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

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Purpose

Medical errorsare problems in types of medical negligence.Medicine behavioristhe most activating part of worevery day.When accidentaleventshappen, they affect patients' safety, worsen patients' condition, prolong the lengthof days in hospitaland even result in death.purpose of the study was to describe medical errorproblems andprevent new staff from abnormal ication administration.

Methods

The study used actual auditing process, abnormal analysis and interviewfor new staff. collection period was from March, 2013 to October, 2013. investigation has shown that new nurse's administrationrevealed 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

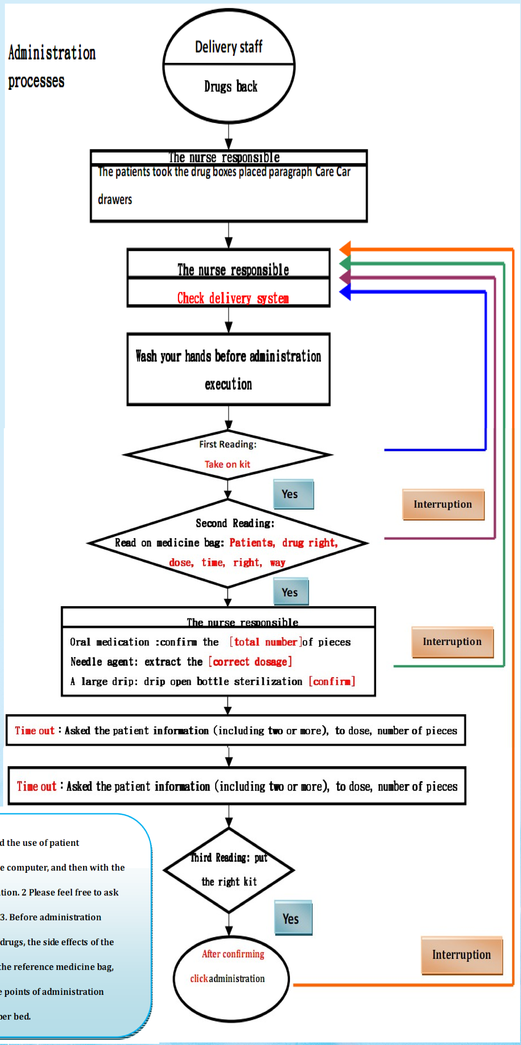
The **Plan- Do- Check- Action** (PDCA)cycle was applied and multiple intervention strategies implemented, **Plan**-(1)Hold continuing administration education (2) case studies of abnormalmedication administration events (3) make DVDs of proper administration(4) redesign the location of similar medicine;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

Results

New nurses the PDCAprocess have made less mistakes from the 24 administration events down to 11 ones. Auditing process rate has reached 100 percent, which representsthe 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.



Compassion Accountability Effectiveness