

251: REDUCING HARM TO PATIENTS BY ADVERSE DRUG EVENTS THROUGH COLLABORATIVE LEARNING

Authors:

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Objective:

The presentation describes a project aimed at reducing harm to patients by adverse drug events, by applying best practice.

Methods:

Adverse drug events – injuries caused by the use (or nonuse) of a drug – affect as many as 1.5 million hospital patients annually, at a cost of three to four billion dollars. As many as half of these adverse drug events are caused by errors and are, therefore, preventable. Improvements in medication safety results primarily from organisational and individual learning. In September 2001 the Dutch Institute for Health Care Improvement started a breakthrough project on medication safety, bringing diverse hospitals together in order to learn and reduce adverse drug events. The project ends in May 2002. The project focuses on the spread of existing knowledge and dissemination of best practices. A team of leading national experts evaluates best national and international practice in the field. Change concepts are being developed based on the established best practice.

Multidisciplinary teams working toward clear aims of reducing harm to patients by medication errors enables improvement. Multidisciplinary teams were taught to test changes on a small scale before fully implementing them, using the model of rapid cycle improvements and statistical process control. The plan-do-study-act cycle is used for testing the change concepts. The presentation will include description of teams' activities in the hospitals, support concept and results.

Results:

In 2002 multidisciplinary teams from 11 general hospitals joined a breakthrough project on reducing adverse drug events. The project focused on reducing harm to patients. Teams worked on aims and objectives varying from pain management, optimising blood glucose in patients with diabetics, correct use of intravenous antibiotics, and reducing errors in the process of medication prescription. All teams reduced adverse drug events. Final results will be available in May 2002 and will be presented at the Conference.

Conclusion:

Some medication errors are harmless, some cause injury, and some are near misses. By making the decision to focus on patient outcomes and not errors, this breakthrough project shows that it is possible to reduce harm to patients.