayed from his study that about 14% of nurses didn't believe that the reporting medication error is significant and also don't think that it may be reliable, 14% believed that it take too much time and having no role to prevent future incident while 25% of staff nurses believed that the supervisor may use medication error reporting against them and may be that supervisor will fire them from their job that's why they are not reporting medication.

It is reveled from the study which was conducted by *Schmidt* in 2011 [24] that the majority of medication error occurs in the phase of administering rather than dispensing of medicine or prescribing of medicine. It's mentioned in his study that almost 50% of medication error occur via administration of medicine while 22% in dispensing and only 8% of error occur in the prescription phase. It is shown in the study that the most common cause of medication error in the phase of administration for which the staff nurses are directly responsible by tracing the error and by proper management these error can be minimized at a significant amount.

Another study which was conducted by *Kim, J et al.* [25] in Korea to identify the barrier of under reporting medication error among nurses. In this study the researcher used convenient sampling method of 220 nurses from seven hospital. The participants of the study were asked about the barriers which they faced in reporting of medication error and the strategy to prevent further medication error in Korean Public Hospitals. It is revealed from his study that about 10% of the participants were involved in medication error in last month, 58% of error occur in intravenous medication while only 10% in oral. The reasons by which the staff nurses didn't report medication error was the fear of losing job and the worse response of the management. 60% of the participant didn't report medication error because of the management response while 48% didn't report medication error because of fear of losing job.

Although under-reporting the medication errors is a global health problem, its extent is larger in the developing countries for lack of appropriate reporting and record-keeping systems.

METHODOLOGY
Study Design
A Quantitative descriptive cross sectional research design used for this study.

Research tool
A self-administered questionnaire was adopted from the article "Barriers to Reporting Medication Administration Errors among Nurses in an Accredited Hospital in Saudi Arabia" written by Ala'a, Z., et al. [26] will be used to collect data from the participants. Questionnaire is consist of 2 sections, (Section A) composed of demographic data which include name (optional) age, gender, qualification, experience and also a question to ask about ever involved in medication error

(Section B) composed of four further subclass which are 1) "Disagreement over definition" consist of 5 questions. 2) "Reporting Effort" composed of three questions 3) "Fear" composed of five questions, 4) "Administrative Response" composed of four questions. The participants can answer these questions through likert scale from strongly disagree to strongly agree. A pilot study of the questionnaire will be done before floating the questionnaire. (Appendix A)

Data Collection Plan
Questioner floated among participant of services hospital Lahore and facilitate the participant and collect after30 mints.

Data Analysis
Data analysis will be done on SPSS version 21.Statistical computer software for data analysis will be done through the SPSS software. Tables and graphs will be developed to portray the information.

Site and Setting
Site for this study will be a tertiary care hospital in Lahore, Services Hospital will be selected.

Target population
The target population for this study will be all the staff nurses' male and female working in Services Hospital Lahore.

Sample Size
The sample size for this study will be 222 which is calculated from the *Slovins formula of sampling* [27].

Total number of staff nurses 500
N=Population, n=Sample size, E= Margin of error

$$n = N/1 + (N)(E)^2$$
$$n = 500/1 + (500)(0.05)^2$$
$$n = 500/1 + (500)(0.0025)$$
$$n = 500/2.25 = 222$$

Including Criteria
- All the staff nurses having diploma in general Nursing and midwifery in Services Hospital Lahore.
- All the staff nurses having degree of BSN or Post RN.
- All the staff nurses having minimum experience of 6 month in designated hospital.

Excluding Criteria
- All the mangers will be excluded from this study.
- All the supervisor and head nurses will be excluded from this study.
- All the Staff nurses outside from Services Hospital will be excluded from this study.

Time Framework
This study will approximately take Feb-May 2017.

Ethical consideration
Letter of conducting research will be taken from the ethical committee of the University of Lahore, Lahore School of Nursing to carry out this research.

Enough information of research will be provided to participants with help of full consent and this will be achieved via a consent form attach to the questionnaire. Confidentiality will be considered by informing participants. The right of participants will be protected by Nuremberg Code of Ethics. Consents will be taken from all the participants and free hand will be given to the participants to take part in the study or refuse to participate. Participants will have also be the right to mentioned name or not.

RESULTS
Data was analyzed by using SPSS version 21. Each question mean and standard deviation were calculated. First of all demographic information of the participants are discussed with percentage mean and standard deviation.

Demographics Information
Demographic include gender, age, education, work experience, ever involved in medication error and failed to report medication error are presented in Table 1-6.

Table-1: Demographics Information

Gender	Age	Qualification	Experience	Involved in MAE	Have Failed to Report MAE
Male 4 (1.8%)	Less than 20 12 (5.4%)	Diploma RN 97(43.7%)	Less than 1 Year 35 (*15.8%*)	Yes 30 (13.5%)	YES 29 (13.1%)
Female 218(98.2%)	21 To 30 132 (59.5%)	Post RN 71 (32%)	1 To 3 Years 59 (26.6%)	No 192 (86.5%)	NO 10 (4.5%)
	31 To 40 43 (19.4%)	BSN 54 (24.3%)	More than 3 Years 128 (57.7%)		Not Experienced MAE 183 (82.4%)
	41 To 50 21 (9.5%)				
	Above 50 14 (6.3%)				

Demographics variable are briefly discussed in figure below

Descriptive Analysis Independent Variable

Summed scores were used to calculate means range, median and standard deviation with the purpose of conducting descriptive analysis of all the variable Sample of 222 staff nurses, the values are given in Table 2 below

Table-2: Summary of Descriptive Analysis

Variable	Range	S.D	Mean
Disagreement over definition	3	.76	3.69
Reporting Effort	4	1.14	3.34
Fear	3	.63	3.23
Administrative response	3	.73	3.39

Reliability Assessment

Presents Cronbach's alpha for four scales used in the study. Cronbach alpha is the most commonly used measure of scale reliability [28]. The values which fall above the range of 0.7 are acceptable and the instrument consider is reliable for conduction research.

Table-3: Summary of Reliability analysis

	Cronbach alpha
Disagreement over definition	.81
Reporting Effort	.76
Fear	.81
Administrative response	.72

Table-4: One-Sample T-Test Result

	Test Value = 0					
	t	Df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Disagreement	72.205	221	.000	3.691	3.59	3.79
Reporting	43.392	221	.000	3.342	3.19	3.49
Fear	69.504	221	.000	3.232	3.14	3.32
Admin	68.394	221	.000	3.389	3.29	3.49

One-Sample T-Test

The 1-sample t-test does compare the mean of a single sample. This is evident from this result that the result are significant .000 on 95% confidence interval, the mean difference for each variable is given in the table 4.

Table-5: Chi-Square Tests

	Value	df	. Sig. (2-sided)
Pearson Chi-Square	35.960[a]	4	.000
N of Valid Cases	222		

Chi-Square Tests

Chi-Square tests were conducted to find whether the worked Experience or Qualification of the participants have any effect on reporting medication error table 6 shows the result, it is shown in the result that both variable are combined significant and have an positive affect on the result.

Table-6: Frequency Distribution Table of Participants Response to Research Questions

S.NO	Question Statement	Strongly Disagree F(%f)	Disagree F(%f)	Not Sure F(%f)	Agree F(%f)	Strongly Agree F(%f)
	Disagreement over definition					
01	It is Necessary for Every Hospital to have Proper reporting Medication Administration Error system	9.9% (n=22)	13.1% (n=29)	9.0% (n=20)	15.3% (n=34)	52.7% (n=117)
02	Nurses do not agree with hospital's definition of a medication error	9.0% (n= 22)	13.5% (n= 30)	9.9% (n=22)	8.1% (n= 62)	12.2% (n=88)
03	Nurses do not recognize an error occurred.	41% (n=31)	10.4% (n=23)	13.5% (n=26)	30.6% (n=68)	31.5% (n=70)
04	Medication error is not clearly defined	15.8% (n=35)	10.4% (n=23)	7.2% (n=16)	24.3% (n=56)	42.3% (n=94)
05	Nurses may not think the error is important enough to be reported	9.5% (n=21)	0.7% (n=46)	9.9% (n=22)	20.7% (n=46)	39.2% (n=87)
	Reporting Effort					
06	Filling out an incident report for a medication error takes too much time.	14% (n=31)	20.3% (n=45)	14.4% (n=32)	23% (n=51)	28.4% (n=63)
07	.Contacting the physician about a medication error takes too much time.	21.6% (n=48)	12.2% (n=27)	16.2% (n=36)	9.5% (n=21)	40.5% (n=90
08	The expectation that medications be given exactly as ordered is unrealistic	18.9% (n=42)	13.3% (n=30)	15.5% (n=34)	17.1% (n=38)	35.1% (n=78)
	Fear					
09	Nurses believe that other nurses will think they are incompetent if they make medication errors.	14.4% (n=32)	25.7% (n=57)	18.9% (n=42)	25.7% (n=57)	15.3% (n=34)
10	The patient or family might develop a negative attitude toward the nurse, or may sue the nurse if a medication error is reported..	19.4% (n=43)	14.4% (n=32)	12.6% (n=28)	20.3% (n=46)	33.3% (n=76)
11	Nurses fear adverse consequences from reporting medication errors	12.2% (n=27)	16.7% (n=37)	9.5% (n=21)	31.5% (n=77)	30.2% (n=68)
12	Nurses are afraid the physician will reprimand them for the medication error	19.8% (n=44)	13.1% (n=29)	20.7% (n=46)	27% (n=60)	19.4% (n=43)
13	Nurses could be blamed if something happens to the patient as a result of the medication error.	19.4% (n=43)	24.85% (n=55)	2.3% (n=5)	27.5% (n=61)	26.1% (n=51)
	Administrative Response					
14	The response by nursing administration does not match the severity of the error.	13.5% (n=30)	10.4% (n=23)	14% (n=31)	30.2% (n=67)	32% (n=71)
15	No positive feedback is given for passing medications test correctly.	20.7% (n=46)	18.9% (n=42)	14.9% (n=33)	17.6% (n=39)	27.9% (n=62)
16	Too much emphasis is placed on med errors as a measure of the quality of nursing care provided	12.6% (n=28)	19.4% (n=43)	9.9% (n=22)	18.0% (n=40)	40.1% (n=89)
17	When med errors occur, nursing administration focuses on the individual rather than looking at the systems as a potential cause of the error.	15.3% (n=34)	9.9% (n=22)	20.7% (n=46)	35.6% (n=79)	18.5 (n=41)

DISCUSSION

Medication error is one of the major hazard for the health of patient and can cause very injurious health problem and consequences. The purpose of this study was to find out the main barriers which prevent reporting a medication error.

This study show system which it will the hospital management to prevent further errors and minimize the possible injury to patients, It is revealed from the results of this study shows most of the participants(68%) were agree that hospital should have proper reporting medication error system. The study

conducted by Benjamin, D. M. [3] in the almost same results. That hospital is very important for health care setup to have proper reporting medication error system 74% of his study participants were agree and want that hospitals should have proper medication error reporting system by which they can identify the gap and prevent the patient from further health problems.

The study show that many of the staff nurses were not even able to recognize an error occurred and they didn't take it significantly. This is portrayed from the result of this study that mostly participant (62%) didn't recognize medication error and didn't take it significantly they were thinking that this is a casual phenomenon and didn't need reporting. This result was also supported by Ala'a Z *et al.* [26] is prevailed from his study that 78% of staff nurses in Saudi Arabia were not able to recognize medication error properly and were not take it seriously.

Another barrier that hinder the staff nurses for not report medication error was the reporting effort of staff nurses in this study (51%) participant believed that falling out in incident report about medication error takes too much time so that's why they didn't want to report medication error, it takes a lot of meetings and discussion so to fall in this situation it's better to windup the situation on time and to not report an error. The same result was also prevailed from the study of Chiang, H. Y [19] it is mentioned in his study that the hospital administration takes too much time via solving the medication error incident, multiple time meetings are conducted for the resolving of issue and to prevent further more errors so that's why staff nurses didn't want to report medication error and it play a role as a barrier in reporting medication error.

The main barrier in by which the staff nurses doesn't want to report medication error was a fear from colleagues and administration, 41% of staff nurses were believed on that falling in reporting medication error incident then their colleagues will think that they are incompetent and malpractice. Instead of supporting each other in a work place environment they think that their colleagues will be discouraging them instead of encouraging or solving the problem. The same result was also revealed from the study of Mohammad nejad, E., *et al*. [20], he carried out his study in Iran and stated that 58% of staff nurses perceive that the colleagues will never take their mistake positively and will think that they are incompetent in their work so that's why they didn't want to report medication error.

Patient are in hand of staff nurses in every hospital and the care of the patient and administrating medication is the primary responsibility of the staff nurses, in this study 53% of the respondents think that if they falling in reporting medication error and something

has happened to the patient then the family and management will placed all the responsibility on nurses. That's why it's better to neither report medication error and nor take the responsibility. The same result as also shown in the study of Elnitsky, C [23] is reveled form his study that 61% of staff nurses didn't report medication error because of putting all the responsibility on patient instead of encouraging or guiding the staff nurse.

Another barrier which play a vital role in underreporting of medication error is the response of hospital administration in this study it is revealed from that 53% of staff nurses do not want to report medication error to supervisor or manger because of their negative response. Administration doesn't match to the severity of the case and they blamed the individual throughout his/her job career. The management focuses on the individual rather than putting efforts on the training or guiding nurses. This result of Tabatabaee, S. S., et al. [1] it is revealed from his study that 60% of the respondent didn't report medication error because of the response of hospital administration sometime management fire them or putting strict observation on them so that's why they didn't want to report medication error.

CONCLUSION

To conclude the study it is found that most of the participant are feared and did not believe in administration way of managing the MAE. Reporting effort and disagreement over definition are also considered the barriers of reporting.

Recommendations

- Every hospital should have proper reporting medication administration system
- The hospital administration should didn't blame the individual staff nurse when he/she report an error occurred
- Proper orientation and guidance should be given to the staff nurses prior starting their duties
- Provide safe medication as much as possible
- double check policy should be necessary in every hospital

Limitations

This study was carried out in one hospital and the design was a cross sectional so it couldn't be generalized to all over the country.

REFERENCES
1. Tabatabaee, S. S., Kalhor, R., Nejatzadegan, Z., Kohpeima Jahromi, V., & Sharifi, T. (2014). Barriers to medication error reporting from nurses' perspective: a private hospital survey. *International Journal of Hospital Research*, *3*(2), 97-102.

2. Cousins, D. D., & Heath, W. M. (2008). The National Coordinating Council for Medication Error Reporting and Prevention: promoting patient safety and quality through innovation and leadership. *Joint Commission Journal on Quality and Patient Safety*, *34*(12), 700-702.

3. Benjamin, D. M. (2003). Reducing medication errors and increasing patient safety: case studies in clinical pharmacology. *The Journal of Clinical Pharmacology*, *43*(7), 768-783.

4. Bates, D. W., Cullen, D. J., Laird, N., Petersen, L. A., Small, S. D., Servi, D., ... & Vander Vliet, M. (1995). Incidence of adverse drug events and potential adverse drug events: implications for prevention. *Jama*, *274*(1), 29-34.

5. Keohane, C. A., Bane, A. D., Featherstone, E., Hayes, J., Woolf, S., Hurley, A., ... & Poon, E. G. (2008). Quantifying nursing workflow in medication administration. *Journal of nursing administration*, *38*(1), 19-26.

6. Maricle, K., Whitehead, L., & Rhodes, M. (2007). Examining medication errors in a tertiary hospital. *Journal of nursing care quality*, *22*(1), 20-27.

7. Covell, C. L., & Ritchie, J. A. (2009). Nurses' responses to medication errors: suggestions for the development of organizational strategies to improve reporting. *Journal of Nursing Care Quality*, *24*(4), 287-297.

8. Joolaee, S., Hajibabaee, F., Peyrovi, H., Haghani, H., & Bahrani, N. (2011). The relationship between incidence and report of medication errors and working conditions. *International nursing review*, *58*(1), 37-44.

9. Kaushal, R., Bates, D. W., Landrigan, C., McKenna, K. J., Clapp, M. D., Federico, F., & Goldmann, D. A. (2001). Medication errors and adverse drug events in pediatric inpatients. *Jama*, *285*(16), 2114-2120.

10. McLeod, M. C., Barber, N., & Franklin, B. D. (2013). Methodological variations and their effects on reported medication administration error rates. *BMJ quality & safety*, *22*(4), 278-289.

11. Watts, H., Nasim, M. U., Sweis, R., Sikka, R., & Kulstad, E. (2013). Further characterization of the influence of crowding on medication errors. *Journal of emergencies, trauma, and shock*, *6*(4), 264.

12. Leufer, T., Cleary-Holdforth, J. (2013). Let's do no harm: medication errors in nursing: part 1. *Nurse education in practice*, *13*(3), 213-216.

13. Ajzen, I. (1988). *Attitudes, personality, and behavior*. Chicago, IL: Dorsey Press.

14. Godin, G., Belanger-Gravel, A., Eccles, M., & Grimshaw, J. (2008). Healthcare professionals' intentions and behaviours: a systematic review of studies based on social cognitive theories. *Implementation Science, 3,* 36.

15. Cote, F., Gagnon, J., Houme, P.K., Abdeljelil, A.B., & Gagnon, M.P. (2012). Using the theory of planned behavior to predict nurses' intention to integrate research evidence into clinical decision-making. *Journal of Advanced Nursing, 68*(10), 2289-2298.

16. Tang, P. C., Ash, J. S., Bates, D. W., Overhage, J. M., & Sands, D. Z. (2006). Personal health records: definitions, benefits, and strategies for overcoming barriers to adoption. *Journal of the American Medical Informatics Association*, *13*(2), 121-126.

17. Henderson, V. (2013). The Nature of Nursing a Definition and its Implications for Practice, Research, and Education.

18. Wakefield, D. S., Wakefield, B. J., Uden-Holman, T., Borders, T., Blegen, M., & Vaughn, T. (1999). Understanding why medication administration errors may not be reported. *American Journal of Medical Quality*, *14*(2), 81-88.

19. Chiang, H. Y. and G. A. Pepper (2015). "Barriers to nurses' reporting of medication administration errors in Taiwan." Journal of nursing scholarship 38(4): 392-399.

20. Mohammadnejad, E., Ehsani, K. K. S. R., Salari, A., Sajjadi, A., & Hajiesmaeelpour, A. (2013). Refusal in reporting medication errors from the perspective of nurses in emergency ward.

21. Almutary, H. H., & Lewis, P. A. (2012). Nurses' willingness to report medication administration errors in Saudi Arabia. *Quality Management in Healthcare*, *21*(3), 119-126.

22. Unver, V., Tastan, S., Akbayrak, N. (2012). Medication errors: Perspectives of newly graduated and experiences nurses. *International Journal of Nursing Practice, 18,* 317-324.

23. Elnitsky, C., Nichols, B., & Palmer, K. (2009). Are hospital incidents being reported? Journal of Nursing Administration, 27(11), 40-46.

24. Schmidt, C. E., & Bottoni, T. (2011). Improving medication safety and patient care in the emergency department. *Journal of Emergency Nursing*, *29*(1), 12-16.

25. Kim, J., An, K., Kim, M. K., & Yoon, S. H. (2007). Nurses' perception of error reporting and patient safety culture in Korea. *Western journal of nursing research*, *29*(7), 827-844.

26. Ala'a, Z., Aljasser, I. A., & Sasidhar, B. (2016). Barriers to Reporting Medication Administration Errors among Nurses in an Accredited Hospital in Saudi Arabia.

27. Slovin, M. B., Sushka, M. E., & Lai, K. W. (2000). Alternative flotation methods, adverse selection, and ownership structure: evidence from seasoned equity issuance in the UK. *Journal of financial economics*, *57*(2), 157-190.

28. Cortina, J. M. (1993). What is coefficient alpha? An examination of theory and applications. *Journal of applied psychology*, *78*(1), 98.

29. Rentero, L., Iniesta, C., Urbieta, E., Madrigal, M., & Pérez, M. D. (2013). Causes and factors associated with reconciliation errors in medical and surgical services. *Farmacia hospitalaria: organo oficial de expresion cientifica de la Sociedad Espanola de Farmacia Hospitalaria*, *38*(5), 398-404.

30. Institute of Medicine. (IOM) (2006). *Preventing medication errors: Quality chasm series,* pp. 105-142. Washington, DC: National Academy Press.