

IMPROVEMENT ACTIVITIES TO REDUCE VERBAL ORDER RISKS

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INTRODUCTION

- ❖ Effective and precise communication, which is timely, accurate, and complete, reduces errors and improves patient safety.
- ❖ Poor communication including verbal and/or telephone orders threatens patient safety.
- ❖ Medical errors associated with verbal medication orders and prescriptions may lead to physical, mental, or economic losses of the patient and/or the physician.
- ❖ Nevertheless, inaccurate verbal orders are frequently used in clinical practice.

OBJECTIVES

- ❖ This study was carried out to recognize the importance of accurate communication and to accurately implement verbal prescriptions.

METHODS

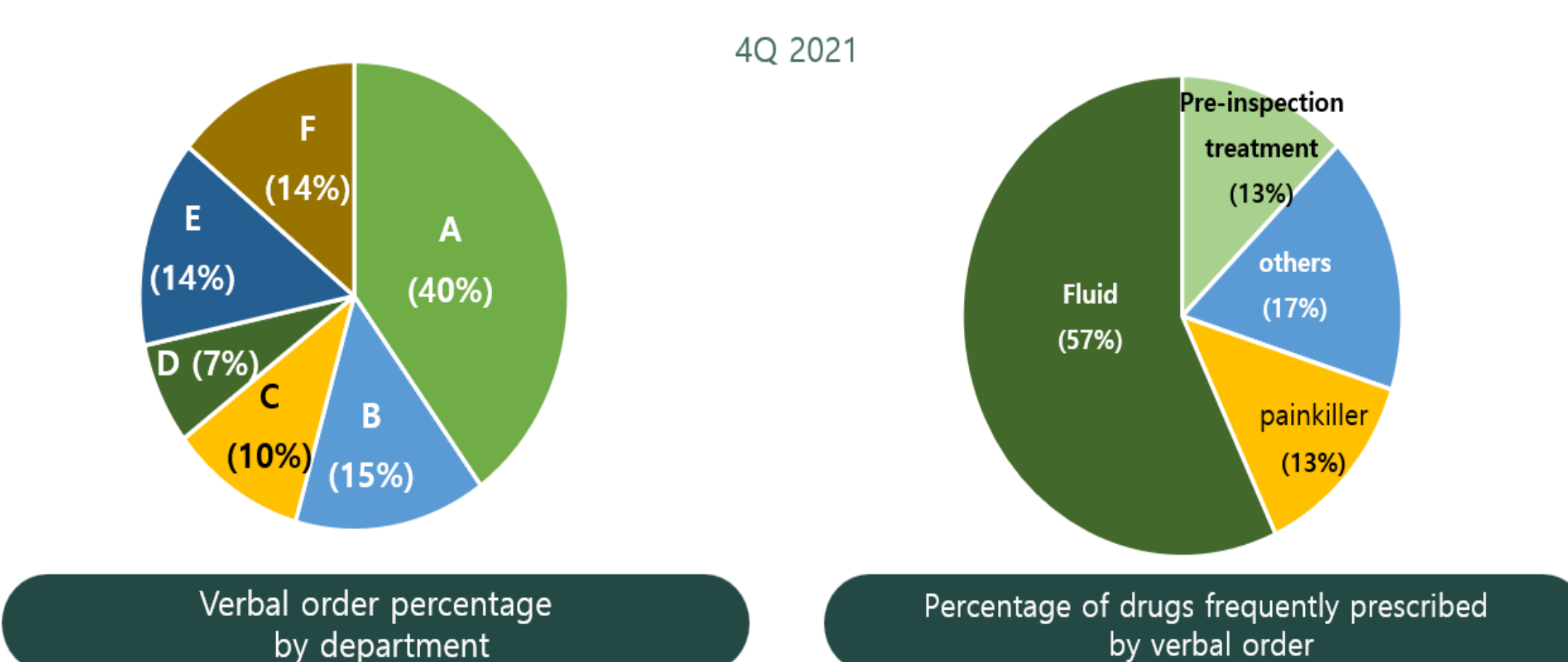
- ❖ Failure mode and effect analysis (FMEA) methodology.
 - ❖ Reviewed the entire verbal order process
 - ❖ Found the potential risk factors of each process.
 - ❖ Conducted a risk analysis and calculated the risk priority score of each potential risk factors
 - ❖ RPN(Risk priority number)
= Severity x probability of occurrence x detectability of the effect
 - ❖ The criticality index of each process was calculated by summing up all RPN values
 - ❖ CI(Criticality index) = $\sum$ RPN
 - ❖ The failure modes were prioritized based on their CI in order to determine which actions should be addressed first.

RESULTS AND CONCLUSIONS

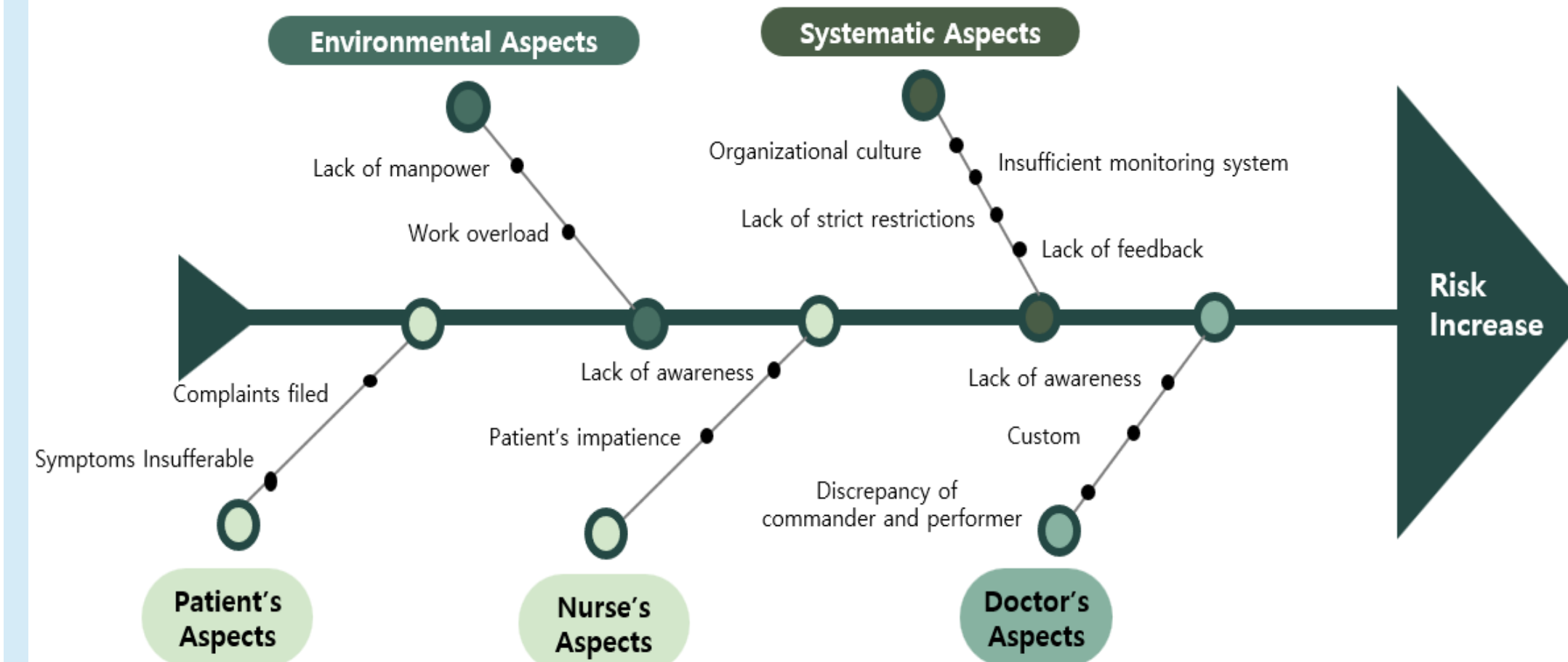
The failure modes were listed in order of CI from highest to lowest. Among them, three items with high scores are derived as follows:

- 1st : Risks during medication administration (CI: 1560)
- 2nd : Lack of awareness of communication risks (CI: 1352)
- 3rd : Failure to comply the protocol by medical staff (CI: 1127)

Problem Analysis 1



Problem Analysis 2



Improvement Activities 1

- 01 Survey
 - Contents : Verbal order awareness, non-compliance, procedure performance, etc.
 - Target : doctors and nurses(78 people)
- 02 Education
 - Contents : Verbal order procedures and policy
 - Target : doctors and nurses
 - Educational methods : Staff training

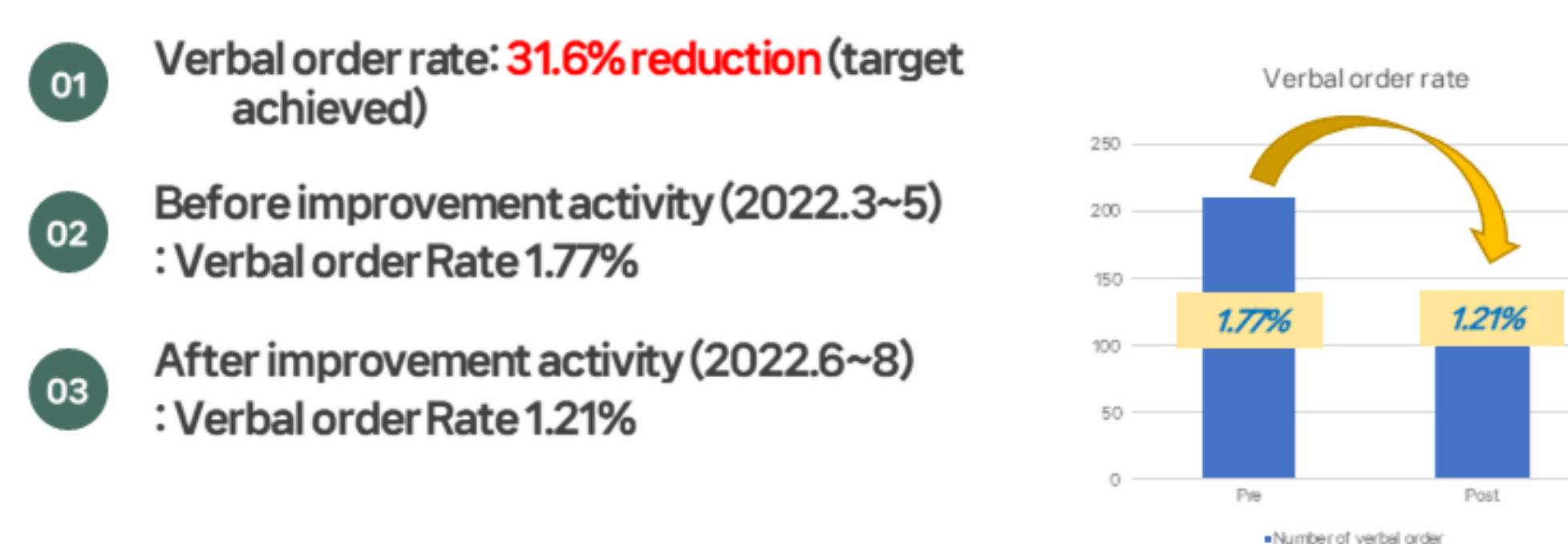
Improvement Activities 2

- 03 Campaign
 - Zero verbal order campaign
 - Distribution of educational materials on communication methods
- 04 System Improvements
 - Check the clinical prescription set orders
 - Develop drug set orders for examination (ex: CT, MRI)
 - Use PRN prescriptions when needed
 - Develop and use CP (Critical pathway)

Improvement activities 3

- 05 Patient safety leader activities
 - 75 patient safety leaders, including doctors, nurses, and people from support departments
 - Role: Discuss, decide, promote and educate patient safety issues and agendas
 - Prepare a strategy to reduce verbal order
 - Participate in the zero verbal order campaign
- 06 Report, share, reward
 - Share verbal order reduction strategy
 - Report the activities at various meetings
 - Reward outstanding ward or department
- 07 Continuous monitoring
 - Perform monitoring of verbal orders: number of cases and medical departments issued

Effect of Improvement Activities



CONCLUSION AND PLAN

Conclusion

- Increasing awareness

The most important step is raising awareness to reducing verbal order prescription which directly affects patient's safety.

PLAN

- Verbal order continuous monitoring
- Continuous activities for effective communication



- ❖ Through the FMEA, we reviewed the entire of verbal order process and found the potential risk factors.
- ❖ The RPN value was calculated when the redesigned procedure was analyzed and piloted. When the CI value was measured after the improvement activity, the possibility of risk of medication administration decreased from '1560' to '130'.
- ❖ Human based communication skill had many error chances, so we decided to import technology based communication program.
- ❖ We will continuously implement accurate and precise verbal order communication. It will only be implemented in necessary circumstances.

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