Promoting Safer and More Efficient Medication Administration within the Accident and Emergency Department at Georgetown Public Hospital Corporation

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Authors’ contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

ABSTRACT

Objective: The Emergency Department is a complex environment in which healthcare providers are confronted with uncontrolled and unpredictable critical patient workload. This necessitates multitasking, organization, critical thinking and clear communication. Safe practices during dispensing and administration of medications vastly reduces the potential for patient harm and decreases medication errors (Institute for Healthcare Improvement, 2008).

Design/Methods: An eight-question survey was developed to determine nurses’ perceptions of the current medication storage system. Participants were asked to identify ways in which this system could be improved and medications organized in a safer, more systematic way. Following initial data collection, all medications were rearranged to improve medication organization and retrieval. The participants were then surveyed following the intervention to ascertain feedback.

Results: 68% of participants noted that they perceived the current system to be chaotic. When asked if organizational changes might improve patient care delivery and safety, 96% responded in the affirmative. Labeling medication with both generic/ brand names and organizing them by class and alphabetically thereafter were all identified as potential options for reorganization. Following

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*Note: This paper was presented in Guyana Medical Research Conference, November 3, 2019, Organised by Arhur Chung Conference Centre, Georgetown, Guyana.
the intervention, a post-survey demonstrated that 100% of respondents remained enthusiastic about the new system approximately 9 months after implementation.

**Conclusions:** The previous medication storage system was fractured and chaotic. Systematic organization of medications by name/class improved nurses’ perceptions of medication safety and delivery while inadvertently reducing the waste of expired medications. Greater measures are needed to truly minimize the risk for a medication administration errors including targeted continuing education and implementation of an electronic medication administration system.

**Keywords:** Medication; accident; emergency department; public hospital.

**COMPETING INTERESTS**

Authors have declared that no competing interests exist.

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