Eliminating Administration Errors of High Alert Medications

Tan Sock Ling Yvonne, Singapore General Hospital
Ng Xin Hui, Singapore General Hospital
Habibah Binte Abdul Rahim, Singapore General Hospital
Xue Zhixia, Singapore General Hospital
Huang Hongjuan, Singapore General Hospital

1. Background of the problem

High Alert Medications (chemotherapy and/or electrolyte replacements) are frequently administered alongside antibiotics and hydration drips. With multiple infusion lines ongoing at the same time, errors may happen due to confusion and can be detrimental in patient safety.

2. Mission Statement

To eliminate administration errors of high alert medications (chemotherapy and/or concentrated electrolytes) in W48, W66 and W72 within 3 months.

Patients on continuous pumps, narcotic infusions or enrolled in OPAT are excluded.

3. Analysis of problem

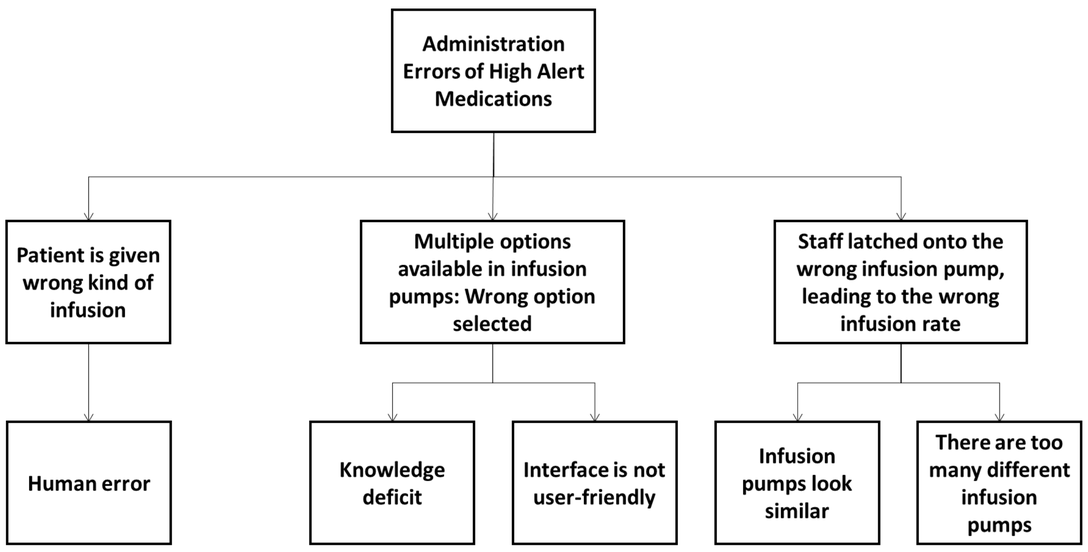

Figure 1: 5-Whys Diagram

The proposed intervention will address the 3rd root cause where there are too many infusion pumps and drip lines, leading to confusion and administration errors.

4. Interventions / Initiatives

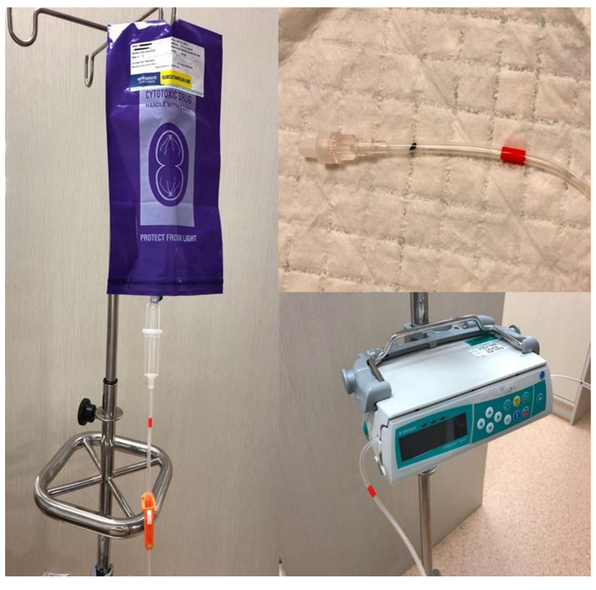

Figure 2: Infusion tubing

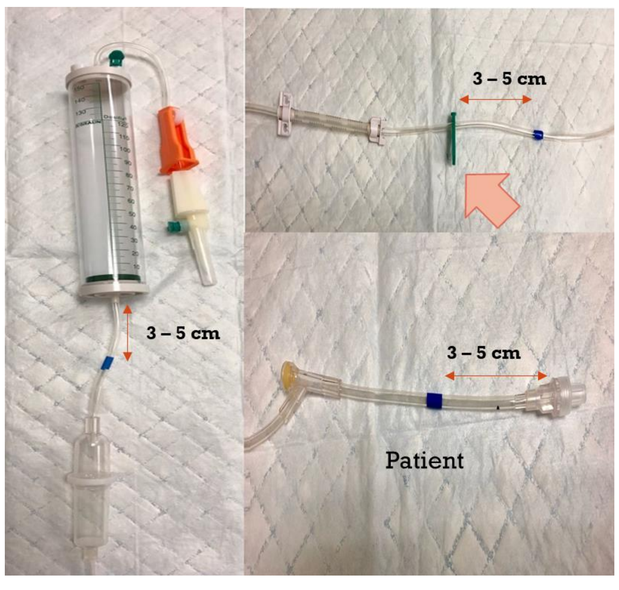

Figure 3: Infusion burette

Colored sticky tapes are used to label and identify multiple infusion lines, as shown in Figure 2 & 3. Sticky tapes are placed on visible spots along the track so as to allow easy visualization of infusion lines.

There is no standardization of colors to prevent staff from making assumptions of the type of infusion.

5. Results

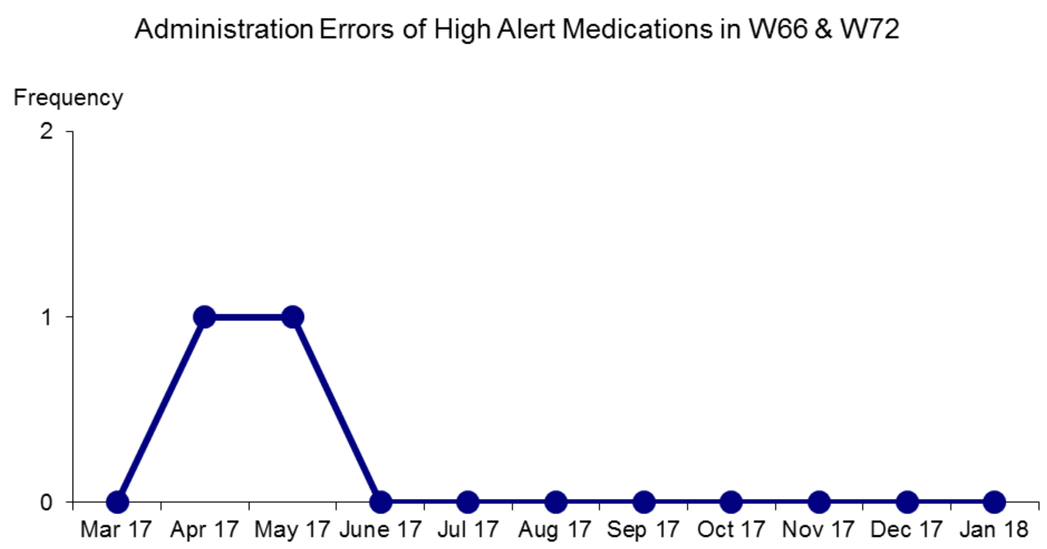

Figure 4: Run Chart illustrating improvement in administration error rate

Since the initiation of the intervention in Dec 2017, there were no reported errors from then on.

6. Sustainability Plans

Random audits will be performed by the team in the following wards to ensure compliance and proper labeling of sticky tapes according to Figure 2 & 3 so as to maintain consistency. New/transferred-in staff nurses will be briefed on the intervention so that they will be informed of this project.