Prevention of Medication Error in Operating Theatre (OT)

Singapore Healthcare Management 2017

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SingHealth

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Introduction

A Medication Error is a failure in the treatment process that leads to, or has the potential to lead to harm to patients. Administrate drugs to patient who is allergy through intravascular (IV) may cause serious anaphylactic shock and danger to patient's life.

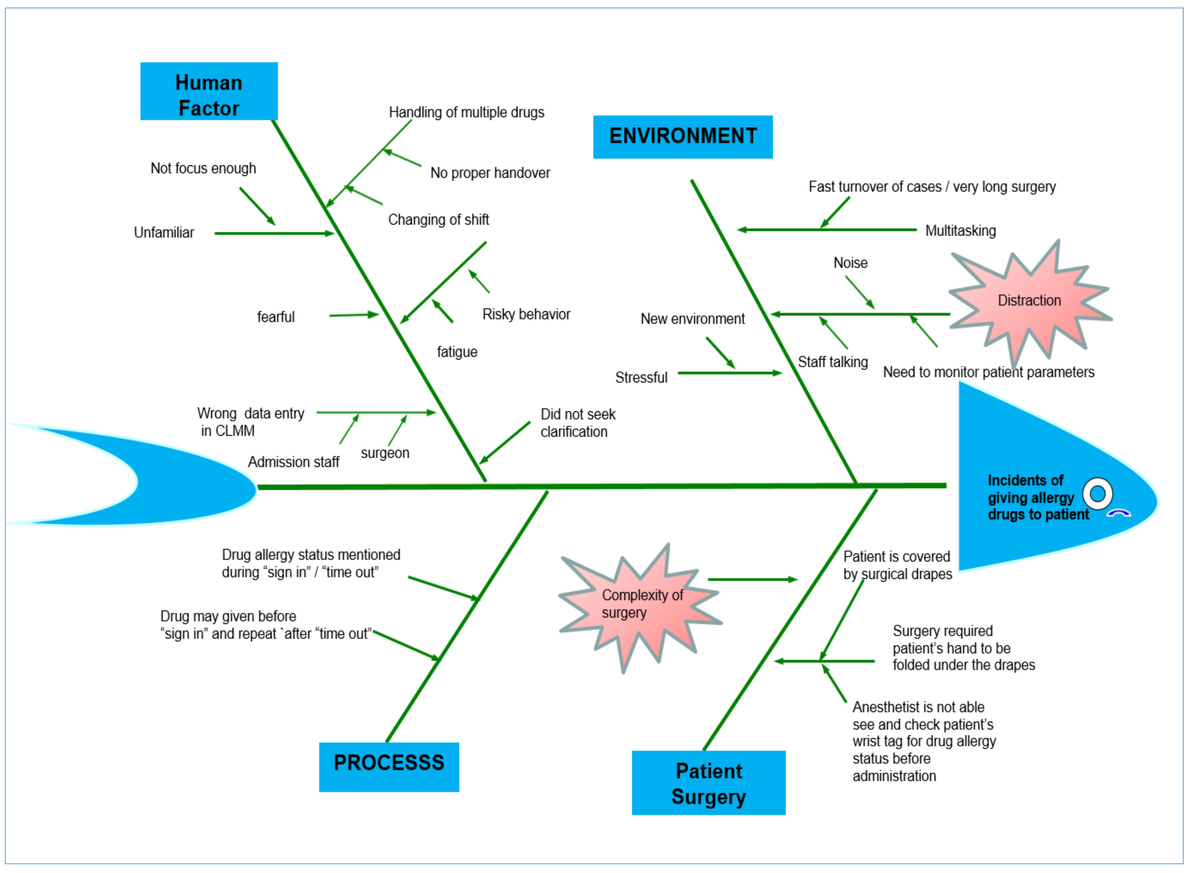
Background

In 2015, there were two incidents of **Medication Errors** in the Operating Theatre (OT) whereby patient was given drugs which she was allergic to. Although there were no serious harm to patients, but these are preventable errors that could be avoided.

Objective

The aim of this project is to identify the root cause for the error and relook into the processes to prevent such errors from occurring. Intervention was implement to achieve Zero Error within the year.

Root Cause Analysis



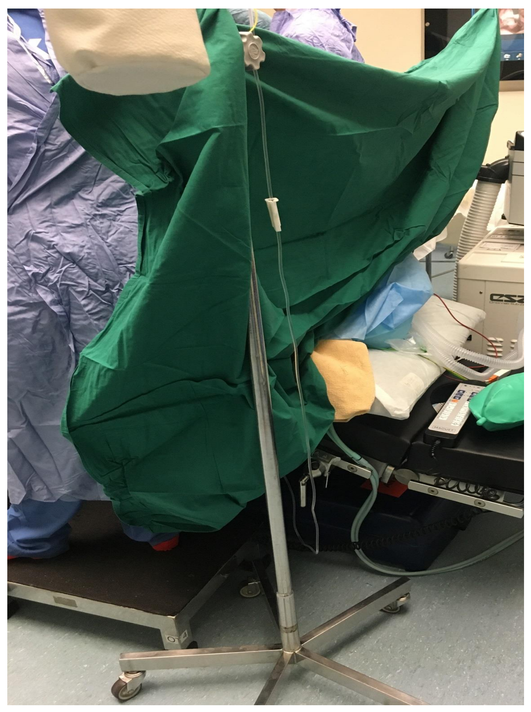
A root cause analysis was conducted to identify the possible factors contributing to such medication errors and to develop interventions to prevent them. The two main contributing factors are distraction and complex of the surgery.

Intervention

Upon identification of the cause, severe suggestions were made including hanging of visual reminder card on IV drip stand, providing red surgical cap for patients who have drug allergy, etc. However these were found not ideal.

Decision was made to paste an allergy red sticker near to the IV injection port to serve as last visual alert, allowing a pause to Anaesthetist before administrating of IV drugs to patient.

Pre implementation



Pre implementation picture on the left is a common screen in the operating theatre with patient under the surgical drapes intra-operatively. It is almost impossible for the anaesthetist to check patient's wrist tag before administration of drugs to ensure patient has no allergy.

The anaesthetist may not remember accurately on every patient's allergy status especially during emergency / long surgery / when the operating list is long.

Post implementation

The red allergy sticker placed near the IV injection port serves as last visual alert, allowing a pause to anaesthetist to confirm the allergy status before administrating of IV drugs to patient.

Result

There were **ZERO** incident after the implementation.

Conclusion

Pasting a drug allergy sticker near the IV injection port is a simple yet effective way to prevent medication error in the operating theatre setting.