Medication Safety:
Protecting Patients and Staff

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Objective

To decrease risk of medication errors at Iowa Specialty Hospitals. At the same time, we wanted the staff to feel safer about the medications they are administering without adding extra cost to the process.

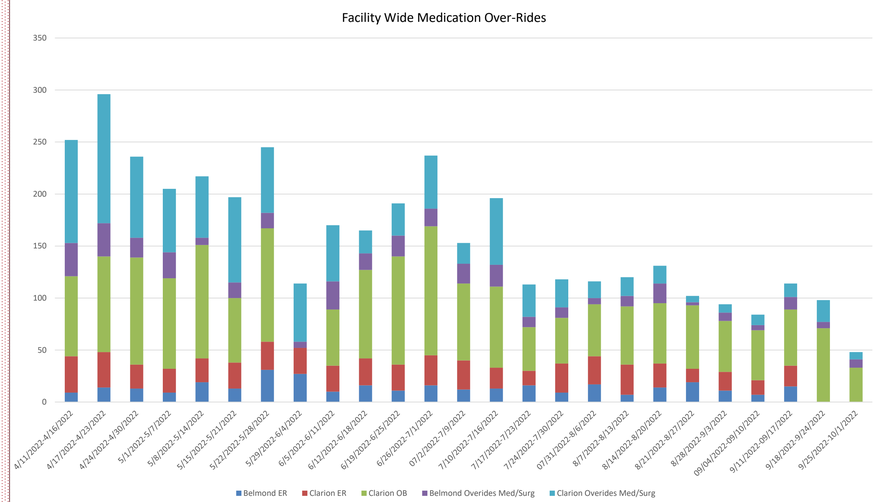
Background

Recently, there has been much publicity around medication errors and resulting injuries and deaths, as well as prosecution of staff. Upon initial review of our system, there were noted vulnerabilities and opportunities to apply already in place safety features to the process.

Analysis

1. Take a closer look at the at the medications being over-ridden at Omnicell by pulling a list medications and digging into why need for over-ride
2. Start looking at medication scanning scores to see where the errors lie. For example: Are medications able to be scanned?
3. Track errors from medications put into rooms where they are skipping the double check of the Omnicell.

Metrics



Actions Taken

1. Weekly meeting set up with Quality, Pharmacy, Nurse Leaders, and Informatics
2. Pharmacy worked on formulary and reduced unused meds and increased frequently used medications in Omnicell.
3. Put a system in place for notifying pharmacy when a medication is not scannable and educated staff.
4. Pulled reports on overrides and reduced the problems specific to each department that caused the overrides.
5. Took medications out of all patient rooms starting July 1st.
6. Worked with staff on any concerns that arose since medications were removed.

Next Steps

Pull reports weekly for over-rides watching for trends and changeable processes. Continue to use process in place to report medications that are not able to be scanned. Continuous education to the staff on safety features in place.

Goal: By next year we will have minimized all over-rides to only emergent situations and will have medication scanning >95% throughout all hospital areas.

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