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The Completion Rate of Medication Administration Process

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INTRODUCTION

The medication administration process is one of the essential nursing procedures performed daily by nursing staff. The complete medication administration process consists of five stages: prescribing medication by physician, dispensing the prescription by pharmacist, administering medication, assisting the patient in taking the medicines, and post-medication assessment and monitoring with record completion by nursing staff. If an error occurs in any of these stages, it is referred to as a “medication error”. “Medication administration error” is the most significant type of medication error. The occurrence of medication administration errors can directly impact the patient medication safety, and in severe cases, it may lead to life-threatening situations for patients. From January 16th to January 31st in 2022, a three-shift medication process audit was conducted, and the result showed the medication accuracy rate of 76%. On January 26th, 2022, a medication administration error occurred. In order to improve the medication accuracy, prevent the recurrence of medication errors, and ensure patient medication safety, improvement measures were implemented.

CONCLUSIONS

Through collaborative discussions by the quality control team, feasible improvement plans were developed, coupled with weekly audits on medication administration. As a result, the medication accuracy rate increased from 76% to 100%. Initially, there were some challenges in implementing this plan, including resistance to behavioral changes leading to colleagues' discomfort, frequent forgetting to include patient medication status during handover among nurses, the need to request physicians to specify the application sites for topical medications, and the presence of auditing personnel during the medication process causing nursing staff to feel pressured and uneasy. With the reminders from the head nurse and quality control team members, along with the collaborative efforts of colleagues in the ward, this project was successfully implemented. It is recommended to schedule regular in-service education and training for nurses in the future to equip them with relevant information on medication safety. Creating a learning-oriented and safe care environment would further improve the patient's healthcare experience and the quality of care they receive.

RESULTS

From March 1st to March 31st in 2022, an audit was conducted on the medication process of 12 nurses. It was found that all nurses followed the regulations correctly. Two instances were identified where intravenous medication was administered outside the one-hour timeframe before or after the correct time. However, after being reminded, all nurses promptly sought physician orders and documented them during handover. Regarding cases where topical medications were prescribed without specifying the application site, nurses were reminded and subsequently requested physician orders for clarification. From April 1st to April 30th, as well as from May 1st to May 30th of the same year, repeated audits were conducted on the medication process of 12 nurses. During both audits, it was found that all nurses followed the regulations correctly. Intravenous medication was administered within the one-hour timeframe before or after the correct time. Any concerns regarding physician orders were discussed with and confirmed by the physicians. The usage instructions and application sites of topical medications were also clearly specified. After a two-month medication process audit, the results showed that the medication accuracy rate increased from 76% to 100%.

METHOD

From January 27th to February 10th in 2022, an audit was conducted according to the standard checklist, and the results showed the main issues as follows: (1) failure to administer medication according to the regulations, (2) failure to discuss over the concerns regarding physician's orders, (3) lack of training for nursing staff to proactively raise concerns about early medication administration. After discussions with the quality control team, the improvement plans include the following: (1) arranging in-service education for colleagues, (2) promoting the correct medication administration process, (3) training on handling concerns about physician's orders, (4) enhancing reminders for physicians to specify the usage and application areas of topical medications, (5) ensuring the current medication status of patients is included in handover procedures, (6) providing instructional videos on proper medication administration for colleagues to learn from, (7) conducting periodic audits of nursing staff's medication techniques, announcing audit findings during routine morning meetings, and using the PDCA (Plan-Do-Check-Act) method to address and improve any deficiencies.

REFERENCES

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