“Reducing medication errors within Critical Care, implementing a ‘bottom up’ approach to medication safety”

Authors: Jing Cao, Alice Smith
Acknowledgements: Critical Care Unit (CCU), Medication Safety Team.

Introduction:
Medication errors can be complex and often involve one or more stages within the medication process.
Nursing staff are at the forefront of the administration stage for which the “5 RIGHTS” were originally designed. These have since been reviewed and redeveloped over time but the broad principles remain the same. These principles of safe practice are consistently promoted within the CCU at Kings College Hospital.

A group of Band 5 nurses set up a Team in response to a rise in preventable medication administration errors. The fundamental aim of which was to reduce errors and improve patient safety.

Method & Aims:
Team plan: quantitative measurement of practice against a set standard.
1) Gain insight into current practice and define problems.
2) Set a standard against which to measure current practice.
3) Design an audit tool to measure and map changes.
4) Implement ‘Medication Awareness Week’, ‘Drug of the Month’, ‘Big 3’ topics along with visual boards and attendance at Medication Safety Group (CCMG).
5) Monitor and share monthly Unit results.
6) Maintaining key project aims and responsiveness to results.

Discussion:
Challenges:
- Team member changes.
- Difficulty in scheduling meetings where all the units can meet.
- Variation in documentation: Electronic and paper prescription charts.
- Role of Team within Governance meetings & consistent access to AI data.
- Reliability of data quality (objectivity within data coding).
- Dissemination of information: time intensive, variable (Unit dependent).
- Clear responsibility: individual units with designated lead and timetable.

Strengths:
- Engaged and motivated Band 5s with increased morale and motivation.
- Clinical Practice Facilitator role within education team as key networker.
- Support of management team with clear guidance on standards.
- Design of an audit tool to measure practice so key data is gathered.
- Environment: Visual whiteboards, safety culture (Big 3)

Conclusion:
This project has produced positive results for both patients and staff. It has required hard work and commitment to transition from its early vision to deep-rooted sustainability.
The success of this project was largely due to the commitment and ownership taken by Band 5 nurses and members of the medication team. This ‘bottom-up’ approach illustrates the value and effectiveness of empowering Band 5s to play key roles within change-making processes.