2017 Performance Improvement Report

STRATEGIC PRIORITY

3. Improve efficiency and decision-making

Project Name

Optimizing the Nursing Medication Administration Process

Site	Department
Riyadh	Nursing Affairs

Project Status	Project Start Date	Project End Date
Completed	06-01-2016	04-30-2017

Problem: Why the project was needed?

Medication administration incidents constitutes 12% of the reported medication incidents during 1 January 2015 - 20 April 2016, with total of 243 incidents. These incidents resulted in 74 temporary harm, 1 (one) permanent functional harm and 1 (one) death.
For that reason, this project has been initiated to ensure the implementation of evidence based strategies to standardize medication administration process and reduce medications administration errors in the nursing units/ areas.

Aims: What will the project achieve?

To reduce medication administration errors with any level of harm by 50% by the end of 1Q 2017.

Benefits/Impact: What is the improvement outcome?
(check all that apply)

☐ Contained or reduced costs
☐ Improved productivity
☒ Improved work process
☐ Improved cycle time
☐ Increased customer satisfaction
☐ Other (please explain)
Click or tap here to enter text.

Quality Domain: Which of the domains of healthcare quality does this project support?
(Select only one)

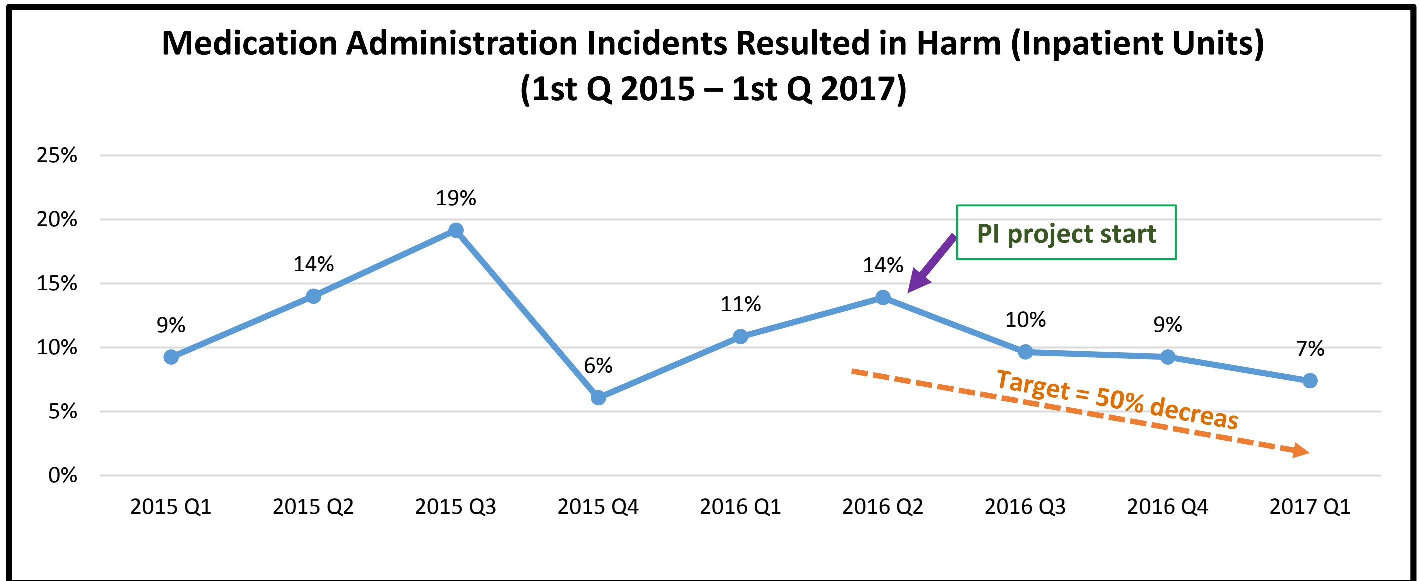
Safe

Measures: Performance metrics to be evaluated	**Targets:** Expected outcomes
Medication Administration Incidents Resulted in Harm	Decrease by 50%.

Interventions: Overview of key steps/work completed

- Introduction of ‘No Interruption environment with minimal distraction’ during medication preparation and administration.
- Introduction of ‘color coded medication bins’ to ensure proper segregation of medication and high alert medications.
- Adding the ‘Right indication/reason’ as the seventh right of medication administration.
- Developing the ‘Smart Pump Infusion Device’ standards of care.
- Developing the ‘Smart Pump Infusion Device’ training and competency based check off.
- Updating the ‘Medication Management and Use for Nursing Staff’ policy content with latest evidence practice in reference to Joint Commission Medication Management and use requirements and Institute for Safe Medication Practices (ISMP) recommendations.
- Updating the ‘Nursing Medication Safety’ iLearn module.
- Introduction of ‘Risk assessment tool’ for medication practice in the unit.
- Improving labeling process for medications and medication IV tubes.
- Initiating a new indicator for medication administration errors.

Results: Insert relevant graphs and charts to illustrate improvement pre and post project
(insert relevant graphs, data, charts, etc.)



Project Lead	Team Members
Name	**Names**
(person accountable for project)	*(persons involved in project)*
Eyad Bashtawi	Kholoud Alshammari Mohsen Alali Youssed Daibes Abeer Hussain Mohannad Odeh Mary Joy Verdadero Susan Almero Bleik Mustafa Rania Alobari Salma AlKhani Sharon Berege Ahmed Abu Lehya Doris Tijada Nahed Alsayed Martin Heppengeimr Joana Buencamino Nursing Quality Team