SUCCESSFUL MEDICATION SAFETY PROCESS
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Our SDS unit does not have a medication room or the ability to create one due to our physical layout. The nurses have to use a counter contiguous to the nursing station to draw up and mix medications. There were constant interruptions and distractions resulting in medication errors. One of the Joint Commission National Patient Safety Goals is to “improve the safety of using medications” and our objective was safe patient care in meeting this standard.

The objective of this project is to improve patient safety by reducing medication errors.

Following numerous meetings with staff members, we were still left without a solution. At a Central Florida OR Director’s meeting the book “Why Hospitals Should Fly” by John J Nance JD, was discussed. Our Director read and shared the book with us. There was an example given where nurses placed a red towel over their shoulder indicating they were dealing with medications. This signified no interruption unless there was a code or a fire. We believed this was a very feasible process for us; we met with our staff, purchased red towels and evaluated the process.

We had 100% staff support and implemented this process on January 26, 2010. We have had no medication errors since.

This process when used appropriately will result in a reduction of medication errors due to interruptions and distractions. We plan to continue this process throughout all of the Perianesthesia departments.