Building a Healthier SCU2 Community

Medication Safety and Culture change within the Medical ICU at Maine Medical Center

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Objectives

• Describe interventional environment which was accepted, yet risky to patients, families, & staff
• Discuss educational interventions for QI project
• Discuss critical knowledge & evidence which changed behaviors
• Progress
Background & Challenges

- Winter 2017 – SCU’s accepted medication practices & culture

  - Medications
    » taken out
    » of Pyxis and used as needed, kept at bedside, or in pocket “just in case”
    » left unsecured at bedside – drawn up or in original packaging, multidose vials used for indefinite times
    » Not routinely wasted in real time
    » Passed from one caregiver to another without sign off (legal issues arise with this).

  - Reasoning:
    » decrease waste, trying to be financially savvy.
    » time constraints
    » unseen safety concerns
    » fear reporting discrepancies & errors due to perceived penalties
Quality Improvement: Education & Awareness of Safety Concerns:

- Meds out and unsecured
  - Risks to visitors: family members, friends, children, visitors with dementias
  - People in & out of room throughout the day- potential interference w/meds
  - SCU staff vulnerability
- We don’t know & it’s unnecessary to know others’ walks of life (e.g.: previous & current struggles w/ abuse or addiction)
- We may be perceived as poor practitioners when we demonstrate unsafe behaviors
- Best practices for safe patient care, changing culture
- And…. the big one - Infection control evidence

*SAFETY RISKS are endless with meds left at bedside*
Medication Safety & Securement is a Nursing Responsibility & Standard

The nurse’s education, license and nursing standard provide the framework by which nurses are expected to practice. When a nurse’s practice falls below acceptable standards of care and competence, this exposes the nurse to litigation” (CorrectCare, 2011).

Substance abuse is the number one reason named by state boards of nursing for disciplinary action (Sullivan & Decker, 2001).

1984- ANA recognized diversion in nursing profession as a problem
QI: Area for Improvement

• Concern for safety:
  - Visitors: family members, friends, children (1,000s of deaths per year because of unsecured meds), visitors with dementias
  - People in and out of room throughout the day- potential interference of meds
  - SCU staff vulnerability
  - We don’t know/ it’s unnecessary to know others’ walks of life
    » Previous & current struggles with addiction
  - 1984- ANA recognized diversion in nursing profession as a problem
  - Also, we may be perceived as poor practitioners when we demonstrate unsafe behaviors

- *SAFETY RISKS are endless with meds left at the bedside*
Yearly, >100,000 doctors, nurses, medical techs, & aides are abusing or dependent on Rx

Almost 70% of pediatric ED visits occurred because of unintentional overdoses; of those, >82% accidental overdoses occurred because children accessed the meds on their own; >35% of the overdoses were non-prescription meds

70,000 kids/year annually in ED for accidental overdoses

>10% of 18-25 year-olds reported misusing pain relievers in the past year

Earlier intervention for addicted persons leads to better outcomes

Meds left “drawn up” in syringes have sterility issues
MAINE

• Since 2009, pharmaceutical narcotics were the most common reason for drug offense arrests
• Inpatient hospital admissions because of substance use are usually due to alcohol, opiates, marijuana, sedatives, & cocaine
• 2013:
  - 2,135,972 Rx filled for narcotics, tranquilizers, stimulants
  - 11,815 Mainers sought treatment for substance abuse; 2,681 for synthetic opioids
  - 4,145 hospital admission for ETOH tx, 3,681 for synthetic opioids
• Mainers: 11% of 18-25 year-olds & 3% of 26+ year-olds pain meds for non-medical use (2011-12)

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Abstract
Does medication safety and diversification education improve medication secreretion practices in SCU2 compared to current practice?

This safety and quality improvement project began as a newly hired SCU2 team member saw an opportunity to improve medication safety practices and culture. The team consisted of nursing directors, medication practice nurses, medication therapists, and medication technicians who were involved in daily medication reviews. The goal was to improve medication safety and quality by creating a culture of medication safety and awareness.

Methods
The project was a single-site implementation study conducted in SCU2, a medical/surgical unit at a tertiary care hospital. The project was approved by the institutional review board. The project team consisted of the principal investigator, a medication practice nurse, and two medication technicians. The project was implemented over a 12-month period.

Results
The project team implemented several interventions to improve medication safety and quality. These interventions included implementing a medication safety checklist, conducting medication rounding, and conducting medication education sessions. The project team also conducted a medication safety audit at the beginning and end of the project to measure the impact of the interventions.

Discussion
The project team implemented several medication safety interventions, including a medication safety checklist, medication rounding, and medication education sessions. The project team also conducted a medication safety audit at the beginning and end of the project to measure the impact of the interventions.

Conclusion
The project team implemented several medication safety interventions, including a medication safety checklist, medication rounding, and medication education sessions. The project team also conducted a medication safety audit at the beginning and end of the project to measure the impact of the interventions.
KPI Assistance

• The unit utilized our institution’s quality improvement program to develop relevant key performance indicators (KPIs). The first KPI focused on the entire team reviewing provided education. Multiple modes and opportunities were developed to enhance learning. A staff sign-off sheet was available once education was reviewed and understood; knowledge and understanding was self-reported. Late April, our unit’s educational KPI ended, and our self-reported "no meds left unsecured at bedside" KPI was enacted post-education. The team was encouraged to use our institution’s incident reporting system to document medication hazards and errors. This current KPI and QI project continues to date.
Shift Change Hand-off Checklist

• 4 eye verification for all IV infusions: correct drug & concentration; correct infusion rate; correct patient weight; labeled correctly; order current prior to dual sign-off

• Check that there are no meds left out on door, bedside table, cart, or in cart’s unlocked top drawer – all meds secured

• Ensure that there are no patient identifiers at the bedside except the patient’s ID band, which is physically on the patient. Alternate limbs for skin protection.

• Ensure that all controlled meds are wasted in real time, or at the end of shift for emergencies.

Peer Review at handoff

Act with kindness and compassion.
Be an active listener.
Be a role model.
Set high standards.
Take responsibility.
Embrace change.
Adding Safety Measures-

- MMC is hiring a Diversion Specialist to educate, provide surveillance, and generate data.
- SCU2 will have a “no meds left at bedside” policy
- Shared governance: Start with one goal? Or should we add immediate witnessing to this process? Thoughts?
- Improved Pyxis machines being purchased and placed
- Standarized auditing process
- Highlight EAP - Earlier intervention- better outcomes
- KPI Ideas-
  - Can I get a witness?
  - No Meds at bedside
Improved awareness and securement of medications post-education and quality improvement project was noted via staff sign-off sheet, self-reported KPI documentation for April-September 2017, and additional feedback will be solicited via anonymous survey post-hardwiring. 93.1% of RNs and 87.8% of staff solicited signed-off on at least one form of education. One medication error noted via RL Solutions system and was reviewed by SCU leadership and Risk Management. Based on these documentations and feedback, overall team buy-in was achieved: safety and diversion education improved medication securement practices post-education. Furthermore, this QI project extended to other units within MMC. Challenges sustaining medication safety practice changes occur during times of increased patient acuity, high patient flow and high census. This quality improvement project for SCU2 will continue until safety and culture improvement is ingrained.
Non-disciplinary vs Disciplinary Approach

Methods:
- Traditional disciplinary actions- suspension, termination, legal action, revocation of license (public record)
- Alternative programs- treatment programs, break from profession, drug testing requirements, job or role change
- Confidential alternative programs e.g. -New Mexico Board of Nursing Diversion Program, NYS – SPAN Program, Florida (80% RNs returned to nursing, <25% relapse rate)
- Some benefits of alternative methods: improved performance, patience, tolerance and compassion

• Important to Note: Many organizations do not participate in diversional alternatives for staff members caught using illicit/altering substances and/or diverting
Results

- Unit leadership solicited feedback continually during introduction, education and implementation processes. A post-implementation survey found that only two out of the six key patient safety questions had baseline scores that were below benchmark, while four of the six questions had scores above benchmark by an average of 10.5 percentage points. Furthermore, 87% of staff gave an overall grade of “excellent or very good”, eleven percentage points above the national benchmark.
BENEFITS of Increased Awareness:

- Decrease infection rates
- Increases staff understanding of problems, challenges, & evidence
- Improved securement creates a culture of safety
- Increased safety which is not contingent upon budgetary constraints
- Earlier intervention = better outcomes; less personal devastation
- Improved perception of safety by staff, patients, & visitors
- Potentially increases the ability for MMC to become hospital of choice
References:


Questions? Comments? Suggestions?