QLL 83

A CLINICAL AUDIT ON IDENTIFYING THE 'RIGHT PATIENT' PRIOR TO ORAL MEDICATION ADMINISTRATION AMONG NEPHROLOGY WARD NURSES IN HOSPITAL SELAYANG

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INTRODUCTION

Hospital Selayang reported the highest number of actual medication errors in total for the year 2022, with one-third of the number belong to the administration error. Right patient identification is the essence component to break the chain of medication administration error.

A target of 100% for the nurses to comply with the standard of practice by implementing 2-point identifiers into the steps to identify the right patient, thus reducing the likelihood of medication error to occur towards hospitalized patients.

METHODOLOGY

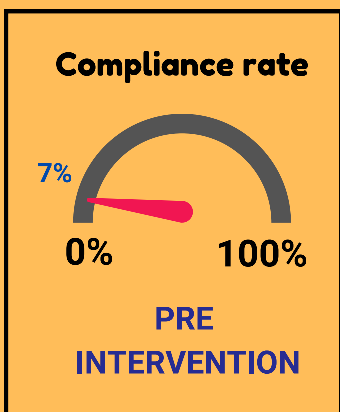
A concurrent audit was conducted from 26 February till 26 July 2024 among 15 registered nurses at the Nephrology ward, Hospital Selayang. A 'Modified Audit Checklist', extracted from NNA E5 AF5.1 form is used, targeted to the important steps and processes for the right patient identification. Root Cause Analysis (RCA) is used to identify the possible issue or contributing factors.

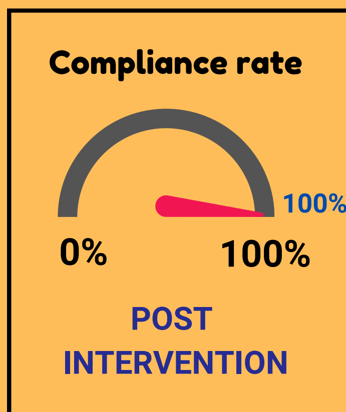
RESULT

Pre-interventional audit result showed only 7% of the nurses were compliant with the standard. Contributing factors to this issue were identified. First, there was limited knowledge and awareness among nurses to implement 2-point identifiers in every step to identify the right patient, and secondly, there was no standardization on patient's details to be written on the medication slips. Interventions made to observe any changes for the remarkable improvement.

Post-interventional audit result illustrated 100% of the nurses were compliant with the standard.

AUDIT PERFORMANCE





DISCUSSION

Discussions were made among core members and together with the respective personnel from departments such as Nephrology & Pharmacy Department prior to implementing these interventions.

Selected strategies were chosen to overcome this issue. First, enhancing the promotional awareness and education via creative video presentation to enlighten and cultivate the right patient concept into their routine clinical practice.

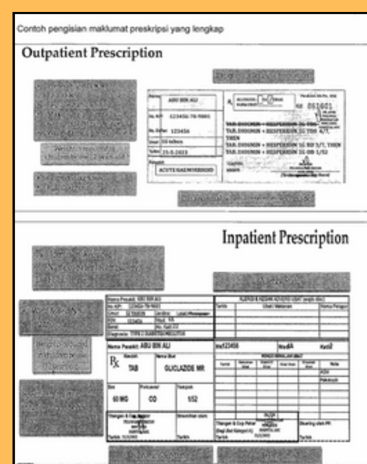
Collaborative action with the pharmacy department for the updated standardization of prescription slips on patient's identification details written by staff at the hospital level was also taken.

Method 1: Promotional awareness via educational creative video presentation.

MEMO

HOSPITAL SELAYANG

PERKARA	KEPERLUAN MAKLUMAT LENGKAP PESAKIT PADA PRESKRIPSI UBAT
KEPADA	SEPERTI SENARAI EDARAN
DARIPADA	PENGARAH HOSPITAL SELAYANG
SALINAN KEPADA	KETUA JABATAN FARMASI


Contoh pengisian maklumat preskripsi yang lengkap

Outpatient Prescription

Inpatient Prescription

Method 2: Standardization of prescription slips details on patient's identification details written by staff at hospital level.

CONCLUSION

Another cycle of audit can be further extended to the other various departments in our hospital for monitoring and sustaining the awareness among all registered nurses to apply a good model of care into their clinical practice and nursing care, thus reducing the probability of medication administration error to occur in the future.

References:

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2. Paul M, Ann C, and Michaela D (2021) *Medication Administration Errors*. Available from: https://psnet.ahrq.gov/primers/primer/47/Medication-Administration-Errors (accessed on 15 April 2024).
3. Tsegaye D, Alem G, Tassema Z and Alebachew W (2020) *Medication Administration Errors and Associated Factors Among Nurses*. Available from: 10.2147/IJGM.S289452 (accessed on 15 April 2024).