

Validating a proposed state-wide medication incident classification system

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Aim

To assess the correlation of responses in classifying medication incident scenarios, as part of development of a state-wide medication incident classification system (taxonomy).

Methods

Health professionals were invited to test the proposed taxonomy by classifying 10 medication incident scenarios, and to provide feedback on the taxonomy using an online survey. For each scenario, respondents selected the relevant medication management process (e.g. prescribing/charting; see Figure 1), then the incident type related to that process (e.g. wrong dose).

Responses to each scenario were analysed for correlation to other respondents and investigator classification, and other feedback was analysed according to theme.

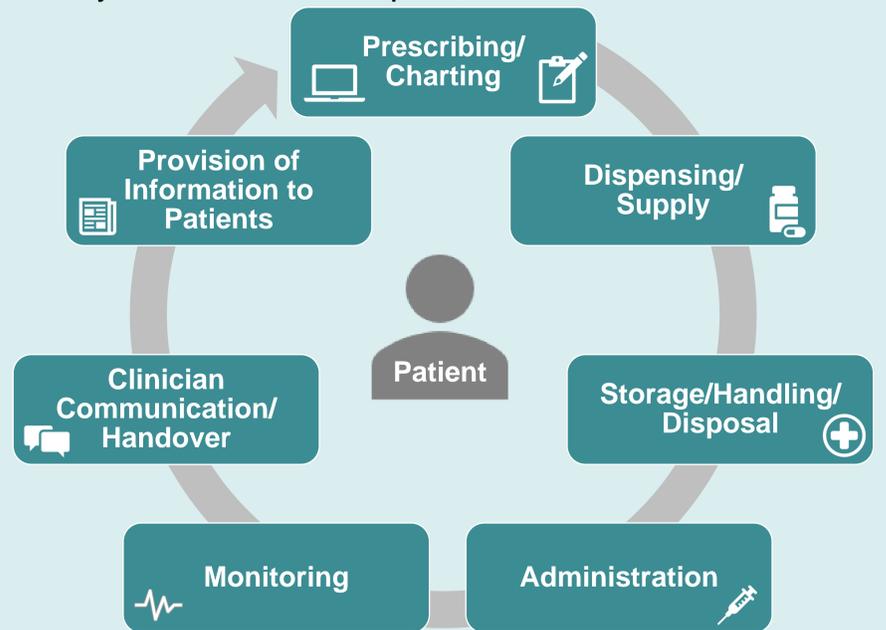


Figure 1: Medication Management Cycle (adapted from APAC Guiding Principles to Achieve Continuity in Medication Management, 2006)

Results

A total of 120 responses were received (87 complete; 33 partial) from various disciplines and roles in medication incident reporting/review.

Six of the 10 scenarios had strong response correlation, including a scenario where the wrong antibiotic was supplied for which all respondents (n=101) selected the "dispensing/supply" process and 94% (95/101) the "wrong medicine/fluid" incident type (Figure 2).

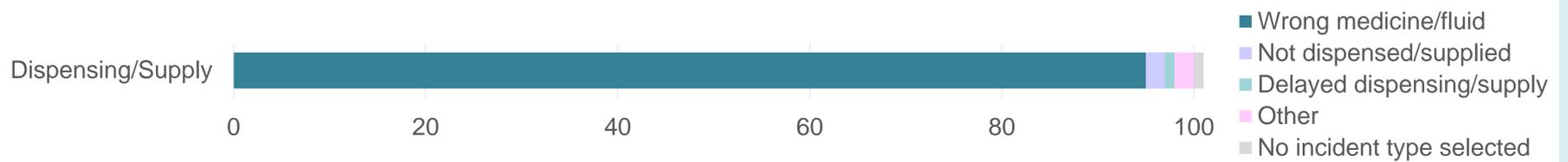


Figure 2: Results of scenario "Five vials of cefepime were sent to the ward from pharmacy instead of ceftriaxone."

Four scenarios had weak correlation of responses, requiring discussion by a working group to reach consensus and inform changes to terminology and/or incident types within the proposed taxonomy. For example, incident classification of a crushed sustained release tablet (Figure 3).

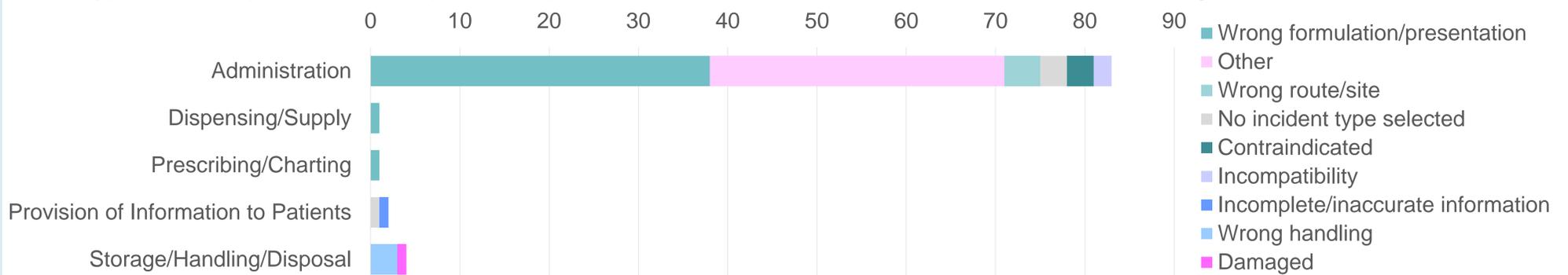


Figure 3: Results of scenario "Nocte dose of Targin 10/5mg (modified release tablet) was crushed and given to patient."

Qualitative feedback relating to the scenarios informed changes to incident types within the taxonomy, particularly for those with weak correlation of responses. For example, in the above scenario relating to a crushed tablet, the administration incident type "wrong formulation/presentation" was changed to "wrong formulation/method". General feedback relating to the proposed taxonomy included a desire to select multiple incident types, and that the taxonomy was comprehensive and easy to use.

Conclusion

Using scenario testing to refine a proposed medication incident taxonomy resulted in terminology and incident types that are intuitive for end users. This has the potential to improve consistency in classification and quality of data used for identification of patient safety issues.

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To obtain a copy of the Victorian Medication Incident Taxonomy, contact your local Therapeutics Advisory Group.

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