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Improving the safety of drug management in an overseas island hospital

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Summary

Background. As part of a recent campaign to improve the quality and safety of care, an educational “error room” was set up with two objectives: to encourage staff members to adhere to care quality and safety procedures using an entertaining educational tool, and to assess the various actions implemented.

Method. Fifteen care safety errors were selected for study and displayed in the errors room. During a 2-day experience, the medical staff was invited to visit the room and search for errors. The errors were explained after the end of the experience. Participants completed a satisfaction survey.

Results. Sixty-five staff members participated in the simulation. The care safety errors they most frequently identified were: an overfilled sharp-objects medical waste container; a urine bag on the floor; a bottle of the patient’s own (prehospital) medications on the bedside

table. The least frequently identified errors were: drug interactions; risk of warfarin overdose; improper identification of drugs and pillbox.

Discussion. Despite the success of the simulation, rapid staff turnover in the setting of an isolated overseas healthcare facility was found to impair the long-term efficacy of the educational action. Greater team stability would improve implementation of the care quality and safety program.

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Introduction

The François-Dunan Hospital Center (CHFD) is a healthcare facility located on the French islands Saint-Pierre-et-Miquelon located in the North Atlantic, more than 4000 km from metropolitan France. The facility has 35 medicine-surgery-obstetrics beds and 24 long-term care beds. The CHFD is the only healthcare establishment on the islands and only recently (July 2010) initiated its certification process with the French health authorities (HAS¹). Certification has not however been awarded to date because of internal structural problems related to a move to new facilities in October 2013. The first “educational” visit conducted within

the framework of future HAS certification was held in July 2016. Since that time, the CHFD has pursued its “quality of care” program. One of the program’s strategic goals is to improve the quality of drug management. The ministerial decree of April 6, 2011 concerning the quality of drug management and use of medications in healthcare institutions is applicable to the CHFD. Consequently, the CHFD is required to implement a management system guaranteeing the quality and safety of care provided by the institution.

The drug circuit at the CHFD was computerized in 2010 and has become a key element for drug safety [1], controlling the daily nominal delivery of individual medications to care units. The second phase of the improvement program consisted in offering the medical staff training concerning systematic analysis of drug errors. An analysis procedure for the review of errors related to medications and associated

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¹ HAS: Superior Health Authority [*Haute Autorité de santé*].

medical devices (REMEDI²) has been implemented since January 2016 and has led to the definition of improvement actions integrated into the institution's improvement program based on a process of learning from errors [2]. Few drug errors are reported despite the fact that all healthcare professionals, irrespective of where they practice, have an obligation to report serious adverse events related to care [3]. A network of reference nurses is available locally to encourage reporting of care-related adverse events, but the culture of care quality and safety is difficult to implant in a small institution and would require longer interventions based on a combination of actions [4]. The first action was the establishment of an educational "error room" created within the framework of the national patient safety week. The objective was to evaluate actions undertaken and to facilitate staff adherence to improved care quality and safety by the use of an entertaining tool not previously available at the CHF.

Material and methods

A working group composed of a pharmacist, a risk manager, a pharmacy dispenser and two nurses first made an inventory of actions conducted over the past year as part of the campaign to improve the quality and safety of care. Among the actions taken to improve the quality and safety of care, the group identified several themes including "drug management" and "management of infectious risk" as well as "reporting of adverse events".

The group applied two criteria – criticality of the risk for which an action had been taken and the feasibility of an error scenario – to select specific care safety errors to be displayed in the error room. The group identified six actions that had been taken in the past and then added nine other errors to the list (Table 1).

The error room was open two days for staff members who wished to participate. A pharmacist and two reference nurses were in the room to assist participants. Participants visited the educational error room and searched for medical safety errors that they reported on a survey form.

The care safety errors were explained in documents displayed in the care units, but after the end of the experience to avoid discouraging participation. These documents recalled Good Clinical Practices and proposed links to the appropriate sources (procedures, guidelines). Participants were asked to complete a satisfaction questionnaire.

During the two days of the experience, a reference nurse visited the care units during handover periods to encourage staff members to visit the error room and participate in the simulation.

²REMEDI: review of errors related to medications and associated medical devices [Revue des erreurs liées aux médicaments et dispositifs médicaux associés].

Results

Participation

Sixty-five staff members visited the error room (Fig. 1). The participation rate was 33% for nurses, 29% for nurse assistants, 27% for physicians. Other participants included administrative personnel, paramedical professionals (physical therapists, dieticians) and personnel with an unspecified occupation.

The majority of participants (76%) were nurses and nurse assistants.

Errors identified

Three errors were identified most frequently: overfilled sharp-objects medical waste containers ($n = 53$, 82%); urine bag on the floor ($n = 50$, 77%); the patient's own prehospital treatment on the bedside table ($n = 46$, 71%). Differences were observed depending on the participant's occupation: the urine bag on the floor was noticed by only one physician (25%) and the presence of the patient's own treatment on the table was identified by 86% of nurses ($n = 19$ %).

The least frequently identified error was a drug interaction between oral gel miconazole and warfarin. None of the physicians identified this risk, but one nurse and one nurse assistant did.

The identity monitoring error was identified by only 62% of the participants, but was noted by 86% of the nurses ($n = 19$). The missing name on the pillbox was noticed by only 28% of the participants, with similar percentages for physicians, nurse assistants and others, but with a higher percentage for nurses ($n = 9$, 41%) (Table 2).

Satisfaction

The satisfaction questionnaire was completed by 62 participants (95%). Among these 62 participants, 15 were in the "other" group with an unspecified occupation. All of the participants who responded to the satisfaction questionnaire thought that the "error room" experience was interesting; 95% ($n = 59$) thought it was useful and 95% ($n = 59$) reported they would participate another time. Only 44% ($n = 27$) were familiar with the principle, with the percentage being higher (65%) for nurses than nurse assistants (30%). On average, 60% of participants reported that the communication about this action was sufficient, with a wide range of percentages for the different groups: 100% ($n = 4$) for physicians; 45% ($n = 9$) for nurses; 57% ($n = 13$) for nurse assistants and 73% ($n = 11$) for others.

Sixteen participants (26%) thought the errors were easy to detect and 21 (34%) reported they had learned things they didn't know before (Table 3).

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