The impact of using total quality management methodology for organization medication safety

Fatima Yousef Ali Ghethan

Head of Quality and Medication safety Department, King Abdullah Medical College, Saudi Arabia

Abstract

The Institute of Medicine's (IOM) first Quality Chasm report, To Err Is Human: Building a Safer Health System,1 stated that medication-related errors (a subset of medical error) were a significant cause of morbidity and mortality; they accounted "for one out of every 131 outpatient deaths, and one out of 854 inpatient deaths. Medication errors were estimated to account for more than 7,000 deaths annually.

1. Building on this work and previous IOM reports, the IOM put forth a report in 2007 on medication safety, Preventing Medication Errors.

2. This report emphasized the importance of severely reducing medication errors, improving communication with patients, continually monitoring for errors, providing clinicians with decision-support and information tools, and improving and standardizing medication labeling and drug-related information.

Whereas one of the predominant causes of medication errors is a drug administration error, a previous study related to our investigations and reviews estimated that the incidences of medication errors constituted 6.7 out of 100 administrated medication doses. Therefore, we aimed by using six sigma approach to propose a way that reduces these errors to become less than 1 out of 100 administrated medication doses by improving healthcare professional education and clearer handwritten prescriptions.

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Biography:

Fatima Yousef Ali Ghetha, Master degree pharmacology Head of Quality and Medication safety Department King Abdullah Medical City, Certified Medication Safety Officer from AIHQ USA, Certified key Performance Indicator Professional From KPI Institute Australia, Certified key Performance Indicator Practitioner From KPI Institute Australia, certificate Patient safety Program John's Hopkins..

Publication of Speakers:

1. Institute of Medicine. To err is human: building a safer health system. Washington, DC: National Academy Press; 1999

2. Institute of Medicine. Preventing medication errors. Washington, DC: National Academy Press; 2007

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