New Process to Reduce Medical Errors at the Bedside

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Objectives

• Identify opportunities for improvement through daily multidisciplinary Huddles
• Improving communication and teamwork
• Decreasing Medication errors through improved process measures
Our Common Thread

- Good Mix of Nurse Experience Levels
- Minimal Changes in Processes and Documentation (except for EHR) in Last 10 years
- Spring of 2012 Brings Fresh Ideas
  - Rollout of HEN Concept and Expectations
  - HUDDLES Initiation - What is it? How do we use it? What is our process?
Positive Team Building

- Building the Huddle Board
- Continuous Conversations in Building Process
- Mercy Huddles Certification Class
- Skills Check Off
- Multidisciplinary Attendance
- Past Experiences and Site Visits by CEO/CNO

Successful Huddles

- **Rapid Cycle Improvement**
  - 1st Huddle was done October 8th, 2012
  - 13 Improvement Opportunities in 1st Week
  - 72 Improvement Opportunities since 1st Huddle
  - 27 Process Change Alerts Implemented since 1st Huddle
  - 12 Patient Safety Alerts Implemented since 1st Huddle
  - Teach Back Documentation was 1st Matrix on Huddle
  - TB was 49% for October, 2012 and is 94% for February, 2013

- **Staff Engagement & Fun**
  - Variety of Huddle Leaders
  - Large Amount of Time Spent on Celebrations
  - Goofy Reflections and “Word of the Day”-Do you know what “SWIVIT” Means?
Adverse Drug Event

- Everything looks good

INR > 5

- Why no ADE if we have elevated INR’s?
- Case Studies
- Findings
Glucose < 50

- Looks good again... No problem here!
- Looking at the whole picture

Medication Errors

- Improving Medication errors
- Looking at trends
- Chasing my tail
- Thank God for Huddle
Standard Work Audit of Medication Errors

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Identifying Causes Building Trust

- Accountability and Transparency can be tough
- Learning a new culture
- Breaking down walls that miscommunication had built
Types and Causes Found

- Standard work audit
- Team review of errors
- Staff survey on medication administration process
- Technology investigation

Technology Drill Down

- Computer on Wheels
- Bedside Scanning
Technology Drill Down

- Medication dispensing system
- Order entry errors

Order Entry Drill Down

- Cause: Order Entry
- Steps in order entry identified
- Tracked where errors occurred
Medication Administration

- Cartless, fully interfaced
- Medications scanned at AMDS and bedside
- CPOE is on the horizon
- New policies on administration & ordering
- High risk meds require hard stop 2X check
- Pain meds & anxiolytics timed responses
- ER take home packs, compliant with regs

Education and Support

- Vendors did initial training
- Training manual, cheat book developed
- Proficiency exams with pharmacist follow up
- New leaders, new vision for achievement
- Improved interdisciplinary collaboration
- Skills fair, protocols, policies, intranet page, RPh working 1:1, monitoring activities
Sustainability

• Skills Fairs
• Onboarding new staff
• Refining policies differentiating what works
• Goal for FY2014 med errors less than 0.09%
• Continually developing improving protocols

Happy Trails