A Networkwide, Multidisciplinary Approach to Improving Perioperative Medication Safety

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The Problem:

In response to multiple quality issues for medication administration in the Operating Room, beginning in May 2011 a work group was created to assess the current processes for medication administration in the Operating Rooms and procedure areas at Lehigh Valley Hospital and Health Network.

The Team:

This group was comprised of Registered Nurses, Certified Surgical Technologists, Educators and Directors from all three operating room sites.

The Time Frame:

May 2011 to March 2012.

The Goal:

The goal of this group was to modify policy, create standard work, create an educational program and deliver the education for safe medication administration in the perioperative areas.

The Outcome:

We now have in place an effective policy, standard work, and educational resources to ensure safe medication administration practices, and an ongoing plan for education of new hires, existing staff, the anesthesia and medical staff and perioperative interns.

The Team Steps:

- Review of medication quality events
- Policy review
- Evidence-based literature search
- Setting of expectations and goals
- Review of the AORN Standards and Recommended Practices, Joint Commission National Patient Goals and Medication Management Standards
- Creation of standard work
  - Managing medications off the sterile field
  - Delivering medications to the sterile field
  - Managing medications on the sterile field
- Policy revision based on standard work
- Documentation review
- Development of audit tool
- Creation of scripting for the educational video
- Filming of the video
- Completion of a pre-education audit
- Presentation of the educational rollout
- Creating of the electronic educational competency
  - Standard work
  - Video
  - Policy review
  - Post test

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