A Project of Applying PDCA cycle to Improve New Nurse Medication Error in Surgical Ward

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Purpose
Medical errors are problems in types of medical negligence. Medicine behavior is the most activating part of their work every day. When accidents happen, they affect patients’ safety, worsen patients' condition, prolong the length of days in hospital, and even result in death. The purpose of the study was to describe medical error problems and prevent new staff from abnormal medication administration.

Methods
The study used actual auditing process, abnormal analysis, and interview for new staff. Collection period was from March, 2013 to October, 2013. Investigation has shown that new nurse's administration revealed as follows: (1) lack of standard training courses (2) lack of auditing process for internal reference (3) lack of knowledge and skills in administration (4) similar medicine were placed close to each other.

Resolution
The Plan-Do-Check-Action (PDCA) cycle was applied and multiple intervention strategies implemented. Plan: (1) Hold continuing administration education, (2) case studies of abnormal medication administration events, (3) make DVDs of proper administration, (4) redesign the location of similar medicine. Do: create a auditing process for internal reference only; Check: implement new target supervising system; Action: revise operating standards of administration flowchart; Administration prompted Pictures.

Results
New nurses' administration process have made less mistakes from the 24 administration events down to 11 ones. Auditing process rate has reached 100 percent, which represented the new staff could issue medication correctly.

Conclusions
By implementation of this project, nurse should be able to amend the accuracy of general medication and elevate the safety of using medication. As a result, patients will receive a better quality of nursing share this sort of problem with other new staff.

Picture 1: A diagram showing the implementation of the PDCA cycle.