MEDICATION SAFETY: A MEDICATION ERROR REDUCTION PROGRAM

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Background and Significance: Patient health, safety, and satisfaction are directly influenced by the timely and safe delivery of medications. Medication administration is a complex process impacted by fatigue, communication, and human factors which can contribute to medication errors. Standardization of the medication administration process can be an effective method to mitigate these factors and reduce medication errors.

Purpose: Examine the current medication administration process to identify non-value added activities and practice variances, and then standardize the medication administration process. The goal was to reduce medication errors to 1% or less for all medications given (per 10,000 doses), reflecting best practice.

Framework: The Veterans Administration Team Aim Map Measure Change Sustain (VA TAMMCS) model guided this project.

Population/Setting: Spinal Cord Injury Unit within an academic Midwest Federal medical center.

Method/Approach: Baseline for the current medication administration process was obtained by observing the delivery process using a standardized tool. Variances in the medication administration process and non-value added activities were identified. Primary factors contributing to medication errors on the unit included lack of a standardized medication process, new patient care unit, and new nursing model. Actionable steps were identified to improve the medication administration process. A standardized medication administration process was developed, piloted, studied, and implemented on the unit with a monthly score card to reflect control measures. Staff were re-educated on the elements of safe medication administration. Medication errors were tracked using the monthly score card.

Results/Outcomes: This project resulted in the development of a standardized medication administration process that was efficient and effective. The process used the acronym SAFE MED PASS and was included in staff education and reminders were placed on all medication carts. The standardized process reduced administration time by 5.5 minutes and had 5 fewer steps. Medication errors were reduced from 5.15% /10,000 doses (October 2012) to 0.38%/10,000 doses (September 2013).

Conclusions/Implications: A new patient care unit and nursing model contributed to increased medication errors. It is imperative that medication administration processes be evaluated to identify factors that impede safe medication delivery. Standardizing medication administration processes can work to reduce factors that contribute to medication errors and improve safe medication practices. Quarterly medication pass audits and error tracking is imperative to avoid practice drift and sustain improvement.