METAS Adventist Hospital, Southern Asia Division

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Quality Improvement Project on Improved Medication Safety for Patients

INTRODUCTION

Medication error is a harmful event that may occur in different stages of patient treatment process & it is a common cause of adverse healthcare incidents that impact on quality of care. Medication errors may account up to one-third of all errors in hospital dealing with. Further efforts in METAS Adventist hospital are currently taking place in this challenging aspect of patient care to provide more strategies for medication error detection, analysis, and prevention.

AIM

Patient safety must be the first aim in every setting, in order to build safer systems, learning from errors & reducing the human & fiscal costs

PROCESS FLOW –PAST STATE

MATERIALS

- Medication stock not checked
- Labels not clear
- Incorrect reconciliation form
- Nurse didn't verify medication history
- Wrong medication entry
- No drug list display

PROCESS

- Double/triple check not performed by Nurse
- Not following checklists
- No patient education
- Delay in drug administration
- Delay transportation of medicine

Medication Harm

PEOPLE

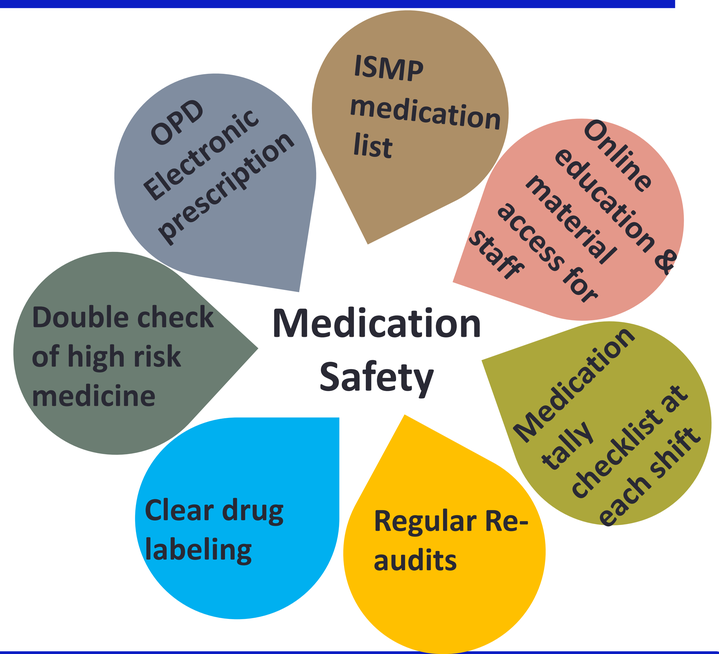
- Poor communication
- Staff work load & fatigue
- Lack of supervision
- Inadequate trainings
- No regular audits
- Increase number of medicine per patient

MACHINE

- Frequent interruption
- Look alike & Sound alike medications not followed

* Formulary restrictions on use of certain medicines
*Different medication in different concentration

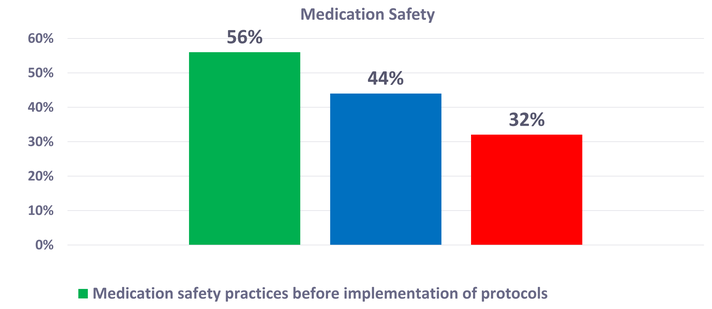
CURRENT STATE



HIGHLIGHTS/ACTIVITIES

- METAS Adventist Hospital implemented following key measures to Increase the accuracy of patient medication safety without harm :
- Implemented Medication reconciliation form at each transition point of care
- Established a "Quiet zone" or Time out when preparing medications for administration
- Provided nursing staff understand generic medication names and formulations.
- Reduced costs associated with an increased length of stay or readmission to hospital, due to medication errors.
- Safety check at start & end of shift
- Improved communication practices & patient engagement
- Provided patient education to take pledge on 5 moments for medication safety
- Implemented Medication added stickers & Look alike & Sound alike labels for high risk medicines
- Appropriate prescription & risk assessment on medication safety
- Involvement of Clinical Pharmacists

GRAPHICAL PRESENTATION BEFORE PROTOCOLS



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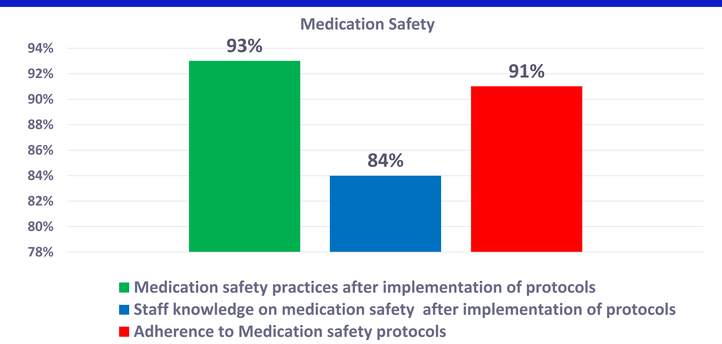
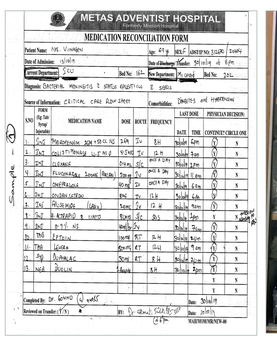
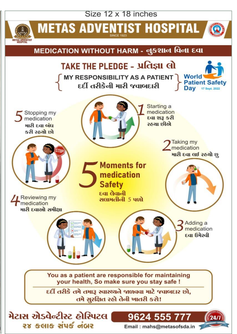


RESULTS

Rate of Medication harm increased when protocols are not adhered. Whereas, after improvement in performance of healthcare staff ,medication errors are decreased & improved Medication safety for patients





FUTURE GOALS

- To ensure Medication safety without harm
- Continue to evaluate the patient for side effects/adverse effects as well as therapeutic medications