



Service Priorities and Programmes
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Incident report 1-year review to minimize medication administration error event

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Introduction

Medication error can occur at any phase of the complex medication process including prescription, transcribing, dispensing, and administration. In-depth analysis of these incidents in the recent years, prescription error often places at the top risk followed by administration and dispensing error. Administration error is the one highly related to the nurses who are subject to a range of practices and procedures, which are dictated through legal, management and medical requirements to ensure safe medication administration (Gibson 2001). The Swiss Cheese Model indicates no matter how measures are implemented medication administration error event still exists due to various contributory factors.

Objectives

The primary objective was to categorize the contributory factors into the five-rights of administration principles as well as other possible principles according to the report of administration incidents of medication in United Christian Hospital (UCH). The secondary outcome was to identify possible measures to minimize medication administration error event by the comparison the difference among the local policy, guideline, measures, and the international measures suggested in literature based on the contributory factors categorized.

Methodology

The administration errors reports occurred between September 2011 and September 2012 were reviewed according to the Quality and Safety (Q&S) website of UCH. The contributory factors were then identified and categorized into the six (five-rights and others) principles. The current guidelines, policy, and practices to prevent the administration errors identified in the previous step were searched through UCH homepage to see if the gap exists. Afterwards, the international measures suggested in literature were identified all studies relevant to the review between 2008 and 2012 through searching in e-Knowledge Gateway (eKG) according to the administration errors identified.

Result

41 administration error events and total twenty contributory factors were identified.

The incident associated with “lack of checking allergy” accounted for 47.8 per cent (11/23) of cases in “known drug allergy” and also accounts for the commonest factor. The incident associated with “knowledge deficits” of “right drug” accounts for 26.1 per cent (6/23) of “known drug allergy”, 3.6 per cent (1/28) of “dangerous drugs”, and 5.3 per cent (1/19) of “others”. None of incident is associated with “right route” of administration error in this review. A variety of local measures have been implemented to address on the above factors. These factors are most likely associated with human factors that nurses do not comply with the principles during medication administration. Interruption and hustle are believed in highly associated with administration errors indirectly and it can lead to raise the internal factors including “knowledge deficits”, “without spelling of medication”, “lack of independent double-checking on medication” and “lack of checking allergy” in the process of administration (Joanna Briggs Institute 2010). Overhead announcement and signage of “DO NOT DISTURB” were suggested to minimize distraction. Education involving more practical and realistic methods can improve individual knowledge and skills and personal responsibilities in medication administration practice. Two suggested measures from literature have been reported in order to address the problems: checking and knowledge deficits. The medication administration errors events should be minimized with different preventive measures. We hope to address the measures that can help improve the internal and external practices and behavior through the education reinforcing programmes and preventive interventions of distraction or interruption respectively. Further studies to evaluate the efficacy of these measures are imperative to be explored in future.