Safety Improvement Initiative – *Medications*

Aim

Gifford Medical Center is working hard to eliminate medication errors that may cause harm or increase the length of stay for patients.

Time frame

This initiative began on July 16, 2007, and continues.

Description

The multidisciplinary Medication Safety Team was formed to improve medication safety. Using Lean efficiency tools and improvement methodologies, the team divided the project into two phases. Phase one determined what the issues were and developed an implementation plan to address the issues. Phase two was charged with implementing the changes.

Description of the problem

Nationally, medication errors make headlines and are a concern for all hospitals. A July 2006 report from the Institute of Medicine found that there are 400,000 preventable medication errors in hospitals each year. Medication errors add to the morbidity, mortality and cost in health care. Confusing medication delivery systems, reduced length of stay for patients, complex care needs, staff turnaround and much more contribute to medication errors. At Gifford, there is a strong desire to improve standards of operation and a culture committed to reporting errors. These elements are essential for improving health-care systems.

Project goals with appropriate measures

1. Reduce preventable medication errors to less than 1 percent of doses administered
2. Reduce medication errors that require treatment, intervention or increase length of stay to zero
3. Reduce transcription errors to less than 5 percent of total medication errors

Description of the intervention(s)

1. Daily multidisciplinary intake rounds with the hospitalist, a pharmacist, the charge nurse, quality improvement specialist, nutritionist, physical therapist, occupational therapist and case manager were implemented. Under this new system, providers write patient orders during the rounds while discussing patient care goals with the group.
2. A color-coded chart or flag system was implemented to alert nurses when new orders were written on their patients.
3. A "Tell the Charge Nurse" Campaign was instituted with buttons and fliers, encouraging staff to minimize distractions and confusion in the nurses' station by filtering all patient care needs directly to the charge nurse.
4. Monthly detailed reviews of medication errors by Medication Safety Team were also implemented.

5. A registered nurse house supervisor role, separate from the evening charge nurse role, was identified as essential for the evening shift and this new position was added.

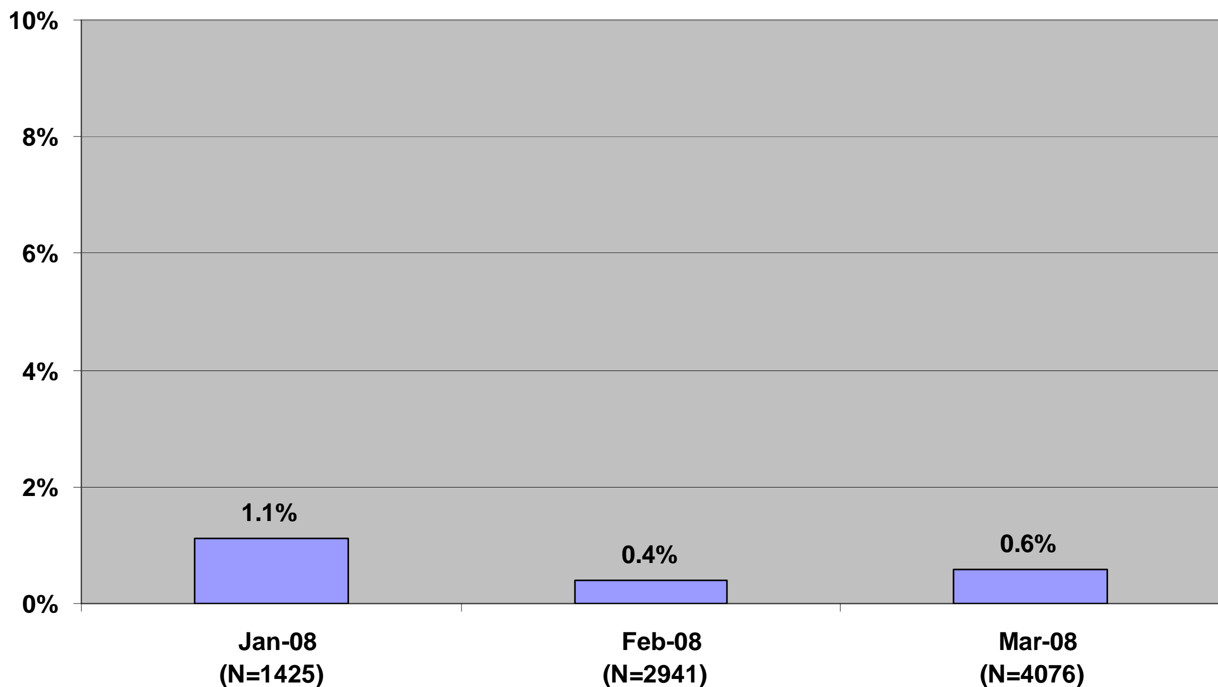
Evaluation process and results

Implementation of the project goals began in early 2008, so it is preliminary to quantify whether the interventions have contributed measurably to fewer medication errors.

Gifford does know that:

1. Writing orders during rounds has lead to more timely orders, clarity of each order, improved communication about order changes and timelier implementation of medication changes.
2. Nurses were surveyed on the effectiveness of the color-coded chart system. Consensus being that it has improved patient care by more timely notification of medication changes to the nurse caring for the patient.
3. The "Tell the Charge Nurse" Campaign has reasserted the role of the charge nurse as the conduit for patient care needs to the hospitalist. This has reduced people, activity and noise in the nurses' station by improving communication and decreasing distractions.

Graph: Medication Errors Per Total Medication Orders*



*Medication orders are not reflective of the doses administered, but the totality of orders entered into the system by pharmacy. Each medication "order" generally represents multiple doses during the hospital stay. "N" is the number of patients seen. Please note the rise in patient numbers in March.

Contact

Quality Management Department
Gifford Medical Center
P.O. Box 2000
Randolph, VT 05060
Phone: (802) 728-2329

Fax: (802) 728-2613
E-mail: QualityDepartment@giffordmed.org