

Safer Systems Research Program
Medication Safety Project
Capital Health & University of Alberta

Appendix A: Medication Safety Inventory

The attached **Medication Safety Inventory** was designed by a research team of nurses, physician and pharmacists* as part of a research project to strengthen the safety of medication administration in our hospital. If you are willing to take part in this research, we ask that you complete the attached inventory.

You are NOT obliged to complete this inventory. Completion of the inventory is not a condition of employment in any way. If you wish to participate, please:

- read the attached letter of information about the research;
- review **PART 1: Dictionary of Definitions**
- complete **PART 2: Medication Safety Inventory**
- return your completed inventory in the attached, addressed envelope to the Coordinator, *Safer Systems Research Program*.

By returning a completed inventory, you are consenting to take part in the research. Please do not write your name on the checklist. It should take about twenty to thirty (20 – 30) minutes to complete.

If you do complete this inventory, thank you for taking part.

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PART 1: Dictionary of Definitions*

Adverse drug event (ADE) - a patient injury that results either from 1) the administration of a particular medication, or from 2) the failure to administer an intended medication.

Adverse drug reaction (ADR) - any unexpected, unintended, undesired, or excessive response to a medication that:

- requires discontinuing the medication (therapeutic or diagnostic),
- requires changing the medication therapy,
- requires modifying the dose (except for minor dosage adjustments),
- necessitates admission to a hospital,
- prolongs stay in a health care facility,
- necessitates supportive treatment,
- significantly complicates diagnosis,
- negatively affects prognosis, or
- results in temporary or permanent harm, disability or death.

Critical incident - a human error or technology failure that could or does lead to an adverse patient outcome, if it is not discovered or corrected in time. The adverse outcomes in question range from increased length of hospital stay to death.

Error - the failure of a planned action to be completed as intended (i.e. an error of execution) or the use of a wrong plan to achieve an aim (i.e. an error of judgment).

Medication error – any preventable event that could contribute to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Errors may be related to individual practices and/or to the nature of specific health care products, procedures, and systems, including: prescribing; communication; labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and use.

Near miss - an event or situation with the potential to lead to an accident, injury or illness that is averted either by chance or by timely intervention.

Potential adverse drug event - an incident in which an error was made, but no harm occurred.

Preventability – an adverse event is preventable when measures for averting a given injury are known and the adverse event results from the failure to apply that knowledge.

**This glossary of terms is adapted from previous glossaries in R Baker & P Norton (Health Canada, 2003); Patient Safety and Healthcare Error in the Canadian Healthcare System, Appendix F. Ottawa, ON; and in L Zipperer and S Cushman (2001)(Eds.) Lessons in Patient Safety. Chicago; National Patient Safety Foundation, Appendix I*

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PART 2

For each **statement**, please **CIRCLE** the number that most closely matches your assessment of this aspect of medication safety. Thank you for taking part.

NEVER = This is not the case in my organization/program/unit (circle 1)

RARELY = (circle 2)

SOMETIMES = I think this is true at least some of the time or to some degree (circle 3)

MOST OF THE TIME = (circle 4)

ALWAYS = This is definitely the case in my organization/program/area of work (circle 5)

	<u>Never</u>				<u>Always</u>
1. On our unit, everyone on the patient care team works together to improve the safety of medication administration.	1	2	3	4	5
2. On our unit, we are treated with respect, fairness, and honesty when you report a medication error.	1	2	3	4	5
3. On our unit, patients and families are treated with respect, fairness, and honesty when a medication error occurs.	1	2	3	4	5
4. On our unit, we follow up on any concerns about medication safety by making necessary changes to practice, policies, staff training or other corrective measures as needed.	1	2	3	4	5
5. The people I work with would report any <u>near miss</u> that had the potential to affect the safety of patient care.	1	2	3	4	5
6. The people I work with would report any <u>medication error</u> that had the potential to affect the safety of patient care.	1	2	3	4	5
7. The people I work with would report any <u>adverse drug event</u> that they were aware of.	1	2	3	4	5
8. Our policies and procedures provide clear direction on how to administer medications safely.	1	2	3	4	5
9. Our policies and procedures provide clear direction on how to report any medication safety concerns.	1	2	3	4	5
10. On our unit, we chart the administration of medications according to clear policies and procedures about the drug names, routes, dosages, frequency of administration, and abbreviations.	1	2	3	4	5
11. On our unit, we follow the policies and procedures regarding medication administration.	1	2	3	4	5

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	<u>Never</u>		<u>Always</u>		
	1	2	3	4	5
12. On our unit, medication orders are written in accordance with policies about the use of drug names, routes, dosages, frequency of administration, and abbreviations.	1	2	3	4	5
13. On our unit, we transcribe medication orders according to clear policies and procedures.	1	2	3	4	5
14. The staff on our unit knows what to do when a <u>near miss</u> occurs in the administration of medications.	1	2	3	4	5
15. The staff on our unit knows what to do when a <u>medication error</u> occurs.	1	2	3	4	5
16. The staff on our unit knows what to do when an <u>adverse drug event</u> occurs.	1	2	3	4	5
17. The vast majority of staff on our unit can safely program and operate the equipment that is used to deliver medications (e.g. syringes, needles, IV administration sets, infusion pumps, needleless devices).	1	2	3	4	5
18. The vast majority of staff on our unit can safely trouble-shoot the equipment that is used to deliver medications (e.g. syringes, needles, IV administration sets, infusion pumps, needleless devices).	1	2	3	4	5
19. On our unit, we regularly participate in ongoing staff education about safe medication administration.	1	2	3	4	5
20. On our unit, we alert each other on the types of medication orders that are most likely to be associated with the occurrence of a medication error.	1	2	3	4	5
21. On our unit, we routinely discuss the factors that may be involved in near misses, medication errors and adverse events, not just after a serious incident has occurred.	1	2	3	4	5
22. On our unit, we encourage patients and families to learn about their medications during their hospital stay.	1	2	3	4	5
23. I can readily access accurate information about our patients' medical history, drug allergies and consent for blood products.	1	2	3	4	5
24. I can readily access up to date information about our patients' lab values.	1	2	3	4	5
25. I can readily access up to date information about our patients' clinical conditions and vital signs.	1	2	3	4	5

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	<u>Never</u>			<u>Always</u>	
	1	2	3	4	5
26. I can readily access up to date communication about new developments in our patients' orders for medication and other treatments.					
27. I can readily access current reference information about the medications that I administer.	1	2	3	4	5
28. We can consult with physicians, pharmacists or other professionals (eg., nurse practitioners) as needed to question or clarify medication orders.	1	2	3	4	5
29. The environment where we prepare medications for administration is clean and free of clutter.	1	2	3	4	5
30. I am able to concentrate and minimize interruptions and other distractions when I am preparing and delivering my medications.	1	2	3	4	5
31. The medication delivery systems and equipment on our unit are regularly checked to ensure that they are functioning safely and as expected.	1	2	3	4	5
32. The way that we store medications on our unit enables me to easily distinguish one medication from another.	1	2	3	4	5
33. If I could do anything else to improve medication safety on our unit, I would (please specify):					

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Sources

Frey, B, Buettiker, V, Hug, MI, Waldvogel, K, Gessler, P, Ghelfi, D, Hodler, C, & Baenzigger, O (2002). Does critical incident reporting contribute to medication error preventing? *European Journal of Pediatrics*, published online 18 September 2002, DOI 10.1007/s00431-002-1055-0.

Health Canada. *Our Health, Our Future. Creating Quality Workplaces for Canadian Nurses*. Final Report of the Canadian Nursing Advisory Committee (CNAC), August 2002. Ottawa, ON: Author.

Healthcare *Papers* 2 (1): Whole issue on Patient Safety.

Institute for Safe Medication Practices (ISMP) Medication Safety Self-Assessment Survey Tool, Canadian Version, accessed 17 July 2003 at <http://www.ismp.org/Survey/ISMPCanadaMSSA.html>

Leape, LL, Berwick, DM, & Bates, DW (2002). What practices will most improve patient safety? *JAMA* Online 288 (4), accessed 20 Sept 2002 at <http://jama-ama-assn.org/issues/v288n4/rfull/jcv20004.html>

Leape, LL, Bates, DW, Cullen, DJ, Cooper, J, Demonaco, HJ, Gallivan, T, Hallisey, R, Ives, J, Laird, N, Laffel, G, Nemeskal, R, Petersen, LA, Porter, K, Servi, D, Shea, BF, Small, SD, Sweitzer, BJ, Thompson, T, Vliet, MV; for the ADE Prevention Study Group (1995). Systems analysis of adverse drug events. *JAMA* 274 (1): 35 – 43.

Marck, PB (2000), Strengthening Integrity: Ecological Error Management for Ethical Health Care, *Provincial Health Ethics Newsletter*, 1- 2.

National Steering Committee on Patient Safety. *Building a Safer System. A National Integrated Strategy for Improving Patient Safety in Canadian Health Care*, September, 2002. Ottawa, ON: Author.

Nicklin, W (2002). Canadian Nurses' Perceptions of Patient Safety in Hospitals. *Canadian Journal of Nursing Leadership* 15 (3): 1 – 11.

Pape, TM (2001). Searching for the final answer: Factors contributing to medication administration errors. *The Journal of Continuing Education in Nursing* 32 (4): 152 – 160.

Reason, J & Hobbs A (2003). Checklist for Assessing Institutional Resilience (CAIR), in *Managing Maintenance Error*. Aldershot: Ashgate.

Sexton, JB, Helmreich, R, Pronovost, PJ, & Thomas, E (2003). Safety Climate Survey, accessed 06 May 2003 <http://www.qualityhealthcare.org/QHC/Topics/ImprovementsMethods/Measures/>

Zuzelo, PR, Inverso, T, & Linkewich, KM (2001). Content validation of the medication error worksheet. *Clinical Nurse Specialist* 15 (6): 253 – 259.