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Increasing Bedside Medication Safety in an Intensive Care Setting

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Increasing Bedside Medication Safety in an Intensive Care Setting

Last Updated: 1/18/2018

Maine Medical Center
MaineHealth

Executive Sponsor: Jon Archibald and Mark Parker **Facilitator:** Natasha Stankiewicz, Stephen Tyzik, Suneela Nayak, Ruth Hanselman and Amy Sparks

Team Members: Natasha Stankiewicz and SCU2 Staff

Plan

Problem/Impact Statement:

The convenience of having certain medications directly available at bedside has long been a priority for our medical intensive care nursing team. There was a lack of awareness and interest in securing medications within the department. However, the risk to our patients, families, visitors and colleagues when medications are left out, available and unsecured was apparent to new staff and leadership. Prior to our education, the accepted practice of unsecured medications was rampant: medications were left drawn up or exposed, sitting in various open areas at bedside or within the room, in clinician's pockets, and often transferred from one clinician to another during shift handoff.

Scope:

Medication safety practices for SCU 2

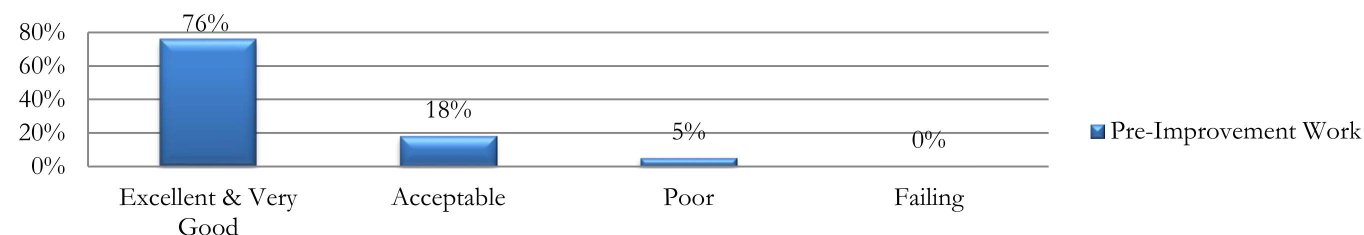
Goals/Objectives:

- Increase team's awareness of safe medication practices
- Decrease safety risk for team & visitors, including: family members, friends, children, people w/ developmental, psychiatric and/or substance abuse history
- Decrease the potential for interference w/meds, people in & out of rooms
- Increase the perception of being superior practitioners when we demonstrate safe behaviors
- Increase adherence to safety policies
- Changes are not contingent upon budgetary constraints

Baseline Metrics/Current State:

Question	Baseline	Bench
We have patient safety problems in this unit. (A17R)	52%	65%
We are actively doing things to improve patient safety. (A6)	90%	84%
Mistakes have led to positive changes here. (A9)	60%	64%
After we make changes to improve patient safety, we evaluate their effectiveness. (A13)	73%	70%
In this unit, we discuss ways to prevent errors from happening again. (C5)	76%	75%
Hospital management provides a work climate that promotes patient safety. (F1)	76%	81%
The actions of hospital management show that patient safety is a top priority. (F8)	65%	76%
Hospital management seems interested in patient safety only after an adverse event happens. (F9R)	47%	61%

SCU 2 Overall Grade on Patient Safety



Root Cause Analysis:

- Meds taken out of the Pyxis™ medication dispensing system early in the shift, then used as needed, or kept at bedside or in pocket "just in case"
- Felt not having meds "readily available" was a patient safety risk
- Left meds unsecured at bedside – drawn up, open or in original packaging
- Meds not routinely wasted in real time; meds kept unsecured until change of shift
- Felt using multi-dose vials repeatedly was fiscally responsible
- Passed meds from one caregiver to another without sign off (additional legal concerns)
- Staff may have feared reporting discrepancies, hazards & errors due to perceived penalties

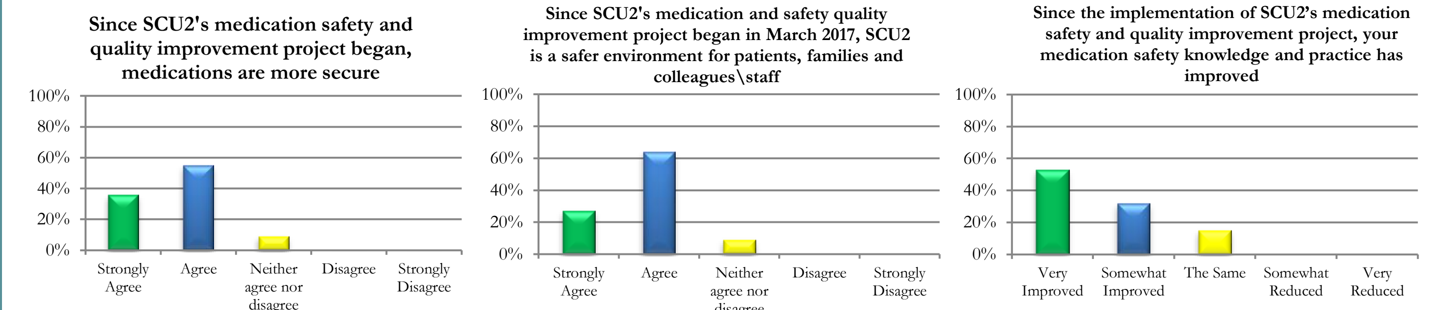
Do

Countermeasures

Action	Owner	Completion Date	Status
Increased education & awareness of medication safety & diversional practices: • Staff meetings/discussions • In-person & virtual presentations • TRIP sheet, PowerPoint® presentations, reminders & articles posted	Natasha Stankiewicz	Spring 2017	Completed
Instituted a safety KPI which read that 100% of SCU 2 staff will have reviewed and understood the following regarding our medication safety quality improvement project: • "Building a Healthier SCU 2 community" PP • "Diversion in Healthcare PP" • "The TRIP sheet on SCU 2 med safety project and initial when done	SCU 2	March – April 2017	Completed
Instituted a safety KPI which read that 100% of the time meds will be secured, no meds left at the bedside	SCU 2	April 2017 – July 2017	Completed
Post-education: • Improved Pyxis™ machines purchased & placed within units • Improved audits • MMC hired a diversion specialist to educate, provide surveillance and generate data	Natasha Stankiewicz	Fall 2017	Completed

Study

Outcomes



Question	Baseline	Current	Bench
We have patient safety problems in this unit. (A17R)	52%	64%	65%
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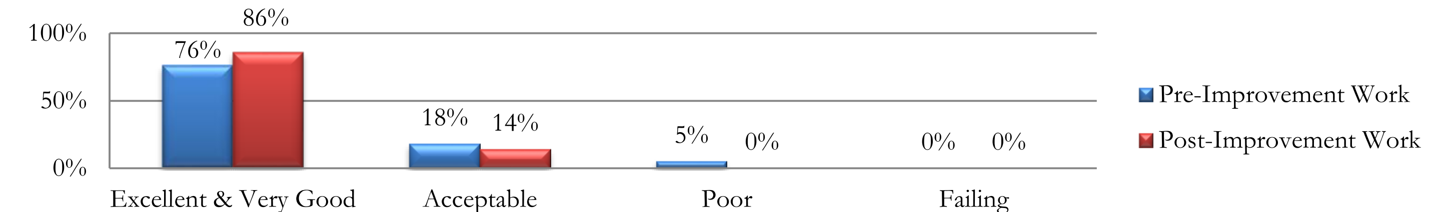
Mistakes have led to positive changes here. (A9)	60%	64%	64%
In this unit, we discuss ways to prevent errors from happening again. (C5)	76%	96%	75%
Hospital management provides a work climate that promotes patient safety. (F1)	76%	91%	81%
Hospital management seems interested in patient safety only after an adverse event happens. (F9R)	47%	27%	61%

SCU 2 Overall Grade on Patient Safety



Act

Next Steps

- Build on SCU2's understanding of recent research & recommendations
- Continue improved medication handling practices to ensure a culture of safety
- Further increase the perception of safety by staff, patients & visitors
- Potentially advance Maine Medical Center's ability to become the hospital of choice