

Suggestions for presentations, of ongoing or already completed work in industry and/or academia (without a paper)

Using FRAM to analyse Medication Administration Incidents

Medication administration is one of five error-prone medication processes. The types of administration errors vary widely, with the most common types including wrong time, omissions and wrong dose. The error rates from direct observational studies range from 6 to 27% with the rate tending to be higher for the older person. In an observational study of stroke and older persons' wards, Kelley and Wright (2012) found that 817 oral doses were given incorrectly out of an observed 2129 potential drug administrations. This equates to a 38.4% error rate. The ward chosen for this study is the Cairns Hospital Older Person's ward which commenced operation on 19th November 2013 and provides 24 hour inpatient nursing care to older patients. Included in this 32 bed ward is an eleven (11) bed delirium and dementia observation area at the southern end of the unit. Medications are currently administered using a combination of paper and electronics systems. Safely administering appropriate medicines is a complicated process with many task interactions, and many opportunities for things to go right and for things to go wrong. Since 2016, the reported medication administration error rate for the ward has ranged from a low of 2 reported errors to a high of 19 reported errors per month. Using FRAM to understand the variability in everyday performance in the administration of medicines in the older person's ward will ascertain what processes are working well with a view to identifying the potential for errors. The aim of this study is to examine the processes during the administration of medicines within the OPERA ward. The study will arrive at a description of task variability and system resonance. The model will assist OPERA ward staff in developing recommendations for amplifying variability that may lead to successful performance and reduce variability that may lead to unwanted outcomes, such as medication errors.

Reference:

Kelly, J. & Wright, D. (2012). Medicine administration errors and their severity in secondary care older persons' ward: a multi-centre observational study. *Journal of Clinical Nursing*, 21, 1806-1815.