Reducing medication errors for patients with a known Penicillin allergy

Case study

Overview

A Monash Health improvement quality medical officer (IQMO) reviewed incidences of prescribed medication errors where a patient was prescribed a medication despite having a known allergy. The focus was penicillin and a staff survey was conducted demonstrating suboptimal awareness of penicillin-based medications.

Summary

The findings from a survey of medical and nursing staff found multifactorial issues that contributed to errors in prescribing and administration of penicillin-based medication to patients with a known allergy.

The major improvements included:

- a reduction in prescribing errors of penicillin to patients with a known allergy
- improved communication between pharmacists and junior medical staff.

Key changes

- Clear identification of penicillin-based medications within medication rooms
- Penicillin-based medications collocated within medication rooms
- Education provided to nursing and medical staff
- Increased awareness and knowledge of penicillin-based medications
- Weekly meetings between pharmacists and junior medical staff

What worked well

- Instigating a ‘no blame’ approach
- Conducting constructive interdisciplinary meetings
- More clearly identifying penicillin-based medication
- Collaboration between the IQMO and pharmacy staff

What could be improved

- Further embedding education with ward staff
- The pace of rollout of pharmacy meetings with all medical units

Health service involved

Monash Health

Project name

Reducing Medication Errors for Patients with a Known Penicillin Allergy

Date of completion

Ongoing

Key indicator

Number of incidents of prescribing or administration errors

Change in performance

Performance remains variable; sustained change has not yet been demonstrated

Established financial benefit

Not yet established

Patient experience

Reduced harm to patients with a known penicillin allergy

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