

Study Of Compliance Of Administration And Medication Technique At FMRI To Reduce Incidences Of Medication Administration Error

INTRODUCTION: Patient safety, specifically safe medication administration and preventing medication errors is an important concern that is threaded throughout. The majority of the errors do not result from individual recklessness, but rather from faulty systems, processes and conditions that lead people to make mistakes or fail to prevent them

OBJECTIVE: The study is to increase compliance of the staff towards following process of drug administration and to reduce the medication errors to its least possible.

STAGES OF MEDICATION ADMINISTRATION:

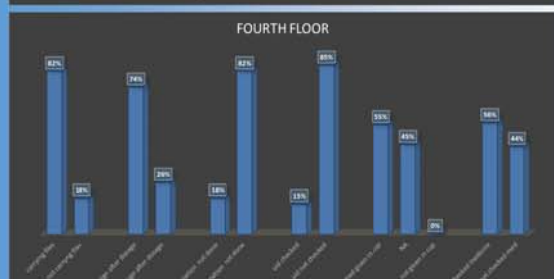
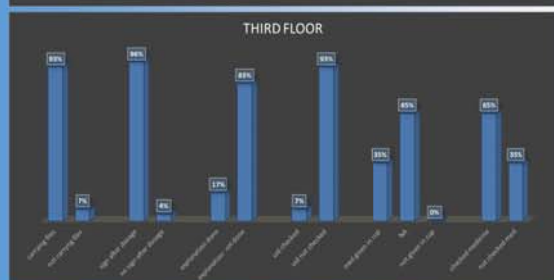
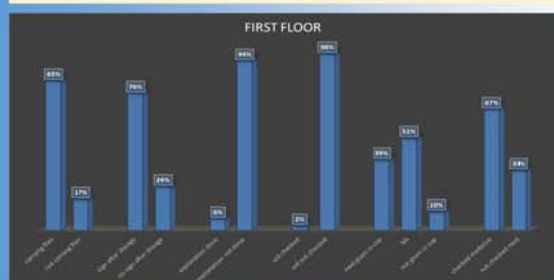
1. Ordering/prescribing
2. Transcribing and verifying
3. Dispensing and delivering
4. Administering
5. Monitoring and reporting

RESEARCH METHODOLOGY:

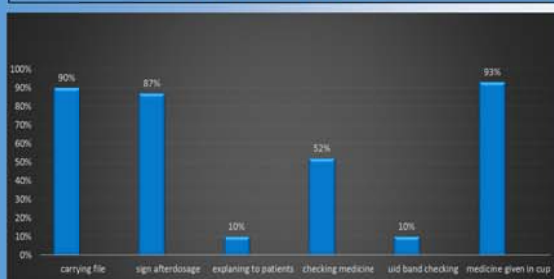
1. Study Design : Observational study
2. Study Site: 1st, 3rd and 4th floor FMRI.
3. Sample Size: 260 observations
4. Sample Type : Purposive sampling.

FINDINGS AND ANALYSIS

FLOOR WISE



COMPILED RESULTS



RECOMMENDATIONS:

1. Small posters to be pasted on patient bedside as a reminder to nurses to follow proper protocol.
2. Encourage nurses to sign the patient file immediately by providing training sessions.

SUBMITTED BY: DR. RAMAN DEEP

RESULTS:

In 4 out of 6 parameters an increase in compliance was achieved.

Small decrease in compliance of "EXPLAINING TO PATIENTS" and "SIGN IMMEDIATELY AFTER DOSAGE"

51 and 52 percent increase in compliance of "CHECKING MEDICINE BEFORE ADMINISTRATION" and "MEDICINE BEING GIVEN IN CUP".

UID BAND CHECKING and NURSES CARRYING FILE TO PATIENT BEDSIDE increased by 10 and 5 percent respectively

OTHER PROJECTS

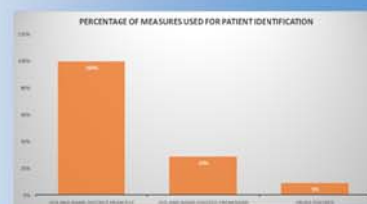
PATIENT IDENTIFICATION:

INTRODUCTION:

Through out health care, the failure to correctly identify patients and match that information to an intended clinical intervention continues to result in wrong person, wrong site procedures, medication errors, transfusion errors and diagnostic testing errors.

PARAMETERS EVALUATED:

1. Checking UID and name from file
2. Checking UID and name from patient band
3. Cross Checking both.



RESULTS: It was found that in 100 % cases one indicator for identifying patient was used.

In 29 % cases two indicators were used to identify patients.

In 9 % of cases observed both indicators were cross checked.

RESEARCH METHODOLOGY:

SAMPLE SIZE-200 SITE-All clinical and diagnostic departments at FMRI.
STUDY TYPE-Observational SAMPLE TYPE -Purposive sampling.

TO STUDY THE CO-RELATION OF CLINICAL AND RADIOLOGICAL DIAGNOSIS AT FMRI FOR OPD

INTRODUCTION: A study of co-relation of radiological and clinical diagnosis was started to shortlist departments lacking correlation of diagnosis procedure.

It was observed that in OPD section the compliance of co-relation of radiological diagnosis and clinical diagnosis was almost 0%.

INTERVENTION PLAN: After observation of the OPDs and radiological department it was concluded that there is large gap in the co-relation of diagnosis.

A simple and plain format was prepared for correlation.

WIFI enabled folder was created which was assessable both by radiology and OPD departments.

Doctors at OPD and radiology were trained and guided to fill the format after every diagnosis.

RESULT: The progress was continuously governed and monitored for improvement and small scale progress was seen in the co-relation of diagnosis.

MEDICATION RECONCILIATION

Minor project on medication reconciliation was done.

Files were checked and patients were cross questioned about the continuation of their previous medication from home.

Patient attendants were enquired about home medicine being taken at hospital and if so it is under guidance of nursing staff.

RESULTS: It was concluded that good number of patients had their home medication along with them which is against the hospital policy.

Most of these home medications were taken under nursing staff guidance.

GUIDED BY: DR. MONIKA CHAUDHARY