Medication Safety-Bar Code Medication Administration

Providence Medical Center (PMC) Wayne, NE

Background

- The typical hospitalized patient is exposed to at least one medication error daily (Aspden, Wolcott, Bootman, Cronenwett, 2018)*.
- PMC implemented bar code medication administration (BCMA) when implementing Cerner 7 years ago, but accountability for department reporting and improvement had not been fully standardized.

Aim

- Improve patient safety during medication administration by ensuring accountability when using BCMA for patient and medication scanning.
- Utilize BCMA technology to aid in assuring the “rights” of medication administration as staff are asked to take on higher patient loads and sicker patients.
- Goal to have 95% compliance with BCMA medication and patient scanning by end of 2023.

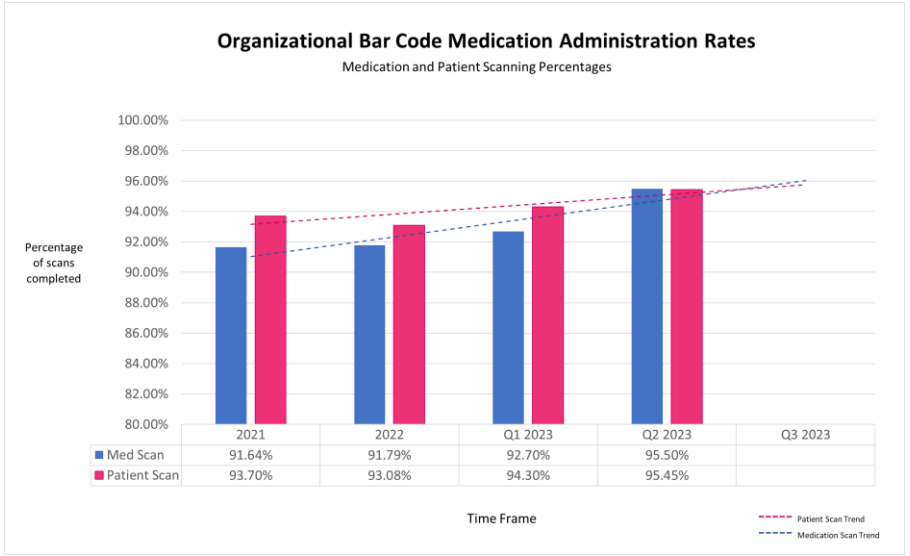
Plan

- Review and update medication safety policy.
- Develop charter for medication safety team.
- Review and validate BCMA reports within Cerner.
- Identify, evaluate and improve areas not meeting goal for BCMA.
- Increase director data reporting of BCMA to identify trends and actions related to departments or staff.

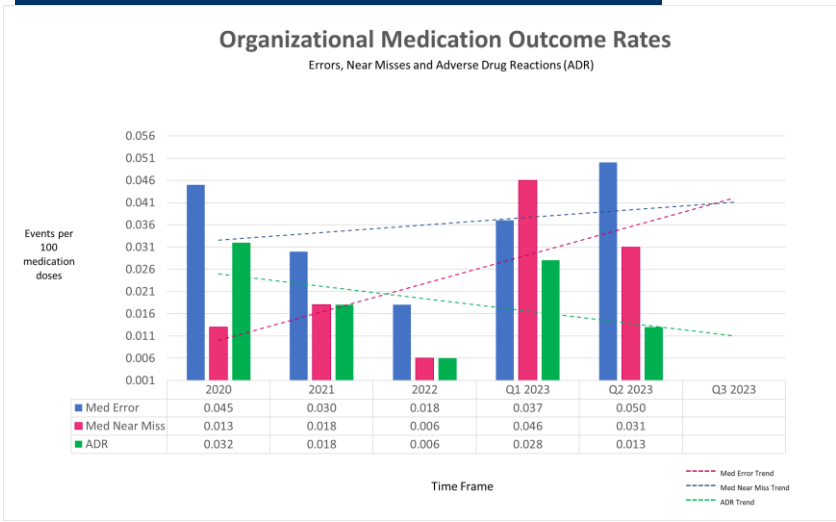
Medication Safety Measures

- Process-Organizational percentage of BCMA scans completed for patient and medication.
- Process-Departmental percentage of BCMA scans completed for patient and medication.
- Process-Staff member percentage of BCMA scans completed for patient and medication.
- Outcome-Medication error rate, medication near miss rate, adverse drug reaction (ADR) rate.

Organizational BCMA Rates



Errors, Near Misses, ADR Rates



Next Steps

- Continue to monitor and share data at medication safety committee.
- Partner with human resources to utilize staff specific data in the evaluation and compensation process.

Medication Safety Team

- Director of Pharmacy
- Director of Quality
- Chief Nursing Officer
- Clinical Informatics
- Directors of Inpatient, Outpatient, Surgery and ER
- Safety/Risk Specialist

* Aspden P, Wolcott J, Bootman JL, Cronenwett LR, eds. “Preventing Medication Errors: Quality Chasm Series.” Institute of Medicine (US) Committee on Identifying and Preventing Medication Errors, July 2006. http://www. nationalacademies.org/hmd/~/media/Files/Report%20Files/2006/Preventing-Medication-Errors-QualityChasm-Series/medicationerrorsnew.pdf. Accessed March 19, 2018