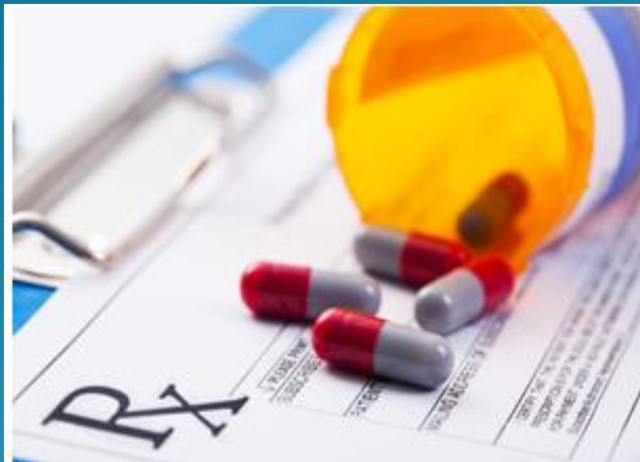
Health
Illawarra Shoalhaven Local Health District
NSW GOVERNMENT

Everybody's Busyness: Promoting Medication Safety-



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Medication Error

A medication error is defined as a **preventable event** that occurs at any stage of the **medication management cycle** resulting in an inappropriate use of medication and which may lead to significant **patient harm**(Hughes & Edgerton 2005)

Background/ Context

- Medications errors are one of the main causes of patient harm in the hospitals
  - Patient-no harm to severe injury or death
  - Healthcare worker-stress, guilt or self-doubt
  - Organization- status
- Acute surgical ward
  - A total 117 medication errors are reported during Jan 2016-June 2018
  - **More than half** of the medication errors were **administration errors**

AIMS/ OBJECTIVES

- To **reduce** the number of medication incidents on acute surgical ward.
- To **increase** the staff awareness of:
  - Medication safety
  - Compliance with medication policy
  - Reporting errors
  - Identify areas for improvement
  - Develop, implement and evaluate the change to improve safety

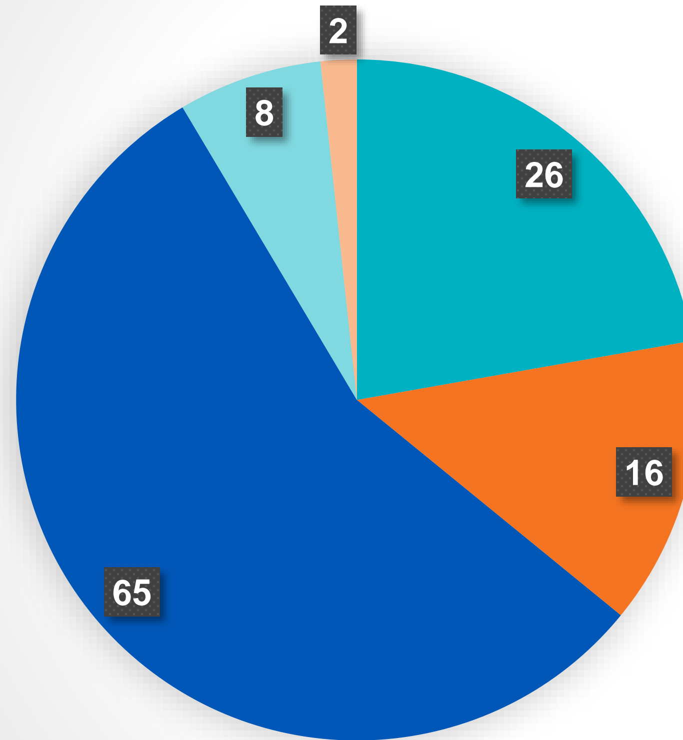
Data Collection and Analysis

- Incident Management System Data (IMS+)
- Safety Attitude Questionnaire Survey Result
- Focus group

Baseline Data-Medication Errors By Type

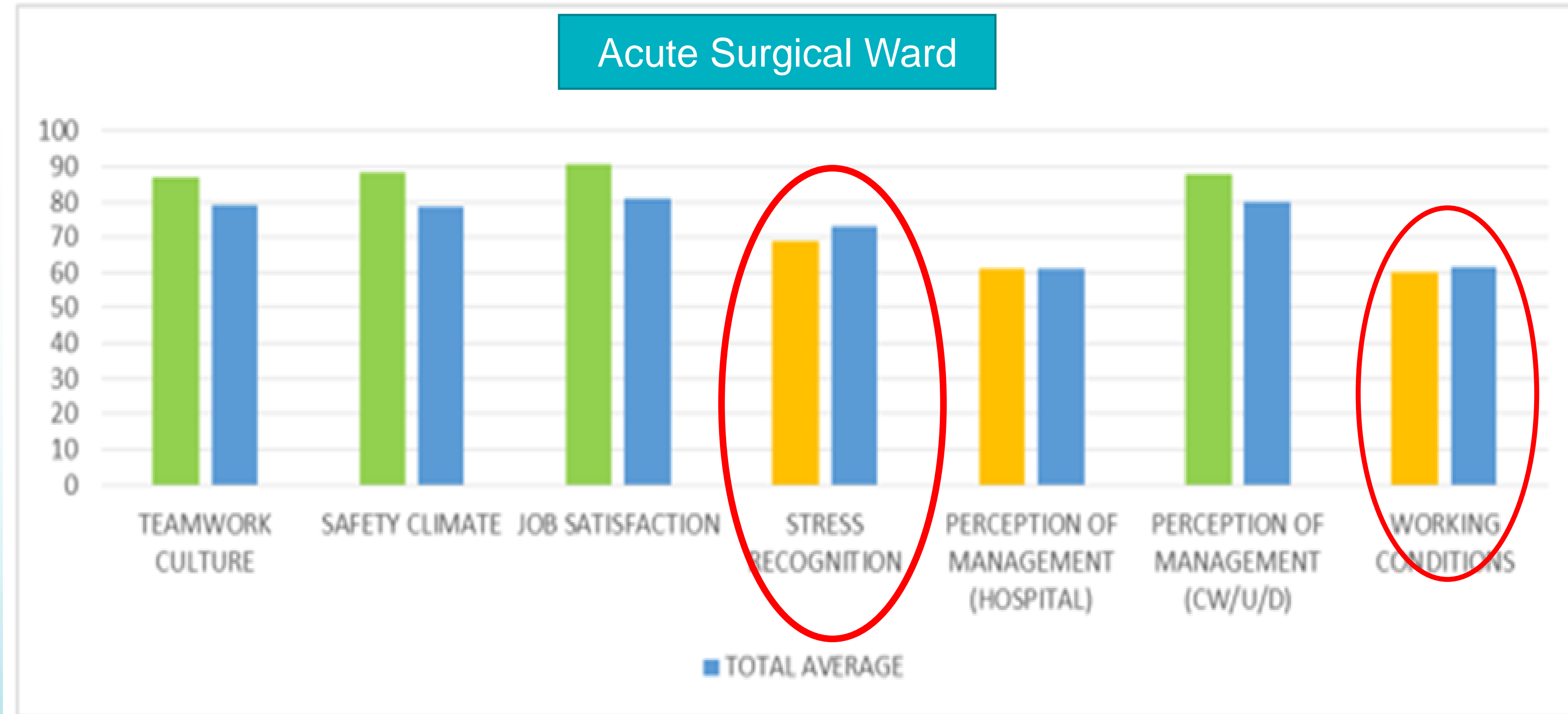
IMS+ Data from Jan 2016-June 2018

Acute Surgical Ward



- Prescribing-22%
- Dispensing-14%
- Administration-55%
- Other- 7%
- Delivery-2%

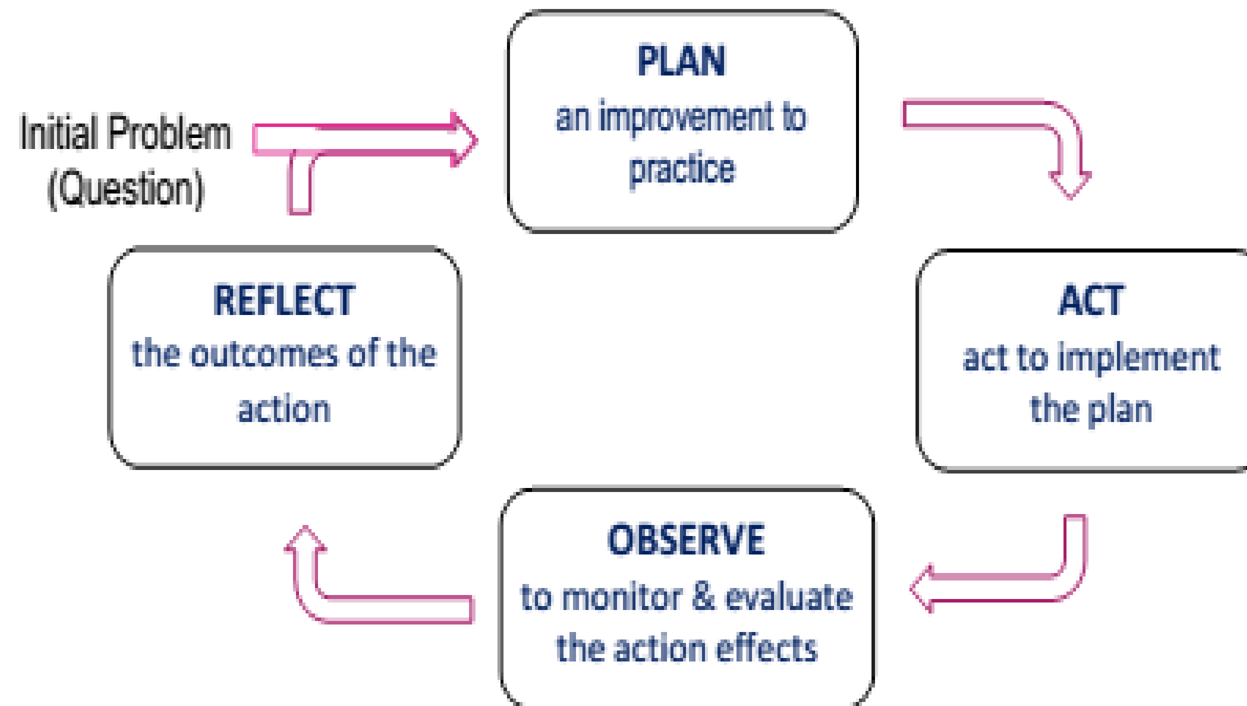
Baseline Data-Safety Attitude Questionnaire Survey 2017



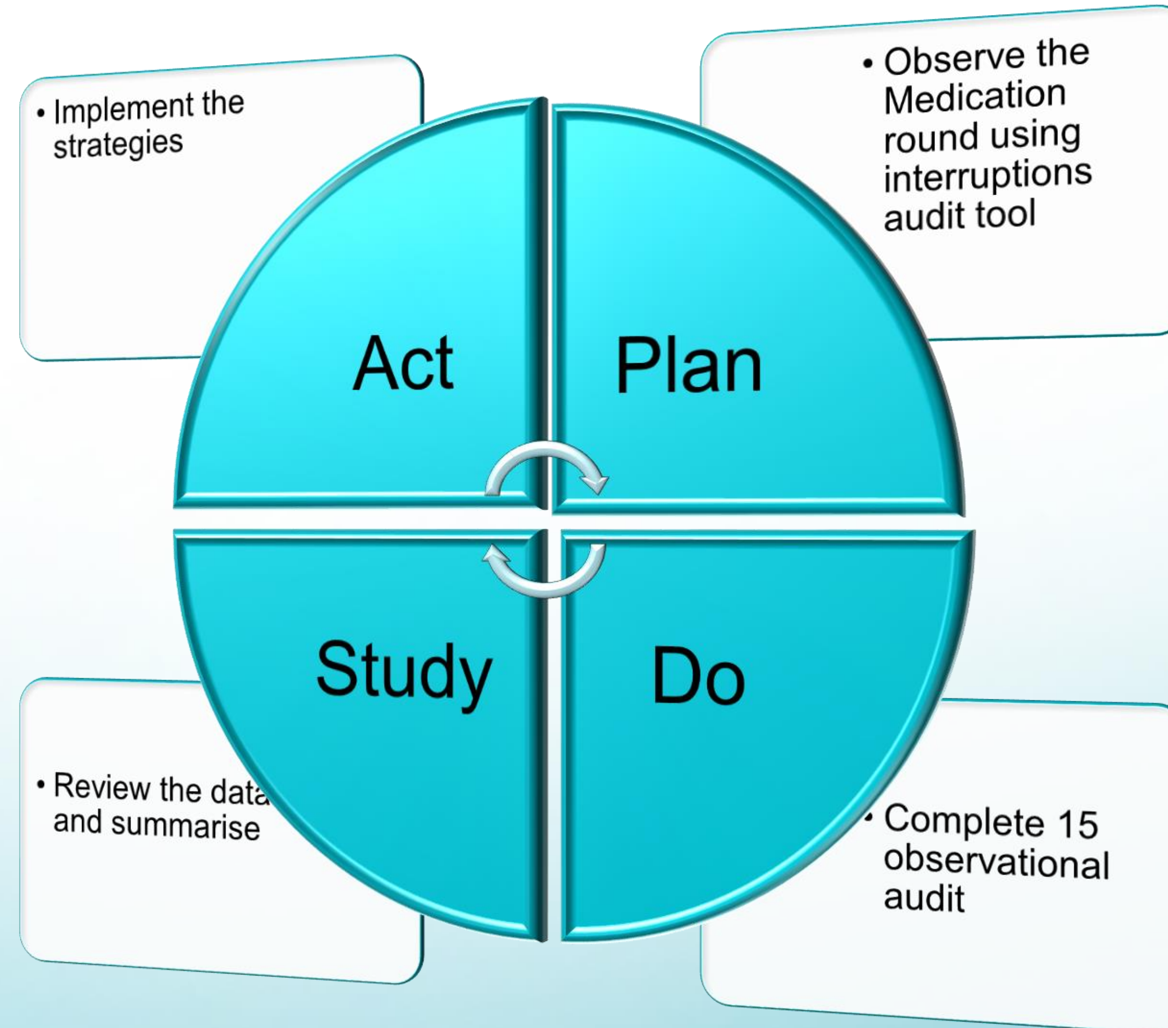
Focus Group Themes

Resources	Barriers	Practice Issues	Education	Prescribing Issues
Sharing the medication Trolley	**Distractions and interruptions**	Not following independent checking	New or unfamiliar drugs	Unclear prescription
No hardcopy of medication manual	Time constraints/ Rushing	Not complying with 5 rights of medication administration		Wrong prescription
Lack of full time pharmacist	Workload	Not clarifying/questioning unfamiliar/new drug doses		
	Stress			
	Lack of stock in the trolley			
	Staff shortage			

Action Research Process



PDSA Cycle



Interruptions /Distractions –Audit Tool

Audit Instructions

- One audit consists of four patient's medication round
- Entire process from dispensing to administration
- Interruptions include:-
  - -Any conversations unrelated to medication
  - -Independent second check for other staff
  - -Getting medication from cupboard

Exclusion

- Patient education or clarification on medication
- Activity between medication round

Date: Time: Location:

Interruptions	Tally
Patients/ Visitors	
Doctors/ AH	
Nurses	
Student Nurses	
Clerical staff/ Domestic	
Phone	
No Stock/ Resources	
Self	

Interruptions Audit Result- Oct 2018

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Acute Surgical Ward

Interruptions by Type	Number of Interruptions
Phone	1
Clerical/Domestic	6
Patient/ Visitors	11
Students	9
Doctors/ AH	18
No Stock/Resources	35
Self	11
Nurses	52

Possible Solutions -From Focus Group

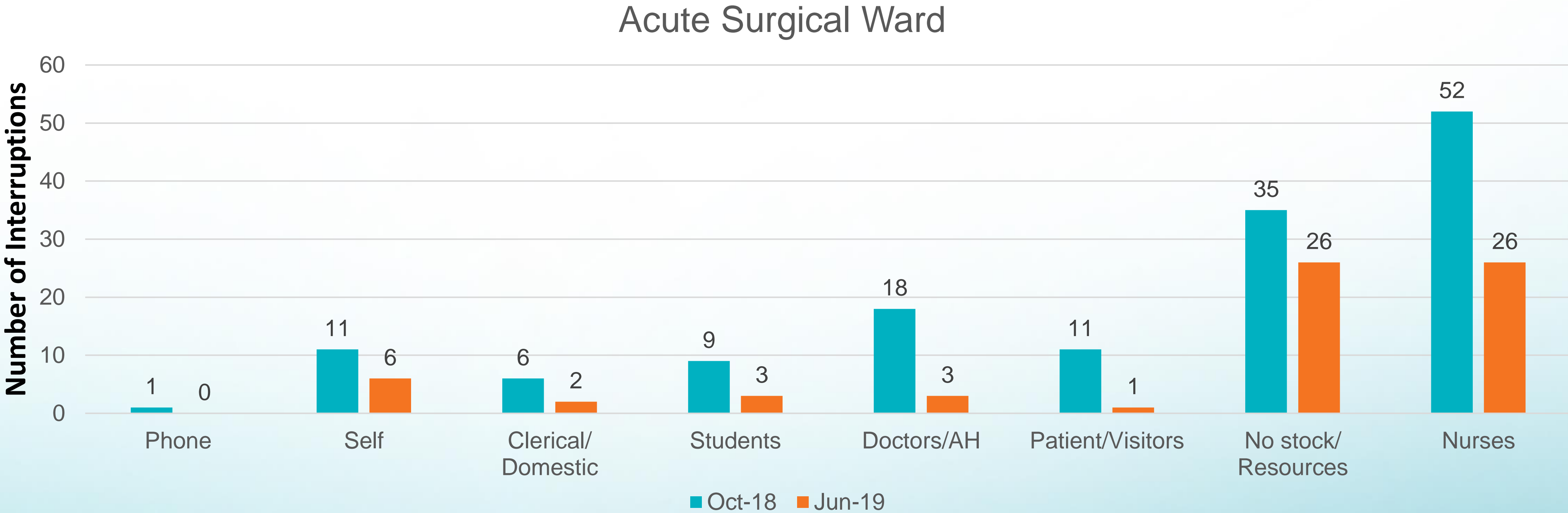
Resources	Barriers	Practice Issues	Education	Prescribing Issues
One Nurse to do the medication round in one section at one time	Restock the medication trolley	Take chart and trolley to bedside	Arrange education as per needs	eMeds
Hardcopy of medication manual	Adequate staffing	Follow 5 rights of medication administration		
Full time pharmacist		Awareness of physical and mental wellbeing		
Do not disturb sign on the trolley		Follow independent second check policy		
		Familiarise self with medication		
		Mindfulness when checking- 24/7		

Project Action Plan- Commenced from Nov 2018

- One Nurse to perform medication round at a time in each allocated section
- Nurses to perform patient rounding before the commencement of medication round
- Insulin administration prior to the medication round
- Restock the medication trolley
- Hardcopy of Medication manual – Introduction of eMED and eMR
- Full time pharmacist for the ward

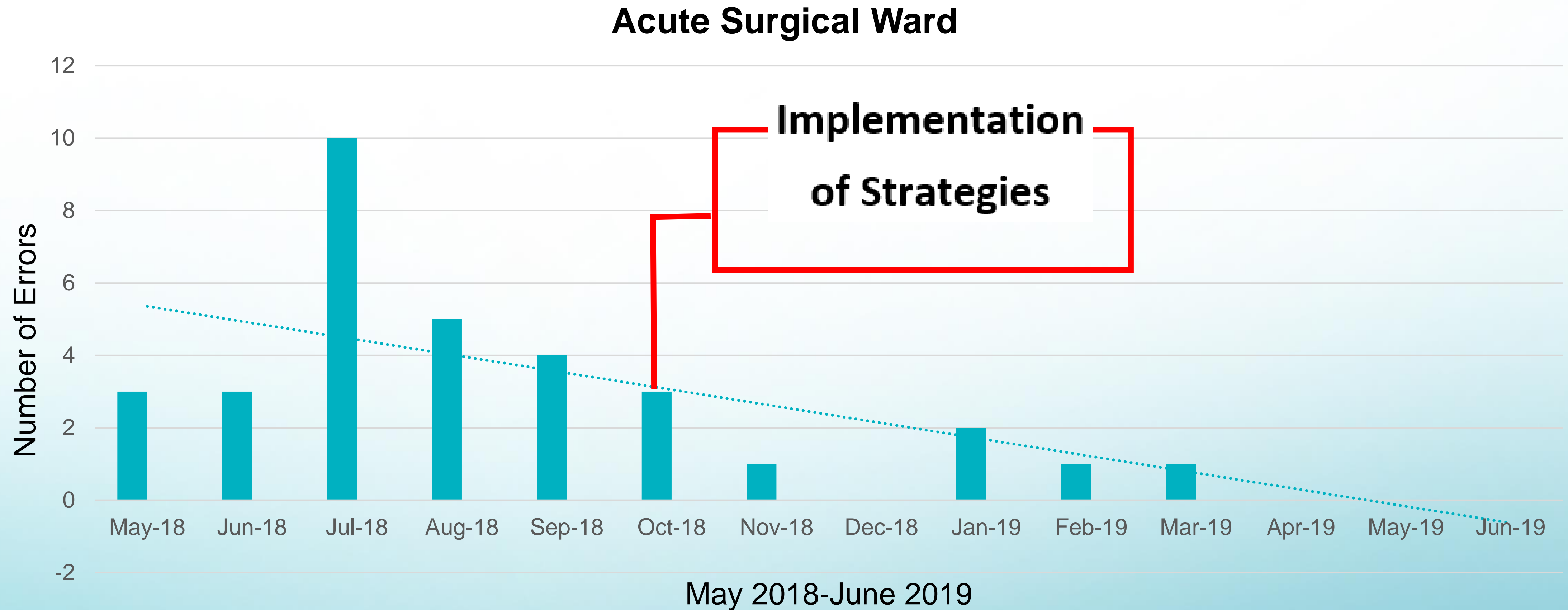
Outcomes:- Interruptions and Distraction Audit

Pre and Post Intervention-Nov 2018 and Jun 2019



Outcomes:-Number of Medication Administration Errors

Comparison of Data:- Pre and Post project



Outcomes

- 43% reduction in interruptions and distractions during the medication round
- 28% decrease in medication administration errors
- Improvement in staff awareness of medication safety
- Strategies are transferable to other clinical areas

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