BLITZ

Caboolture Public Hospital

Presenter: Timothy Dunn, Director of Pharmacy

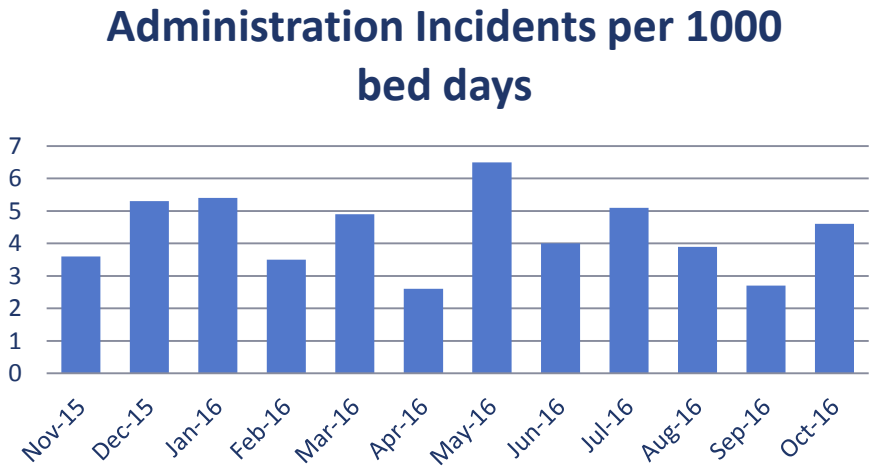
HRT 1713 'B14 - Medication Improvement'

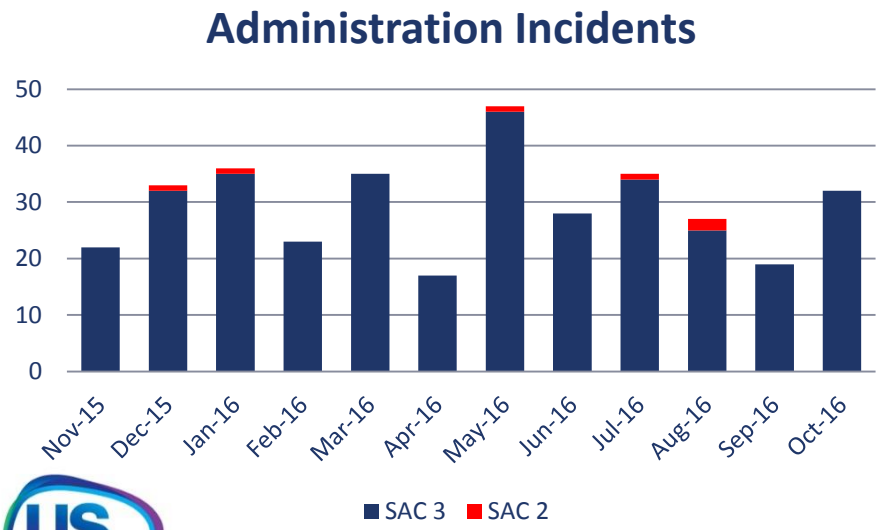
21 & 22 June 2017

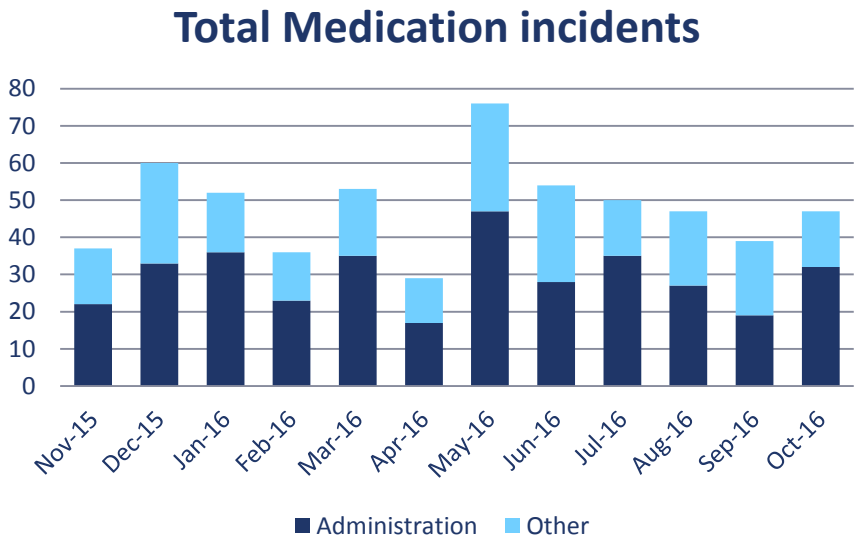
Brisbane

Key Problem

- PRIME reporting, administration errors accounted = approximately 50% of all reported medication related clinical incidents.







Aim of this innovation

- PRIME reported medication related incidents -> Medication Safety Sub-Committee, Medication Management Committee and Service Improvement Groups.
- Said Committees:
  - “identify triggers, risks, environmental factors, work flow issues and human errors impacting on safe medication administration”
  - “implement strategies to address any prevalent issues”
- REDUCE PREVALENCE OF MEDICATION INCIDENTS, SPECIFICALLY THOSE RELATING TO THE ADMINISTRATION OF MEDICATIONS

Methodology

- **BLITZ** – **bi-directional learning incidents towards zero (omg)**
- Strategically place Nurse Educators (3months) - undertake observational audits and provide real time education to nurses during medication rounds.
  - Developed standardised audit tool
  - Created nurse educator roster, matching up with individuals on shift to ensure as many staff captured as possible
  - Spoke about the reason for the process – “real time feedback exercise” with staff prior to commencing audits (ward meetings)
  - Attended unit at morning medication – full medication round with each RN
  - Follow up with staff who required multiple prompts/high level of support during audit -> resident Nurse Educator

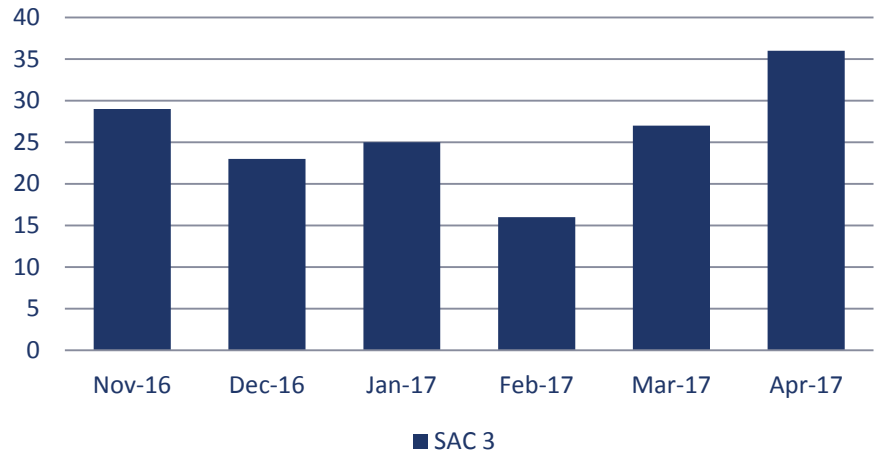
Key Changes Implemented

- System/process deficiencies
  - Overcrowded medication rooms during peak administration time –> ward remodelling
  - Lack of hardcopy MIMs
  - Lack of injection trays
  - ANTT breach – lack of injection trays at bedside
  - Documentation – Withheld symbol (W without a circle) mistaken for initialling as administered
  - Multiple locations for medications / no restocking at the bedside mean several interruptions to administration –> change in workflows
  - Prescribing errors noted corrected prior to administration, but no incident report –> copy of medication charts prior to correction for feedback to medical teams.

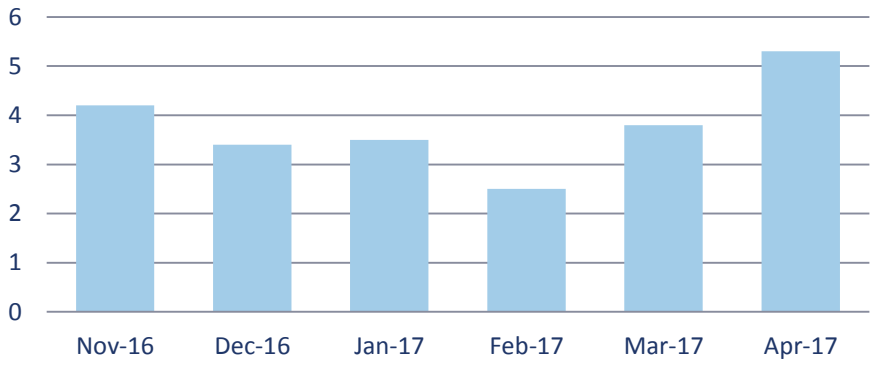

Important
UNGRY?
NGRY?
ATE?
ONELY?
IRED?
ADDITIVE LABELS
TOPICAL LOTIONS

Post implementation results

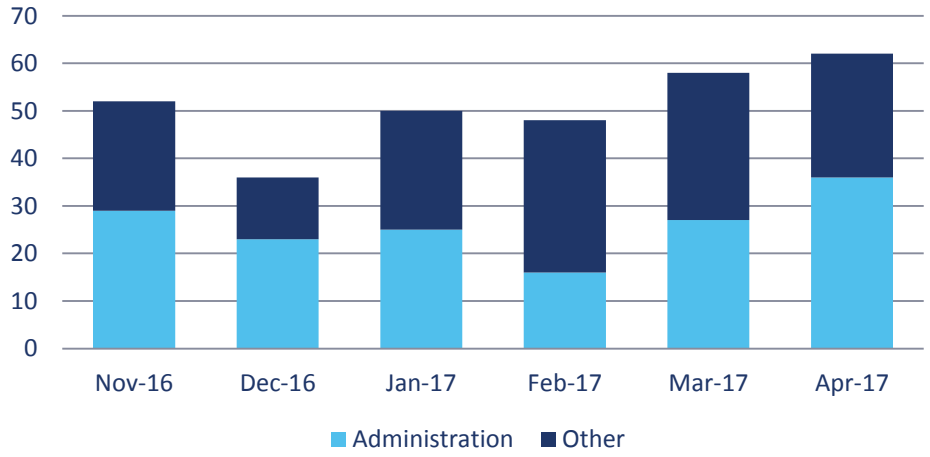
Administration Incidents



Administration Incidents per 1000 bed days



Total Medication incidents



Outcomes so far

- Prime medication administration incidents 12 month period prior - average 4.3 medication administration clinical incidents/1,000 bed days (29.5 administration errors a month)
- The observational audit was carried out in November 2016 to January 2017.
- Prime medication administration incidents November 2016 to April 2017 - average 3.8 medication administration errors /1,000 bed days. (26 per month)
- ??Reporting culture enhancement – we think so!
- Mature discussion/Whole of system perspective
  - Bring i.Pharmacy into our reporting (prescribing errors/interventions)
  - Mandate Prime entry in Pharmacy for PINCH medications/ADR interventions/wrong patient interventions

Lessons Learnt

- Many ward nursing staff who initially thought this initiative was punitive, were grateful for the feedback and found it a worthy educational process.
- Unexpected benefit (Anecdotal) - nurses feel more comfortable approaching the medical staff with requests for improving the orders, as the momentum of several staff asking for rewrites made it a more ‘normal’ process.

- For more information Contact: Tim Dunn, Director of Pharmacy, CABH
- Tel: 07 54338661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