Introduction
Errors with prescribed medications may occur when the medications are prescribed, dispensed and/or administered to the patient within an inpatient or outpatient setting, and self-administered by the patient at home. The National Institute of Health cites that 7 million patients are impacted annually by preventable medication errors at a cost of approximately $21 billion dollars (National Institute of Health (NIH), 2018). During patient self-administration of medications, medication errors occur with approximately 7,000 deaths annually, and a cost of approximately 300 billion dollars (Flynn et al., 2016). The Institute for Healthcare Improvement Suggests a Model for Improvement that can support healthcare providers to lead changes that result in improvements in quality and safety for patients (Institute for Healthcare Improvement (IHI), 2018). One of the model’s first questions is, “What changes can we make that will result in improvement?” According to research by Ahrens & Wirges (2013), patients often lack knowledge regarding their prescribed medications, therefore, medication errors occur when self-administering at home.

Purpose
To educate patients regarding medication dosage, frequency, timing and duration during medication administration resulting in improved patient safety. Patient education occurring with each medication administered during the inpatient stay can support safety for patients who will be self-administering medications once discharged home.

Methods
- A quality improvement project was initiated with an initial literature search focused on patient education during medication administration.
- An evidence-based patient education approach demonstrating improved patient outcomes was identified. The “SAID the MED” approach includes the medication name, side effects, action of the medication, indication for use, and the dose required (Woolley, 2015).
- A visual presentation was developed, and presented, to educate the staff nurses on implementing the approach during medication administration. A pocket sized reference with an acronym reminder was designed and made available to the unit for use by staff during medication administration.

Findings
- Feedback from the nursing staff and unit manager was solicited following the visual presentation.
- Attendees verbally stated that they were unaware of evidence-based education approaches, such as “SAID the MED”, being applied during medication administration, and now recognized that applying such an approach would contribute to improved patient safety within the hospital setting and post-discharge.

STOP Has your nurse ‘SAID’ the MED?
S – side effects
A – action
I – indication
D – dose

References

Disclosure
Authors indicate no personal, professional, or financial relationship that would have influenced the implementation of the “SAID the MED.”