Implementation of Communication Strategies for a Medication Administration Time-Out

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BACKGROUND

- Nurses administering medications are distracted and interrupted as often as once every two minutes.
  - The risk of any medication error increases 12.7% with each interruption
  - The risk of a harmful medication error is doubled when nurses are interrupted four times during a single drug administration and tripled when interrupted six times
- Medication administration time-outs may reduce the number of medication errors but they can be difficult to implement.
- Hospital culture has a permissive attitude toward interruptions.
- Communication to and collaboration with members of the healthcare team may improve success of a medication administration time-out process.

PROJECT AIM

Using the Six Sigma ***Define, Measure, Analyze, Improve, Control*** **framework**, nurses on a medical/surgical orthopedic care unit at a 176-bed community hospital collaborated with members of the healthcare team to develop communication strategies to support a daily medication administration time-out during 0830 – 0930 every day, which is the unit's busiest medication administration hour of the day.

TAKEAWAYS

- Focusing on communication-specific strategies in collaboration with other members of the healthcare team, can support a medication administration time-out, and improve patient safety.
- Implementation on other units should be customized to the needs and process flow of those units.

References Available Upon Request

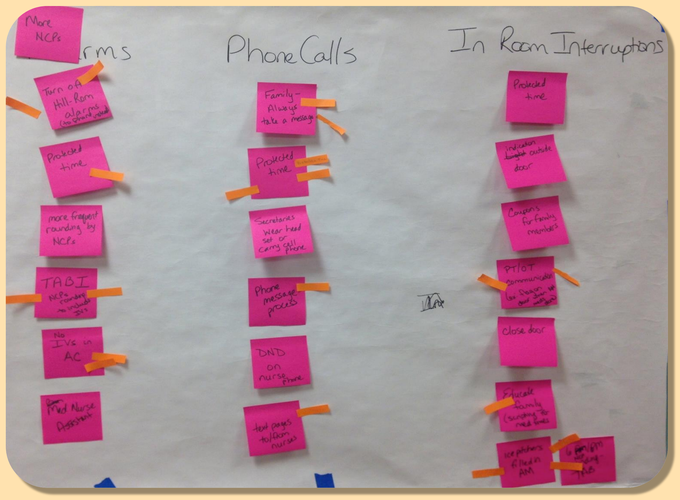
DEFINE Goals

Changes to **Unit Culture**

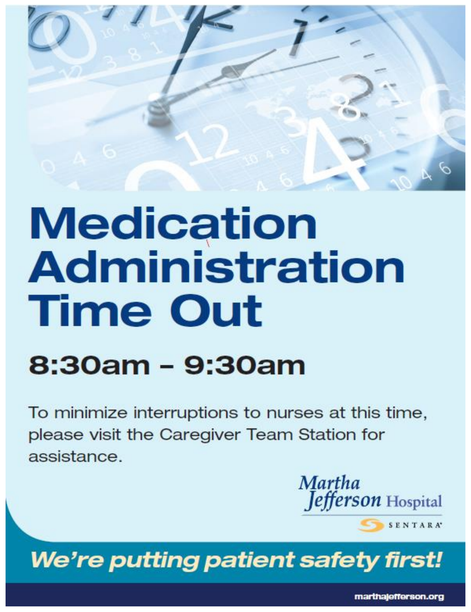
Reduce **Nurse Interruptions** during Medication Administration

Decrease **Medication Administration Errors**

ANALYZE: All involved in morning processes --physicians, physical therapists, occupational therapists, transporters, managers, and nursing care partners --were brought together to identify causes of interruptions. Communication was identified as a major root cause of interruptions.

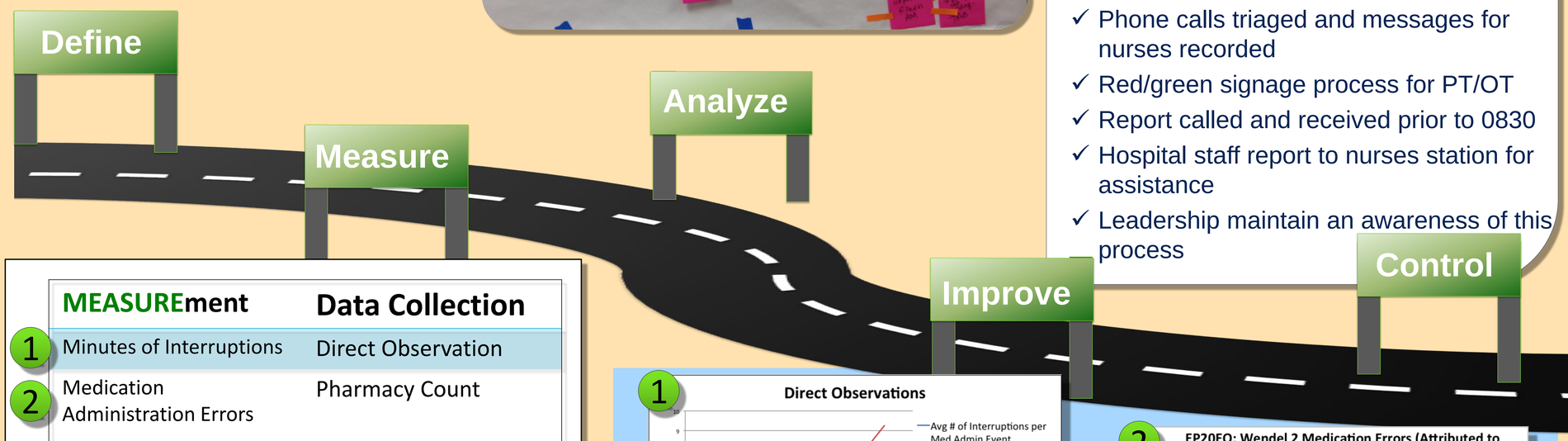


IMPROVE: Each morning between 0830 and 0930 signs are posted on the unit



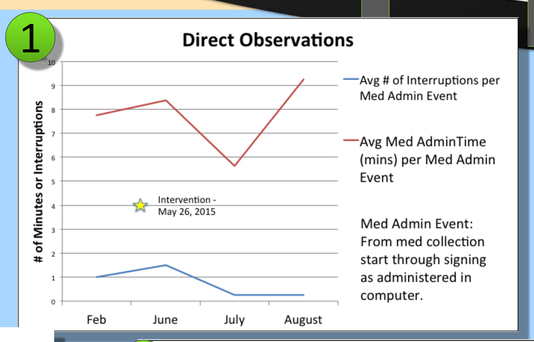
Additional communication **IMPROVE**ments

- ✓ Hall lights dimmed
- ✓ Phone calls triaged and messages for nurses recorded
- ✓ Red/green signage process for PT/OT
- ✓ Report called and received prior to 0830
- ✓ Hospital staff report to nurses station for assistance
- ✓ Leadership maintain an awareness of this process



	MEASUREment	**Data Collection**
1	Minutes of Interruptions	Direct Observation
2	Medication Administration Errors	Pharmacy Count
3	Frequency of interruptions	Nurse Survey
4	Quality of Medication Instruction	Patient Satisfaction Survey

1



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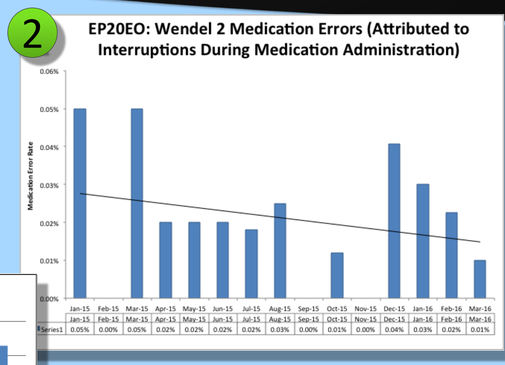

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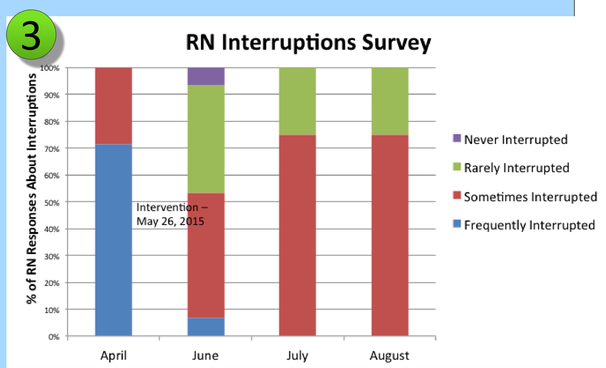

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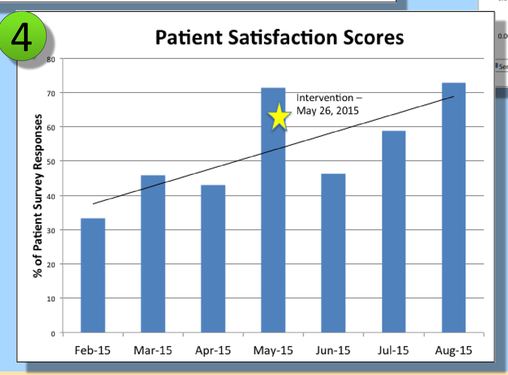

CONTROL: All metrics continue to improve (Graphs 1-4)