



To improve the health professionals' awareness of the risks of errors related to the medication-use system, a simulation of medication errors was created" Daupin et al (2016).

Abstract:

RATIONALE, AIMS AND OBJECTIVES: The medication-use system in hospitals is very complex. To improve the health professionals' awareness of the risks of errors related to the medication-use system, a simulation of medication errors was created. The main objective was to assess the medical, nursing and pharmacy staffs' ability to identify errors related to the medication-use system using a simulation. The secondary objective was to assess their level of satisfaction.

METHOD: This descriptive cross-sectional study was conducted in a 500-bed mother-and-child university hospital. A multidisciplinary group set up 30 situations and replicated a patient room and a care unit pharmacy. All hospital staff, including nurses, physicians, pharmacists and pharmacy technicians, was invited. Participants had to detect if a situation contained an error and fill out a response grid. They also answered a satisfaction survey.

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RESULTS: The simulation was held during 100 hours. A total of 230 professionals visited the simulation, 207 handed in a response grid and 136 answered the satisfaction survey. The participants' overall rate of correct answers was $67.5\% \pm 13.3\%$ (4073/6036). Among the least detected errors were situations involving a Y-site infusion incompatibility, an oral syringe preparation and the patient's identification. Participants mainly considered the simulation as effective in identifying incorrect practices (132/136, 97.8%) and relevant to their practice (129/136, 95.6%). Most of them (114/136; 84.4%) intended to change their practices in view of their exposure to the simulation.

CONCLUSIONS: We implemented a realistic medication-use system errors simulation in a mother-child hospital, with a wide audience. This simulation was an effective, relevant and innovative tool to raise the health care professionals' awareness of critical processes.

Reference:

Daupin, J., Atkinson, S., Bédard, P., Pelchat, V., Lebel, D. and Bussièrès, J.F. (2016) Medication errors room: a simulation to assess the medical, nursing and pharmacy staffs' ability to identify errors related to the medication-use system. *Journal of Evaluation in Clinical Practice*. May 17th. .

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