



SAFE MEDICATION ADMINISTRATION IN ENAYA WITH PYXIS-RUMAILAH-ESCC

Introduction

Enaya specialized care center is a long term care facility under Rumailah Hospital and is located in medical city. It was started in 2010. The Enaya Specialized Care Centre is 156 patient beds (8 units) support facility and It provides 24-hour care to long- term tracheostomy & non-tracheostomy male/female adult patients.

Background

The main issue which leads to this initiative was high incidence of medication administration and dispensing errors due to of lack of pharmacy department in the facility .The practice was the medication used to be ordered by the physician in Enaya and was collected from Rumailah hospital main pharmacy .This process was complicated and there were high chances for medication errors due to the distance of main pharmacy from facility resulting in delay in dispensing and administration of medication .

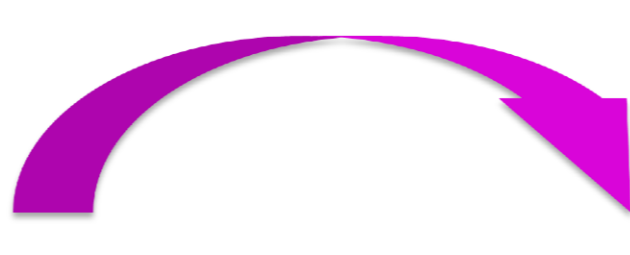
Aim

To reduce the medication error across ENAYA from 151 incidents during 2014 - 2015 to zero incident by the end of dec-2016 by using Pyxis system for medication administration .



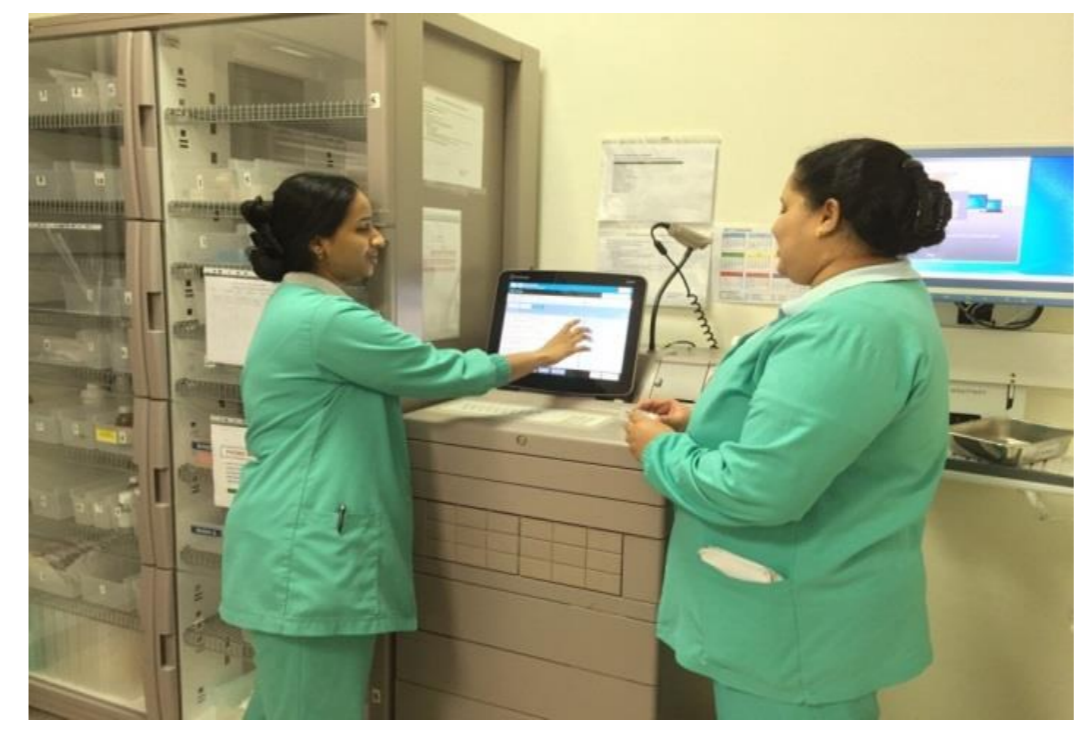
Before Pyxis

1. The incidence of medication errors was high (151 events) in 2014 - 2015 .
2. Receiving the monthly medication from main pharmacy (RH) and storing it in unit after counting the whole medication for one month.
3. Work load for the staff to refill the medication on weekly basis and counting the medication before each shift.
4. Delay in administration of emergency and stat medications.
5. Time consuming .



After Pyxis

1. The events of medication errors decreased to 26 in 2015-2016.
2. Highly configurable system management saves time and standardizes process.
3. Eases traceability and enable the limitation of access to drugs.
4. Easy availability of medication in the unit for emergency situation.
5. Improve patient safety.
6. Work flow is more centered on the patient and delivering best clinical practice.

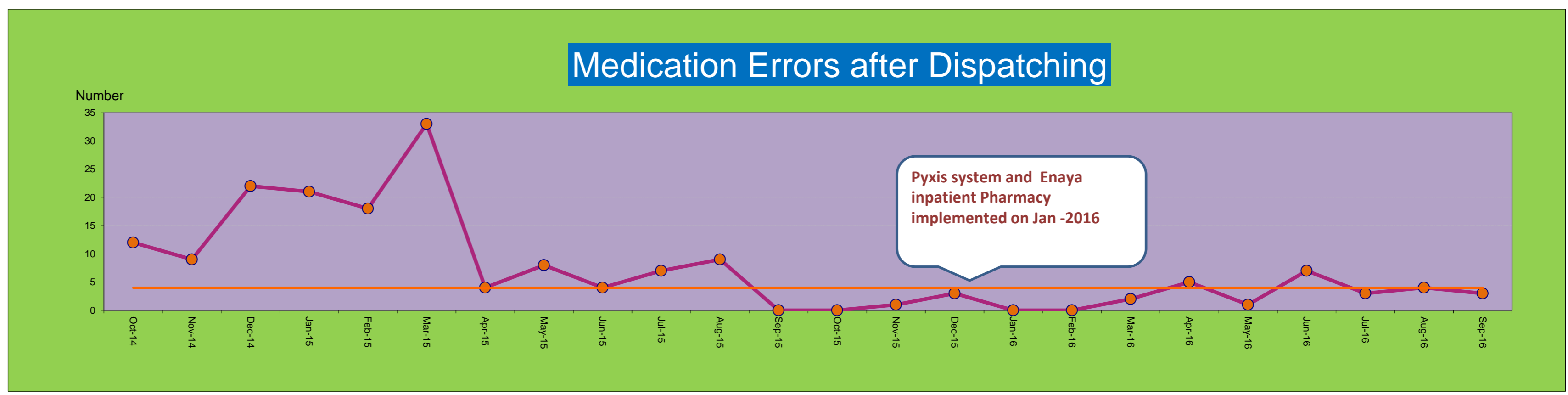


Next steps

1. Periodic observation rounds by medication committee and pharmacy lead to ensure safe medication administration and Dispensing.
2. Reinforce all the staff to read medication administration policy to improve safe procedure.
3. Arranging education and training section of Pyxis for all new staff.

References

1. Rumailah hospital clinical policy on medication management program CL 7205 .
2. Automated Dispensing cabinet policy CL6074.
3. Pyxis care fusion online training .



Method

PLAN

- Provide online Pyxis care fusion training for all staff.
- Individual finger print scanning access give to all staff .
- Annual mandatory competency validation of medication administration
- Medication administration by 2 Registered Nurses to avoid medication error.
- Pharmacy quality lead has to monitor usage of override medication and dispensary in pyxis.

DO

- All staffs completed online pyxis CareFusion training section.
- Provided individual finger print scanning access .
- Completed annual mandatory competency validation of medication administration.
- Strictly following 2 Nurses medication administration.
- Pharmacy quality lead monitoring and reporting usage of override medication and dispensary in pyxis.

ACT

Continuously monitor to improve medication administration and dispensing process and to achieve zero number of events in medication error after dispatching by the end of Sep-2016.

STUDY

Throughout the study it was identified that the medication error events after dispatching was high in administration and dispensing before the Pyxis and inpatient Pharmacy implementation.

Result

As per the data from oct-2014 to Sep-2016 showing that the medication Error after dispatching was declined from "33" Events (Mar-2015) to "0" Events (Jan and Feb 2016) and the Events are decreased on following months after the Pyxis and Inpatient Pharmacy implementation .

Conclusion

Medication error rate is inversely proportional to patient safety so we will Continuously monitor to improve medication administration process and to achieve zero percentage of incidence rate in medication error by the end of 2017



Team Members

Author: Mr. Raneesh Neelengadan,SN

Co- author:Ms. Sweta Alex,SN

Executive sponsors:
 Ms. Elizabeth Thiebe (ACEO RH)
 Dr. Abdul Aziz Darwish (MD RH)
 Dr. Amal Abousaad (AED QPS RH)
 Dr. Hanadi Khamis (Chairperson Geriatrics)
 Dr.Steven (EDON,RH)

Team Leader: Ms. Magda Attia, HN

Team Members:
 Dr. Mariam , consultant
 Dr.Amina ,Pharmacy Director,RH
 Ms.Lynne Mendonsa, DON
 Ms. Lisha Abraham ,NDS
 Ms.Rasha ,Pharmacist.
 Dr.Faiza Malik ,SQIR
 Mr. Anish Abrham,SQIR
 Ms. Simmy John,CN
 Ms. Rintu Kurian,SN
 Ms. Soumya joseph,SN
 Ms. Anu Varghese ,SN
 Ms. Bobby Mathew,SN
 All nursing staff from ESCC .