Reducing Medication Errors Related to Patient Consuming Own Medications

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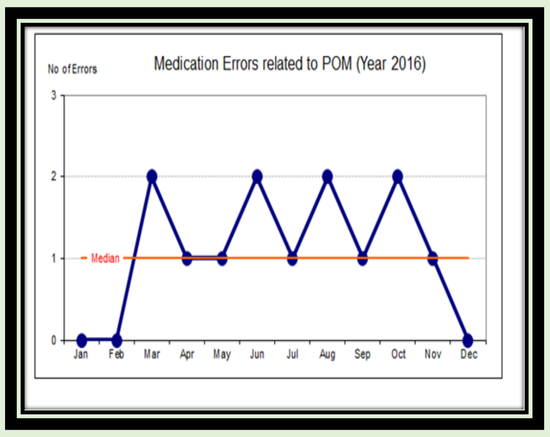
Background

Medication administration is a complex multistep process that errors can happen at any step. Based on the Risk Management System (RMS), there is a rise in medication errors when patient consumed their own medicine (POM) brought from home without the nurses' knowledge. There were incidences where patients consume their own supply of medication without informing nurses. This leads to double dosing of the same medication or a medication that has been discontinued but consumed by the patient.

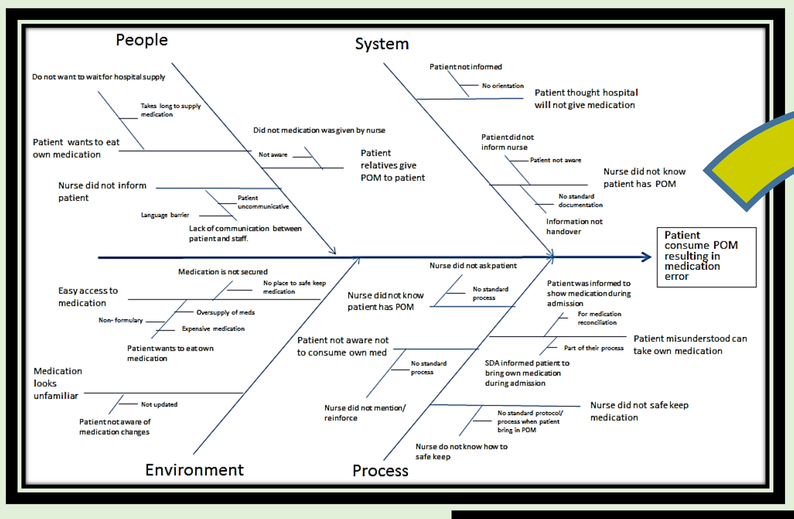


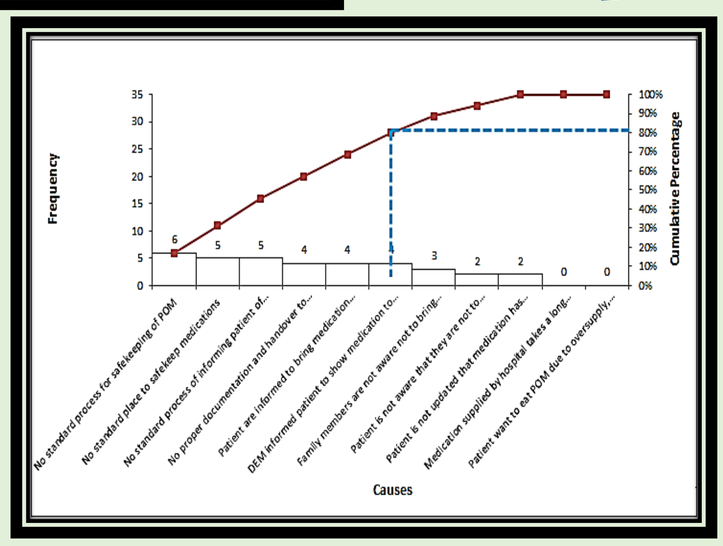
Mission Statement

To eliminate medication events related to patients consuming own medications

Project Analysis

Possible root causes were identified from the cause and effect diagram. The team verify all these possible root causes with data from incident reporting when a medication error happened and feedback from the nurses

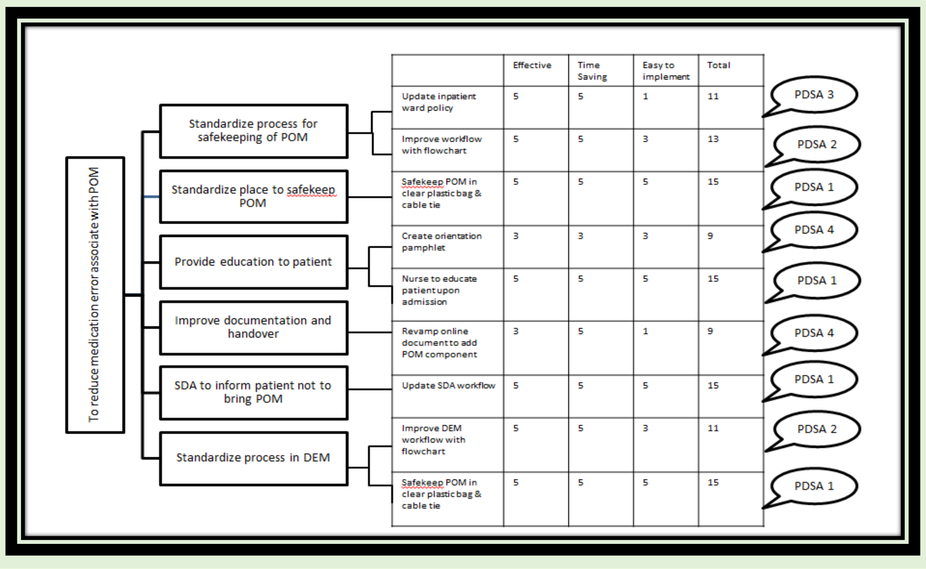




From the Pareto chart, final root causes were identified:

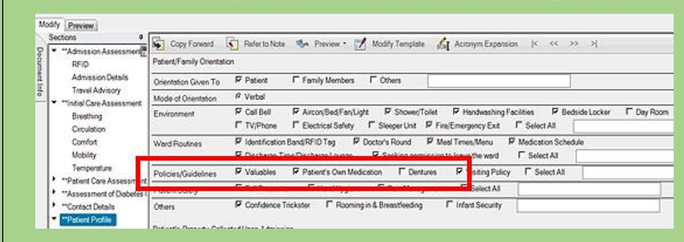
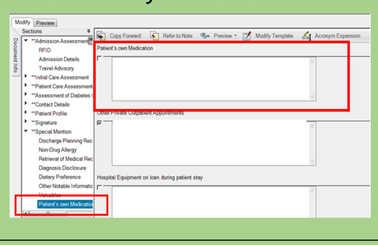
- No standard process for safekeeping of POM
- No standard place to safe-keep medications
- No standard process of informing patient of POM
- No proper documentation and handover to nurses if patient has POM
- Patient are informed to bring medication from nurses in SDA
- DEM informed patient to show medication to doctors

Tree Diagram and Prioritization Matrix were used. All the solutions were implemented sequentially to the ranking.

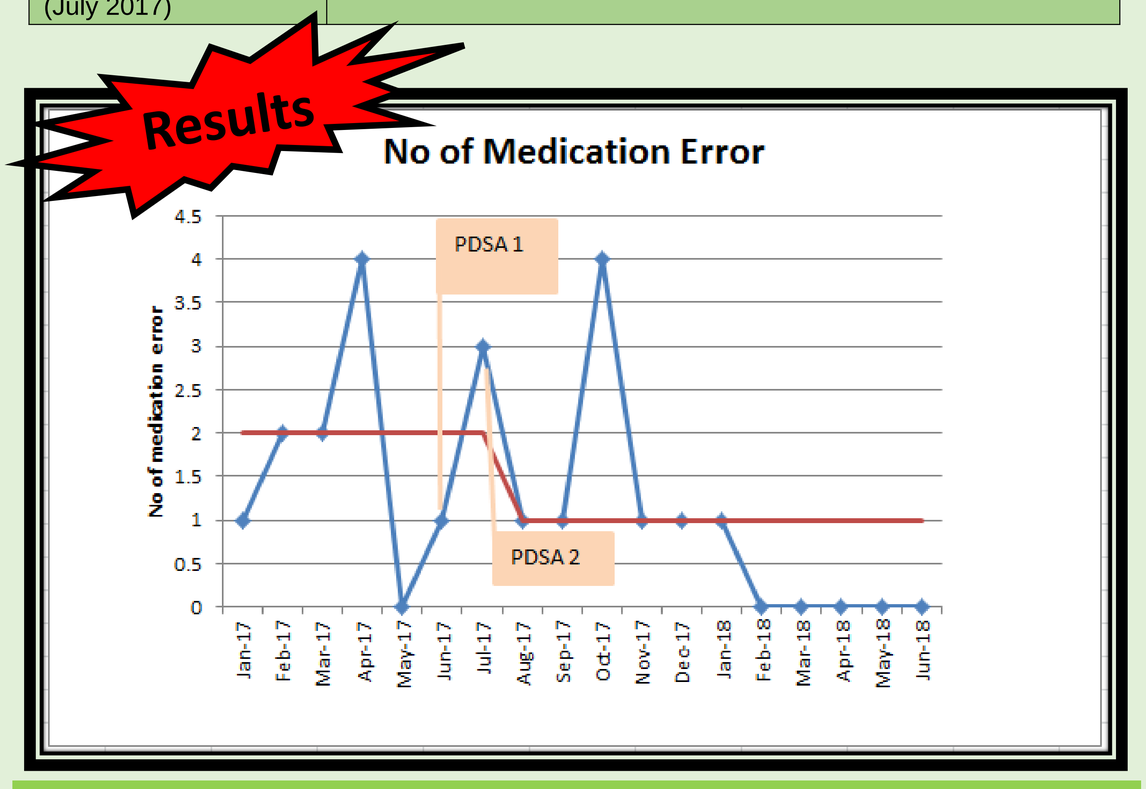


	Effective	Time Saving	Easy to implement	Total	
Update inpatient ward policy	5	5	1	11	PDSA 3
Improve workflow with flowchart	5	5	3	13	PDSA 2
Safekeep POM in clear plastic bag & cable tie	5	5	5	15	PDSA 1
Create orientation pamphlet	3	3	3	9	PDSA 4
Nurse to educate patient upon admission	5	5	5	15	PDSA 1
Revamp online document to add POM component	3	5	1	9	PDSA 4
Update SDA workflow	5	5	5	15	PDSA 1
Improve DEM workflow with flowchart	5	5	3	11	PDSA 2
Safekeep POM in clear plastic bag & cable tie	5	5	5	15	PDSA 1

Methodology

Solutions	Description
PDSA 1 Safe keep POM in clear plastic bag & cable tie (June 2017)	POM that are brought from home will be put into a clear plastic bag and cable tied. This will make it secure and will not be readily accessible to the patient.  For smaller quantity of POM  For larger quantity of POM
PDSA 1 Nurse to educate patient upon admission (June 2017)	Patients are orientated to inform nurse if there are POM 
PDSA 1 Update SDA workflow (June 2017)	The nurses in SDA were instructed to inform patients not to bring POM. By advising patients, it will prevent the patient from consuming their own medicines
PDSA 2 Improve workflow with flowchart (July 2017)	Flowchart was created for easy reference
PDSA 2 Update inpatient ward policy (July 2017)	Nursing Policy was updated for easy reference and standardization of practices
PDSA 2 Revamp online document (July 2017)	Dedicated place on the system for documentation 
PDSA 2 Include advice in orientation pamphlet (July 2017)	The orientation pamphlet was rephrased to remind patient to inform healthcare workers if they are taking POM

Results



Results showed that there is a reduction of medication error related to POM. However the mission to eliminate errors was initially not achieved as nurses was not aware when patient family members brought in POM during the hospitalization stay. Ah-hoc audits was performed and workflow was reinforced to the nurses. Medication errors related to POM was reduced.

Apart from this team, a multidisciplinary team is looking into the issue of family members bring in POM during the hospitalization stay

Conclusion

Staff was briefed on the new workflow for collection of Patients' Own Medication. Constant evaluations were conducted to ensure new workflow carried out with ease. Constructive feedback was gathered and taken into consideration on how to further improve/ modify the workflow process.