

# Medication Safety Forum



## A multidisciplinary medication safety team

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**A multidisciplinary medication safety team can help to implement the medication-related themes of a government national safety programme.**

### Introduction

In 2007, the government in The Netherlands introduced a national safety programme in health care to reduce preventable damage to patients [1]. Ten specific themes were identified as potentially high risk. Three of these were directly related to medication: the preparation and administration of parenteral medication, the prevention of contrast nephropathy, and the transfer of medication-related information.

Medical Centre Haaglanden (MCH) is a teaching hospital with two locations, one in the centre of The Hague and the other in Leidschendam. A theme owner and project leader were assigned to manage each of the 10 themes. In 2010, a medication safety team (MST) was also established. We would like to share the achievements of this team and highlight the projects that are currently ongoing.

### The medication safety team

The MST consists of a hospital pharmacist, a pharmacist, three ward managers, four (senior) nurses, and a quality and safety officer. Other clinicians have also joined the team to help with specific projects.

The team was principally assigned to identify and reduce medication errors on all wards. It was also responsible for two of the three medication-related themes of the national safety programme—the transfer of medication-related information was left to a separate body.

### Risk evaluation

Voluntary incident reports between 2007–10 indicated that 28% of incidents were errors related to medication, and that most were reported by nurses. Administration errors were the most frequently reported (49.3%), followed by prescription errors (18.6%) and transcription errors (14.2%).

Further evaluation of these incidents revealed that the methods in the administration and registration of medication were inconsistent both within wards and between wards. Consequently, in addition to its two national safety programme themes, the MST identified the following priority tasks: the administration and registration of medication on the ward in general, the prescription, administration and registration of insulin and oral anticoagulants, and the administration of medication in patients with a stomach tube or who have difficulty swallowing.

### The two national safety programme themes

In 2004, an MCH protocol on the preparation and administration of parenteral medication, consistent with the method advocated by the national programme, was introduced [2]. However, the 2010 evaluation showed that the protocol had not been followed. Hygiene was lacking and adequate checks were not in place.

A re-training session for nurses was arranged. These sessions were given frequently, with 4–10 nurses attending each session. These small groups prompted discussion and knowledge sharing about the different working methods utilised across the wards.

Each ward also received a photocard on which the nurses of that ward depicted the protocol. The teaching institute of the hospital bought an e-learning module so that the module could be repeated annually.

### Other projects and future plans

This year, the MST managed to review both the administration and registration of medication on the ward in general and the prescription, administration and registration

of insulin and oral anticoagulants on the ward. A uniform protocol has now been initiated for both and will be implemented this autumn. The administration of medication in patients with a gastric tube or who have difficulty swallowing is scheduled for 2012.

We are also planning to review how pharmacy technicians can improve medication safety on the ward, e.g. by taking over certain tasks from nurses like the preparation of parenteral medication and/or performing medication reviews with patients who are being transferred.

### Conclusion

On the whole, working with a MST is a pleasant and effective experience. Because of its multidisciplinary set-up, the team presents different perspectives on potential risks and solutions, whilst providing broad support for the hospital. In coming years, we plan to continue to evaluate risks and improve medication safety.

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