Increasing Medication Error Reporting
Kernan Orthopaedics and Rehabilitation Hospital

Program/Project Description.
The number of medication errors reported at Kernan Hospital were underreported when compared to many of the benchmarks noted in medical and quality literature. Many sources, such as in the 1999 landmark publication "To Err is Human", have suggested error reporting rates exceed the numbers Kernan staff have reported utilizing our current incident reporting system. Not only were the number of med errors reported at Kernan low, but between last year and the previous year, the number of reported errors were further decreased by approximately 40%. By staff accounts, reporting of near misses were also not widely regarded as worthy of the time required to complete an incident report.

The goal was to identify and remove the barriers to reporting medication errors. Another goal was to convey that most errors are a result of a system issue and not a result of staff incompetence. In doing so, the result should be an increase in the number of medication errors, and near misses reported by staff. System enhancements that result from these reports will make our medication system safer for all our patients.

Process.
An interdisciplinary team of nurses, pharmacists, physicians, dentists and nurse practitioners from a variety of patient care settings (inpatient rehab units, outpatient clinics, post op area, and dental suite) were selected to conduct a FMEA (Failure Mode Effect Analysis) to determine what the barriers were to reporting medication errors. Once the barriers were identified, the team brainstormed solutions. Solutions that represented the best chance of positively impacting the rate of error reporting were identified by the team. Solutions were plotted on a grid based on their ease of implementation and their ability to have a high impact on increasing medication error reporting. Those items categorized as easy to implement with a high impact were the items selected for implementation. A subgroup from the Patient Safety Council, was formed to implement solutions.

Solution.
Solutions were grouped and fell under three broad categories; Staff Education, Organizational Culture and Reporting System Enhancements

Staff Education covered what incidents should be reported, the definition of a medication error, versus an adverse drug events, versus a near miss. Several articles were published in the hospital newsletter. Presentations were scheduled during nursing grand rounds on preventing medication errors, the process of medication error reporting and investigating errors from a system perspective versus an individual practitioner prospective.

Organizational Culture addressed managerial response to staff who reported errors, introduced "Just Culture" concepts, and explained the process of investigating a med error. Tipsheets were developed for managers to help ensure supportive language was used during conversations with staff who were involved with errors. Senior Leadership was engaged to promote discussions around reporting of medication errors throughout the organization. Managers were asked to discuss medication errors at staff meetings. CPOE (Clinical Physician Order Entry) system changes that resulted from medication errors reported by staff were shared hospital wide

Reporting System Enhancements improved accessibility to the system and minimized data requirements to complete each incident. Unit based sign-on codes were created to help staff remember their passwords. A link to the medication error system placed inside the CPOE system made access easier for all staff.

Measurable Outcomes.
In the first five months of this fiscal year, we have equaled the number of medication errors that were reported in all of last fiscal year. Staff more openly dialogue regarding medication errors. Some positive changes to our CPOE system have resulted from error reports.
Sustainability.
The Medication Error Team is responsible for reviewing all medication errors. Additional data analysis will now include reporting medication error trends to Senior Leadership by unit in order to identify patient care areas with inadequate reporting. Leadership rounding will include discussions around med error reporting. Employee orientation will include a presentation on reporting med errors. Employees who have reported medication errors will be recognized and reminded that their report will help minimize future errors. Nurse managers and pharmacy leadership will have annual goals to ensure reporting is sustained.

Role of Collaboration and Leadership.
FMEA and the Implementation Team is comprised of multiple disciplines: pharmacy, nursing, therapy, dental, and medical. Organizational leadership will be given data on med error reports. Staff will be acknowledged for reporting med errors/near misses that result in system changes. Leadership fully embraced the need to increase error reporting and willingly offered suggestions on how to disseminate the message of reporting.

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