

Implementing improvements in medication safety in intensive care: a simple reproducible audit feedback methodology

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Background

- Medication errors more common in ICU
- Reported medication error rates in ICU vary
 - 2 to >2000 events per 1000 patient days
- Direct observation probably gold standard for detection
 - Local system relies on voluntary reporting

Aims

- Develop a simple, reproducible audit methodology to determine rates of medication errors in ICU
- Use results to increase awareness of medication safety & reduce high risk medication practices

Improve medication safety culture in intensive care

Ingredients

- Clinical Pharmacist + ICU Nurse
 - Within existing resources
- 1-2 hours per audit
- Simple, easily adaptable tool
- Rapid feedback mechanisms
 - Daily handovers
 - Weekly newsletter / meetings
- Themes from local error reporting systems

ICU Infusions Audit

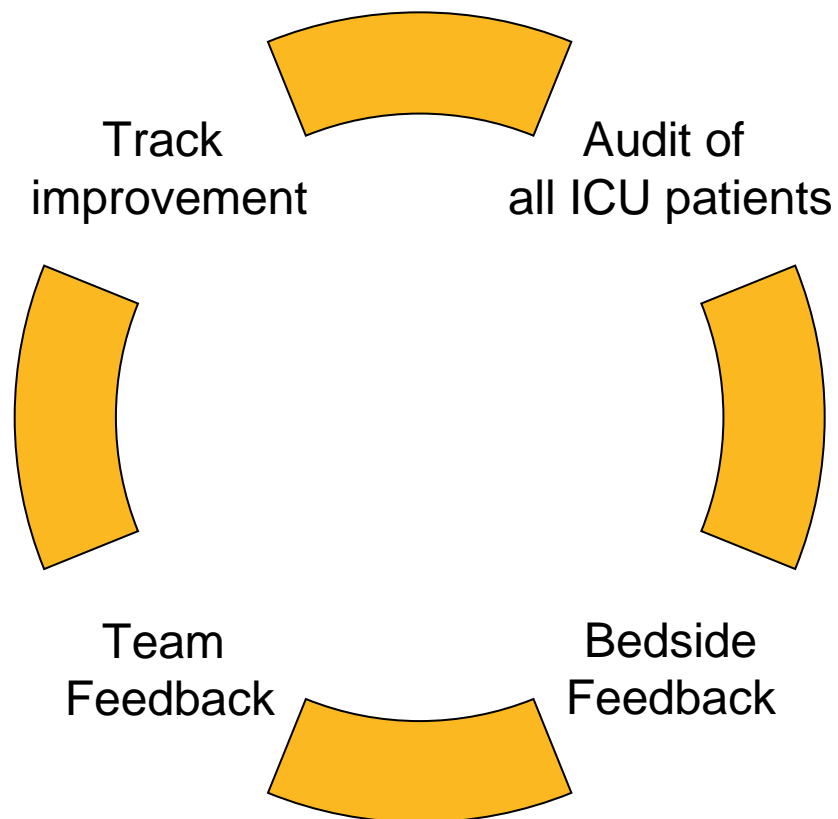
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Patient #		Patient name	Medication name	Dose	Volume	Diluent	Expired
	Prescription						
	Infusion						
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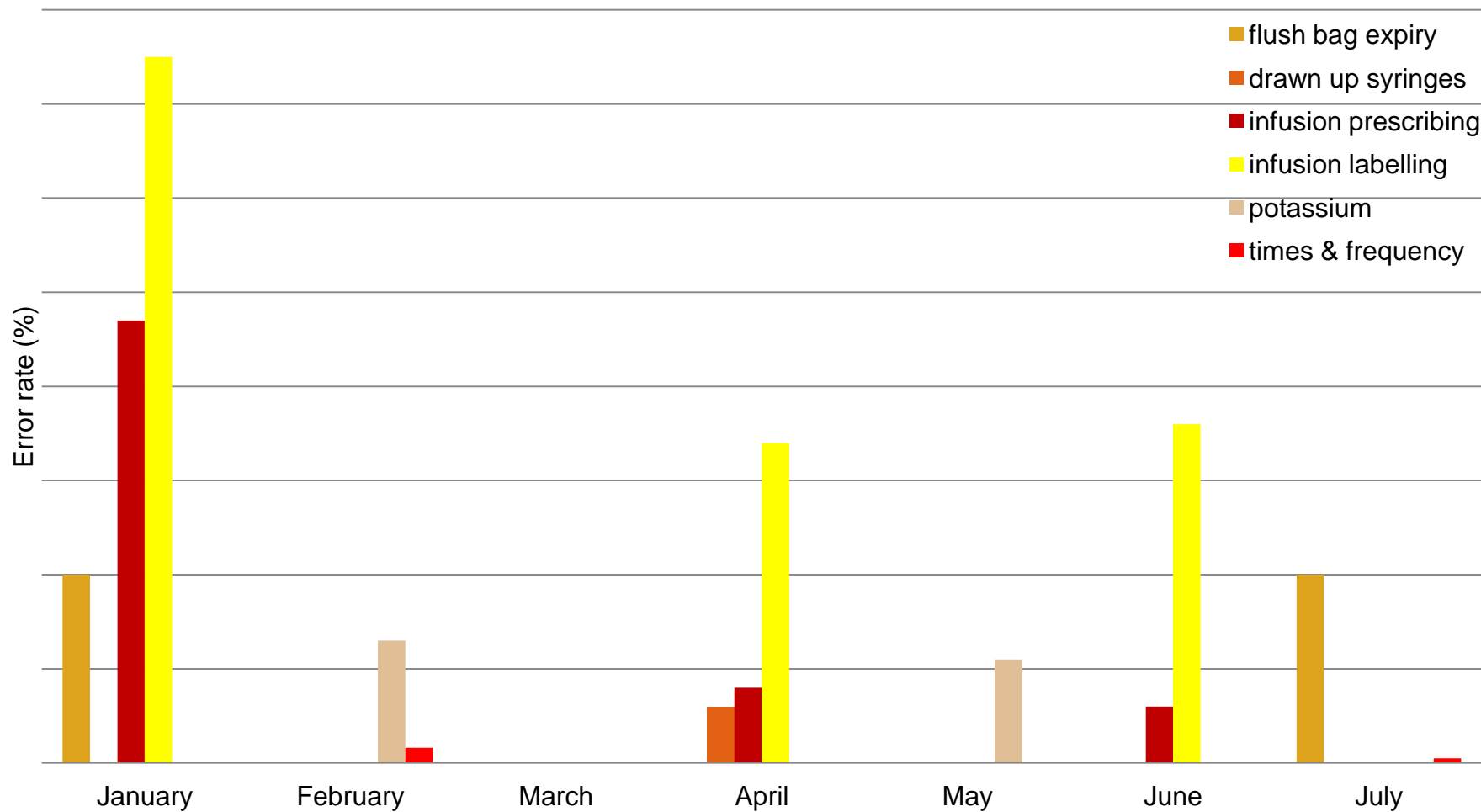
Audit Topics

- Infusion prescription and labelling
- Flush bag expiries and prescribing
- Potassium ampoule storage at the bedside
- Prescribed frequency does not match times charted
- Drawn-up drugs storage at the bedside
- Illegible / illegal / incomplete prescriptions
- Controlled drugs storage at the bedside

Methodology



Results



Discussion

- Demonstrated improvement
 - Specific interventions / solutions
 - Involve wider Quality and Safety community
- Conducted regularly
 - Fortnightly
- Support from senior medical, nursing and pharmacy staff

Limitations

- Snapshots don't tell the whole story
- High risk practices don't always result in error

Conclusions

- Successful development and implementation of simple and effective audit methodology
- Improvement in rates of errors / high risk practices
 - Sustained
- Increased awareness of medication safety in ICU

Acknowledgements

- Dorothy Hau, Kristen Penny – Rotational Clinical Pharmacists
- Deb Harrison, Kirsty Riddle, Darryl De Plooy, Ben Schreenan – ICU Nursing Staff
- Tim Leong – Deputy Director of ICU, Quality and Hyperbaric Medicine