Case Study of Quality Improvement in The Free Medical Clinic of DuBois, Inc.

DuBois, PA

November 2014

The 5-Point Medication Check Process

About the Clinic

Name of Clinic: The Free Medical Clinic of DuBois, Inc.

Type of Clinic: Free Clinic

Location: DuBois, PA

Year Founded: 1999

Budget: $256,000

Unduplicated patients: 397

Patient visits: 2,700

Paid staff: ~5 FTEs: 1 FT-Executive Director, 1 FT-RN, 1 FT OM, 1PT-Clerical, 1PT-SW

Volunteers: ~60

Hours Open: Mon., Wed., Thurs., Fri. 8:30-3:30, Tues. 12-8

Services: Medical consultations, diagnostic testing and procedures, vaccinations, medications, and specialty referrals

Leadership: 21-member Board of Directors; Executive Director; Clinic RN Coordinator is the Chair of the Clinic's Quality Team and reports to the Board's Quality Committee.

For further information: Darlene A. Brink, CRNP, MBA, email: dabrink@phhealthcare.org

Addendum: There are some changes that have occurred since the beginning of this project. At the onset of the project, Elvira DelaTorre was the Executive Director at the free clinic. Several months ago, she transitioned from the clinic to another opportunity and has been replaced by Darlene Brink, CRNP, MBA, the current Executive Director. Another change that has transpired was the 4 point check. The original report has been revised to a 5 point process in July 2014, with the Licensed Independent Practitioner (LIT) being more involved in the process and dispensing of medications.

Summary of Quality Improvement Project

The Problem: Confusion about medications from patients and discrepancies with medication documentation

The Approach: The clinic created a **new 5-point medication check process**. Before a medication is dispensed to a patient, it is checked (i.e., reconciled) in assorted ways by five separate stages of the dispensing process. Each medication is checked according to the 5 rights of medication administration (i.e., right patient, right drug, right dose, right route/method of administration, and right time

Free Medical Clinic of DuBois Medication/Sampling Process

1. The clinician issues an order for the medication.
2. A registered nurse prepares the medication as written following the 5 rights of medication; medication labels/warnings are printed, the medication is counted out, the medication record is documented and an audit sheet is prepared, reviewed and initialed by the preparer (Step 1: medication processed by RN).
3. The original bottle, new filled bottle, the audit sheet, the medication order, the labeling with computer generated warnings and the medication record are presented to the practitioner.
4. The practitioner reviews the label, audit sheet, medication, instructions and medication record for accuracy and the labeling is applied. The labeling, audit sheet and medication record are initialed by the practitioner as evidence of review (Step 2: Licensed Independent Practitioner (LIP) review of processed medication).
5. If not processed during a clinical visit the triage nurse reviews the medication record with the patient during registration for pick-up (Step 3: triage review of medication record with patient).
6. The samples are then disbursed to the patient by the doctor/pharmacist/CRNP/PA (Step 4: medication disbursed by LIP).
7. The patient reviews the medication(s) given for accuracy and signs for receipt (Step 5: medication received by patient in consult with LIP).

Pharmaceutical Dispensing Samples Administration PDSA in Action

The free clinic carried out Pharmaceutical Dispensing Samples Administration (PDSA) cycles for two related quality initiatives: (1) to monitor compliance with new procedures for dispensing medications referred to as a "5-point medication check" and (2) to determine the medication error rates.

Quality Improvement Initiative #1

PLAN 1: To determine compliance rate of the 5-point check process was followed for each medication dispensed at the clinic.

Do 1: The clinic performed a monthly chart review on 100% of the patients that came to the clinic from August 1, 2010 through December 31, 2011. The compliance rate started at 90%. The team decided that the compliance rate of 90% is too low, prompting the clinic to post reminders and conduct one-on-one discussions with staff/volunteers. The goal of 98% was later attained and maintained at this level from May through December of 2011. In 2012, the team decided that the goal of 98% will be maintained and the sample data were reduced to 10% and compliance was maintained at 98%. In 2013, the team increased the sample data to 20% to determine if the additional data points captured more non-compliant charts. These data revealed a compliance rate of 91% on 1 month; however the overall average still remained at 98%.

Study 1: Determine compliance rate for each check point and obtain reasons for falling compliance. Identify specific check points where compliance rates have been low.

Act 1: One identified cause of the lower than desirable compliance rate was not having enough work space to spread out the chart and medication at check-out time. In addition, some reported that they were still getting used to signing at each step. Some said that the medication record was confusing. Further discussion and revisions to the form were made. Reminder signs were posted. The 5 rights of medication administration sign was posted as well. As chart review was decreased, however, people became lax with this process. As a result, the clinic will maintain at 20% chart review.

Quality Improvement Initiative #2

Plan 2: To eliminate medication errors and minimize medication questions or issues. Because there was no benchmark in the free clinic setting, the clinic adopted a hospital medication error benchmark of 5% as advised by a board member who is also the pharmacy manager of the local hospital.

Do 2: Conduct the initial study of investigating all medication questions.

Study 2: Identify actual medication errors. Initially, issues/questions were simply categorized as documentation error, near misses, or medication errors.

Act 2: Identify if the 5-point check was performed in each case and identify at which point the failure occurred and why. It was actually noted that issues/questions were detected during one of the 5-point check. In 2013, a medication error grading system was formulated. Issues/problems were further defined in a medication error grading system, grades I-IX, as: documentation error (grades I, II), "near misses" (i.e., mistake caught before medication was taken, grade III), and medication error taken by patient (grades IV-IX). The form was piloted and further revised. The grading of medication errors remained from I-IX, however each category was further defined in more detail.

Q & A[i] with Elvie Dela Torre, Executive Director, The Free Medical Clinic of DuBois

Quality Improvement Efforts at Your Clinic

Q*: What was the impetus for initiating improvement at your clinic, and when did you first start focusing on improvement?*

A: How to make things easier and improve a process was always my rule. Formally tracking an initiative started when I decided to pursue qualifying for the FTCA medical malpractice program. The FTCA application requires that a free clinic has a formal, written quality improvement plan. Although it took me over a year to complete this task, FTCA approval materialized in January 2011. The first quality initiative was formally started in August 2010—the year before the FTCA program.

Q: How were you able to achieve staff/provider/volunteer/organizational buy-in to your QI initiative?

A: Sharing my goal of pursuing the FTCA qualification and its value with the Board of Directors prompted a retired RN Board Member to volunteer in the Quality Improvement portion of the FTCA application project. She became my advocate to the Board as well as volunteered herself to take on the task of organizing the actual data collection for the application. The monthly meetings provided active discussion and feedback from all members and a rationale for decisions with open discussion of expected outcomes. There was a willingness to review the process when a comfort level was achieved among members and staff.

Q: What are the core values driving your clinic? How important have core values been to your improvement work? How do you communicate your core values to your staff and volunteers?

A: Our mission is to provide healthcare free of charge to the eligible residents in our area. While guided by this mission, I practice certain core values that I impart to my staff: "to help our patients" and "to provide the care safely."

Q: What activities have been especially important to sustaining improvement?

A: Having a written guideline such as the 5-point medication check "cheat sheet" [When Performing the 5-Point Check] posted in the department for staff to follow was especially important. Also important were monthly meetings with the nurses, a yearly volunteer conference, the compilation of monthly statistics and studies for the Board Committees, and communication with staff/volunteers through various channels: meetings, newsletters, and one on one interaction.

Q: Was leadership important to your improvement efforts? How so?

A: The Board of Directors is important in the quality improvement. They provide the support and direction during monthly meetings. When policies are created and revised, the Board, having special knowledge and expertise, plays an important role.

With my tenure as Executive Director dating since April 1999 (FMC of DuBois started March of 1998), I have an understanding of the Clinic history, and I am able to share how/why certain processes are in place. As a result I am able to provide insight into the past while being open to new ideas.

Q: Do you have an ongoing team that leads improvement in your organization? If so, please describe who is on it, how often they meet, and the structure for initiating improvements.

A: We have a quality team (QT) that meets monthly and is composed of the Executive Director, Clinic Coordinator (Chair), and all nursing staff as well as volunteer nurses. The Quality Committee (QC), composed of the a few clinical board members, members of the QT (Ex. Dir. and Clinic Coordinator) and professionals designated to evaluate and oversee the quality initiatives, meets on a quarterly basis. A board member chairs the QC. Issues, concerns, and suggestions are presented as they arise and are needed. If warranted, further investigation is conducted and results are then discussed at the following QT meeting. Finalization depends on the scope of the problem and its impact on existing policies or procedures.

[i] Questions were taken or adapted from Houck, S. (2004). *What Works: Effective Tools and Case Studies to Improve Clinical Office Practice.* Boulder, CO: HealthPress Publishing.

Q: Have there been specific processes or ways of using resources that you have focused on?

A: We decided to focus on patient safety, and in particular, high-volume, high-risk processes. Over the years in providing services to our patients, we have realized that our free medication program has been the main appeal to our patients, who depend on this service the most.

Q: How do you track and post results or outcomes? (These include operational, clinical, satisfaction, and financial.) How do you select which metrics to use? Have you found it important to limit the number of metrics used? What metrics do you use?

A: We have an electronic medication system, KeyCentrix, since June 2002. We also have an electronic health record (EHR), DataNet, which was implemented in 2012. To date only portions of the EHR are being utilized, so we also maintain the paper chart. For the purpose of this specific quality initiative, we use chart reviews, which includes the medication form as part of paper chart and the KeyCentrix computer system. Chart reviews of all patients seen each clinic are conducted by the LIP. Results are tallied and compiled monthly.

Q: What lessons have you learned during the QI process? If you were starting your improvement work now, what would you do differently? What would you do the same way?

A: What I would have done differently is to have started this much earlier. What I would do the same is continue involving the people responsible (or directly involved in the daily process) into the quality team and quality committee. This direct involvement in the meeting reports and discussions lead to better buy-in improvement measures is implemented. We also have found that more control is achieved by the use of employed personnel and less volunteers. This also provides a more uniform process.

Q: To what do you attribute your success in your QI efforts?

A: I attribute our success to involving the key people directly involved in the process in the discussions as well as the active participation from every member in the team and committee: the Board, the staff, the volunteers all with a desire to provide the same quality of care patients receive in the private sector.

Q: What advice do you have for other clinics that are new to QI?

A: I like the NIKE slogan, "Just Do It." Don't be afraid to ask open ended questions; listen to the responses given and probe, as needed, for clarification. Use small steps when able and don't try to change everything at once.

Q: I've heard clinics say, "I don't have the time" or "I don't have the resources/staff" to do QI. What would you say to a clinic that is reluctant to start using QI?

A: I said that too. One just needs to be vocal and show your passion, and eventually someone out there with the same interest is bound to hear it and share your vision. It is safer, faster and easier to do something correctly the first time rather than having to fix something wrong. Develop the understanding that QI is exactly what it stands for…QUALITY.

Q: What are the benefits and drawbacks of engaging in a QI process?

A: One will be able to see the overall picture. You can compare outcomes and see trends over time. The greatest benefit I see is that it forces people to be more careful. QI also provides a deeper understanding of a process for all involved and a greater appreciation for the services. When someone "walks a mile in your shoes" they have a far better idea of what the job entails and are more open to suggestions. Drawbacks? Other than being perceived as being too picky and anal, it is time consuming and, at times, labor intensive. If you have an over achiever staff, one will try to accomplish too much, too fast. Take time.

Quality Improvement Initiative:
5-Point Medication Check

Q: Can you give us a "before" and "after" portrait of the problem you wanted to address? What problem(s)/barrier(s) were you trying to address? How did you decide on the problem?

A: QI Initiative #1: Before the 5-point medication check quality initiative was created and studied, questions and issues about medications were voiced by patients and staff. For example, a patient would complain in the change of the color of the pills or not having enough to last the month. Staff sometimes would get confused with the chart documentation. Sometimes there were inconsistencies with the documentation in the computer from the paper chart. Ultimately, in August 2010, the 5-point check was initiated and made a part of the Form 13-Medication Record [Problem, Medication, and Treatment Record].

Before a medication is dispensed to a patient, it is checked (i.e., reconciled) in assorted ways by 5 various stages of the dispensing process. Each medication is checked according to the 5 rights of medication administration (i.e., right patient, right drug, right dose, right route/method of administration, and right time).

Free Medical Clinic of DuBois Medication/sampling process:

1. The clinician issues an order for the medication.
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3. The original bottle, new filled bottle, the audit sheet, the medication order, the labeling with computer generated warnings and the medication record are presented to the practitioner.
4. The practitioner reviews the label, audit sheet, medication, instructions and medication record for accuracy and the labeling is applied. The labeling, audit sheet and medication record are initialed by the practitioner as evidence of review (Step 2: LIP review of processed medication).
5. If not processed during a clinical visit the triage nurse reviews the medication record with the patient during registration for pick-up (Step 3: triage review of medication record with patient).
6. The samples are then disbursed to the patient by the doctor/pharmacist/CRNP/PA (Step 4: medication disbursed by LIP).
7. The patient reviews the medication(s) given for accuracy and signs for receipt (Step 5: medication received by patient in consult with LIP).

After we created the 5-point check system, the first thing we did was to conduct a study through chart reviews to see if the 5 point checks were done. The first month revealed 88% - 95% compliance for each point check.

QI Initiative #2: In conjunction with the above, all medication issues/questions were now listed on a form and investigated by the clinic coordinator through chart review. Then, once questions were clarified, practitioners were consulted and an intervention was initiated. There was no formal follow-up. We weren't sure how often (and what type) of medication errors occurred.

Now (after the QI Initiative was adopted), a standard problem solving sheet (SPSS) is completed for every issue/question. While completing this form, it is further indicated whether the 5 point check was performed and at which point the issue/problem was detected. The findings are categorized using a grading system and the medication error rates are tracked.

Q: What aims did you set? Were they measurable?

A: QI Initiative #1: We currently aim for 98% compliance on performing the 5 point checks. We also decided that since we were new to quality improvement and had a very willing volunteer that we would review 100% of all charts instead of a sample the first year, now currently at 20%.

Regarding medication errors QI Initiative #2: We also realized that there is no benchmark for a free clinic setting, but became aware of (and adopted) a national hospital medication error rate of 5%.

Q. What was your theory (reasons) why you were experiencing this problem? What did you need to change?

A: Human error, storage conditions, unnecessary interruptions, unfamiliarity to the process and lack of attention to details are all contributors. With patient safety in mind, we wanted to eliminate medication error and reduce medication questions and issues by adhering to the 5 point check process.

Q. What did you need to change?

A: We needed to develop a measurement system for medication errors with attention to the process rather than the person. We wanted to provide tools for improvement, not blame. We:

- Started the monthly RN meeting which became the Quality Team;
- Installed half doors to decrease traffic and unnecessary interruptions;
- Posted visible procedure signs and reminders;
- Implemented structural changes in the physical layout (e.g., new medication shelving systems) and increased lighting;
- Added 1 more PC station; and
- Purchased a pill counter.

Q: Who was involved in the QI process? Who were the key players? Was leadership important? How so?

A: The RN coordinator acts as the chair of the Quality Team (QT) as her job role includes managing the RN medication schedule, as well as receiving all the medication questions. Members of the QT are the medication nurses, all staff RNs, volunteers RN, 1 clerical staff member and the Executive Director (ED).

Initially, the ED acts as the main driver and script writer, laying the ground and identifying the key

participants. The ED sits in the monthly meeting to provide support and guidance. This committee reports to the QC, which is chaired by a Board member who in turn reports to the Board of Directors. Members of the QC include the ED, Medical Director, President, a staff CRNP, and a clerical staff member. Leadership offered support in providing other knowledge especially from the hospitals where they work. For example, since we were not able to obtain a benchmark from the free clinic, our Board member who works at the hospital provided us the medication error rate in the hospital setting as a basis of comparison.

Q: What tools/templates/worksheets/diagrams/instruments/charts/data/metrics did you use in your improvement efforts (in each of the PDSA stages)?

A: We carried out PDSA cycles for two related quality initiatives: (1) to monitor compliance with new procedures (i.e., a 5 point check) established for dispensing medications and (2) to determine the medication error rates.

Quality Improvement Initiative #1

Plan 1: To ensure that the 5 point check was followed for each medication dispensed at the clinic at an average compliance rate of 98%.

Do 1: We performed a monthly chart review on 100% of the patients that came to the clinic from August 1, 2010 through December 31, 2011. The compliance rate started at 90%, so we posted reminders and had one-on-one discussions with staff/volunteers. Our goal of 98% was later attained and maintained at this level from May through December of 2011. In 2012, the sample data were reduced to 10% and compliance was maintained at 98%. In 2013, we increased the sample data to 20% just to see if they capture more non-compliant charts. This revealed a drop in compliance to 95%. The specific form reviewed is Form 13-Medication Record where each step is initialed by each person checking. A daily tally form is utilized where a total count of charts is noted and 10% number is calculated. The 10% charts are then pulled and listed on this same sheet.

Study 1: Determine compliance rate for each check point and obtain reasons for falling compliance. Identify specific check points where compliance rates have been low. The data from the tally sheet (mentioned above) are then entered into an Excel spreadsheet, which already has formulas and calculations imbedded in the template so that once data are entered, compliance rates with the 5-point check and medication error rates are generated immediately and automatically at the end of the report.

Act 1: One cause of the lower than predicted compliance rate was not having enough work space to spread out the chart and medication at check-out time. In addition, some reported that they were still getting used to signing at each step. Some said that the form was confusing. Further discussion and revisions were made. Reminder signs were posted. The 5 rights of medication administration sign was posted as well. As chart review was decreased, people became lax in this process. We will maintain at 20% chart review.

The medication record has been revised multiple times. Use of this form has changed as well. It started out that the form simply listed the medications processed now, but staff now indicates their checks on the same form. We learned that patients don't always pick up their medication on the days it is processed, so we added an additional pick-up date. Another column entry was added to the form to accommodate the situation when the practitioner decides to adjust the medication.

Plan 2: To eliminate medication errors and minimize medication questions or issues. Because there was no benchmark in the free clinic setting, we adopted a hospital medication error benchmark of 5%.

Do 2: Conduct the initial study of investigating all medication questions. This started with simply writing the issue on a blank sheet of paper with the name and date. This has evolved into a formal form called the SPSS form. This form is initialed by staff.

Study 2: Identify actual medication errors. Later the issues/problem was further defined in a medication error grading system, grades I-IX, as: documentation error (grades I, II), "near misses" (i.e., mistake caught before medication was taken, grade III), and medication error taken by patient (grades IV-IX). The SPSS forms will further be completed through the investigation.

Act 2: Identify if the five point check was performed in each case and identify at which point the failure occurred and why. In 2013, a medication error grading system was formulated. The form was piloted and further revised. The grading of medication errors ranges from I-IX, with actual medication errors beginning at grade IV and continuing through grade IX. The 5-point check investigation will be documented on the SPSS form.

Forms used: Medication log form, statistic tallying forms, medication issues log form, excel spreadsheet reports, five point check reminder sign (i.e., 5 rights in medication administration), Standard Problem Solving Sheet (SPSS) form, and SPSS grading system.

The most useful forms were the Medication record

and the SPSS and grading system forms. The medication record form served as a guided step for everyone to follow along until medication is given to the patient. The SPSS form affords a more uniform way of documenting the chart investigation. The grading system determines the strength or intensity of the issue/error and makes the result measurable.

Q: What did you propose to do (want to change) to address the problem?

A: The main goal was to eliminate medication error and minimize medication issues. The first step was for the member of staff to be aware of the problem so discrete steps were created through the point checks.

Q: How did you go about testing the change(s)?

A: We have tested (and revised) several features (e.g., forms, sampling strategy) of the 5 point check program. For example, we have revised the medication record form several times. The nurses tried the form, resulting in clarifications and suggestions for refinement. The staff also decided to post the five point check reminder sign "5 Rights of Medication Administration" at each existing check point, prompting opportunities for conducting the checks.

The Standard Problem Solving Sheet (SPSS) form also was revised to tailor to our process and set-up. The SPSS Grading System, a 9 graded identification of medication errors, was established through trial and error since we had to create it from scratch. The idea for the Grading System came from a hospital board member based on his experience with a "Harm Score Key" form.

Q: What were the results of your intervention?

A: During 2012 our compliance goal of 98% was maintained, and we subsequently reduced our review of medical charts to 10%. In 2013 the QT decided to increase the sampling of charts to 20%. With the additional data, the compliance rate dropped to 95%, prompting us to maintain the chart review at 20%.

Along the way, the team noticed that medication questions/issues were captured at one of the 5 point checks, enabling us to catch "near misses": mistakes corrected before reaching the patient. This was a desirable outcome the team did not expect. The biggest surprise was realizing how low our medication error rate is compared to national error rates (see Table 1). We are in the early stages of utilizing the grading system.

Table 1. Medication Error Results According to SPSS Grading System

Year	Error Rate % (Grades IV-IX)	Near Misses %	Documentation Error Grades (I-II)
2011	0.52	0.23	0.11
2012	0.55	0.15	0.28
2013	0.006	0.008	0.036

Q: How did you spread the change?

A: We have made changes to documents, written policies and procedures, and our infrastructure in order to establish permanency. These include: printing the last prescription for continued orders from the electronic records when possible (rather than hand rewriting) for the practitioner to sign when refills run out; reassigning old/last prescriptions so that the old prescription is no longer listed on the current list; requiring all RNs who enter information into the computer to read all completed SPSS forms so that they become familiarized with common process mistakes; discussing all mistakes face-to-face between the Clinic Coordination and the individual making the mistake; limiting access to the medication storage room during clinic hours by creating half-door access to lessen interruptions; installing medication shelving to help prevent pulling the wrong medication; and purchasing a roll-cart to afford a bigger table area when checking-out patients and reviewing each medication.

Q: What have been the implications of your QI initiative(s)?

A: Tracking the medication dispensing process has made us more aware of medication issues and has increased the attentiveness of nurses in processing and appropriately documenting medications. This method has been very helpful in a setting where volunteers are utilized in such an important process. The goal of patient safety is attainable despite the utilization of Registered Nurses in the absence of Pharmacists. Most of the changes are discussed, and welcomed by the group.

Questions in boldface taken or adapted from ***What Works: Effective Tools and Case Studies to Improve Clinical Office Practice.***

Standard Problem Solving Sheet

Puller	Computer RN	RN med check out	Pt pick-up check	Record Review	GRADE: refer to list I,II,III,IV,V,VI,VII,VIII,IX

MRN#: 1234 Issued by: staff Date: 2/19/2013

Forwarded to: GRADE: II

Step 1: Recognize Problem

What is the problem? Problem description:

Problem statement:

Discrepancy in Rx label vs Signed Script.

Detailed Description:

Signed Rx reads: 2 Mon & Fri; 1 other days. Rx # 26641 label reads: Take 2 PO on Mon & Fri, one tab every other days

Step 3 & 4: Planning + Carrying Out

Which measures were taken to solve the problem?

What	Who	When
1] Call to patient - clarified how med is being taken. Dose corrected	PD	2/22/2013
2] Clarified Rx Key to read on other days - deleted word "every"	PD	2/22/2013

Step 2: Finding Causes

Containment Measure:

Why? filling RN typed in Rx Key "on other day"

Why? Rx key changed to "every other day"

Why? Unknown why Rx key deleted the word "on"

Why? Staff forgot or unaware of the automatic short cut Sig

Why?

Data Collection: Data sheet Finding

Causes: 5 Why's/Brainstorming

Step 5: Checking

How can further occurrences of this problem be prevented?	Outlook
1] Recheck phrasing prior to printing label	
2] Med Check out nurse - compare Rx to label	
3] Remind/reeducate staff of the list of the automatic shortcut Sig programmed in the system	
4] Have all RNs involved review SPSS forms monthly	

Done: **Date:**

Status: Problem Recognized; Causes determined and written down; Measures taken and problem put down; A further Occurrence is not expected

Outlook: Choose Symbol:

Quality team resolution: **Date:** March 15, 2013: It was decided to tada tada tada .....

BLANK SPSS FORM.xls

Standard Problem Solving Sheet Grading System

The SPSS will use a grading system as follows:

Grade:

I	Documentation/Clarification only. Absence or omission of appropriate documentation. (ex: forgot to write in refill #, forgot to initial form).
II	Documentation/No patient involvement. Discrepancies in documentation. Conflicting orders or information.
III	Near miss. Inconsistency in any of the 5 Rights of Medication Administration. Discrepancy has been corrected prior to leaving the premises.
IV	Error occurs when a medication change order is missed and patient continued on with old orders.
V	Error with incorrect labeling that reached the patient however patient was taking it correctly (as prescribed).
VI	Error which reached the patient and left the premises with incorrect labeling or medication, patient taking as labeled (not as prescribed) with no harm to the patient.
VII	Error which reached the patient and left the premises with incorrect labeling or medication with adverse effects requiring medical intervention.
VIII	Error which reached the patient and had left the premises with incorrect labeling or medication with reversible damage to the patients health.
IX	Error which reached the patient and left the premises with incorrect labeling or medication with irreversible damage to the patients health.

An actual "med error" begins with SPSS Grade IV

RN/QT meeting: 4/10/2013
Approved/Updated: 6/11/2013; 7/10/13; 8/14/13

Appendix B. QA Med Process

FREE MEDICAL CLINIC, INC.

SPSS forms

QA MED PROCESS documentation Month / Yr: Aug-13

Clinic Date	Total Patients Seen	20% of Patients seen	Helper / Puller init.	Computer RN init	check-out RN init	Patient pick-up init	TOTALS	Comments
6-Aug	32	7	7	7	7	7		
13-Aug	48	10	9	9	9	9		
20-Aug	49	10	10	10	10	10		
27-Aug	34	10	10	10	10	10		
							0	
OTALS	**163**	**37**	**36**	**36**	**36**	**36**	**Avg**	**MED PROCESS GOAL**
20%		33	97%	97%	97%	97%	**97%**	98%

Clinic Date	Total Patients Seen	10% of Patients seen	Helper / Puller init.	Computer RN init	check-out RN init	Patient pick-up init	AVERAGE	Comments
January	207	24	100%	100%	100%	96%	99%	
Februar	179	20	95%	95%	95%	80%	91%	
March	190	35	97%	97%	91%	89%	94%	
April	204	39	97%	95%	97%	92%	96%	
May	175	31	100%	97%	100%	100%	99%	
June	171	38	100%	100%	100%	100%	100%	
July	189	38	95%	95%	100%	100%	97%	
August	163	37	97%	97%	97%	97%	97%	
OTALS	**1478**	**262**	**98%**	**97%**	**98%**	**94%**	**Avg 97%**	

Medication Issues/questions

TOTAL # OF IN-HOUSE MEDS	# Others (i.e. documentation)	% Others (i.e. documentation)	# Near misses	% Near misses / total in-house meds	# Med Error	% Med error / total in-house meds
514	0	0%	1	0%	2	0.39%

NEW 4 Point check; QA measure rept 2013.xls

Appendix C. Performing the 5-Point Check

WHEN PERFORMING THE 5 POINT CHECK

Please consider the 5 Rights of Medication Administration

Right Patient

Right Drug

Right Dose

Right Route

Right Time

15