Medication Safety Matters

Authors

Erin McGinnis, BSN, RN; Matthew Tanner, PharmD, BCPS;
Kelly Bodnarchuk, MBA, BSN, RN, CNML, CENP;
Peter Ashton, BSN, RN; Ann Alway, MS, RN, CNS, CNRN;
Ben Burlison, MBA, BSN, RN, CCRN;

Background

A Salem Health RN asked administrators for additional safety measures while obtaining overrides from the Omnicell for urgent medication administration. The risk for pulling the wrong medication is high in some circumstances and nurses lack confidence in the current processes due to a highly publicized incident.

Purpose

Salem Health Nurse confidence with current Omnicell processes is ranked at only 8%. The purpose of this project is to take actions to increase nurse confidence.

Methods

-An interdisciplinary group studied the problem of medication safety while using the Omnicell device
-The first Lean Test of Change (TOC) implemented an evidence-based practice recommendation: entering the first five letters of Rx instead of one letter.
-Second TOC or process metric was a medication spelling list
-Third TOC or process metric extended the Rx keyboard entry time to 5 seconds rather than 3 seconds

Pictured left to right: Peter Ashton, Jennifer Ditter, Kim Mullins, Erin McGinnis, Matthew Tanner, Barbara Merrifield.

Salem Health Foundation

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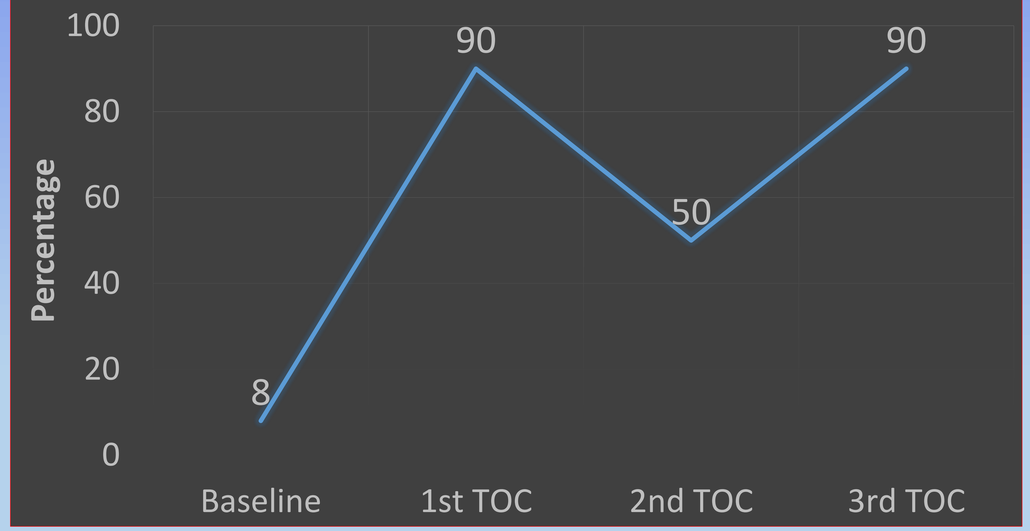
Nurse Confidence in Omnicell Safety Improves following these actions:

-Adopting First Five Rx Letters

-Visible Spelling List

-Extending Rx Entry Time

Percent of nursing confidence with Omnicell Safety Measures at Baseline and following each Test of Change (TOC).



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Pictured left to right: Kelly Bodnarchuk, Ann Alway, Kim Mullins, Erin McGinnis, Seunghyo Hong. Standing in from on the CVCU Omnicell and the Blue Page of alphabetized medications.

Results

- Outcomes are shown in the chart to the left.
- Confidence at baseline rose from 8% to 90% with the addition of the first 5 Rx letters.
- Confidence dropped to 50% with an alphabetized spelling list
- Confidence increased back to 90% after increasing the active keyboard time to 5 seconds.

Conclusions

Confidence in medication safety is much higher with the three actions now bundled together. Pharmacy re-set the Omnicells and Nurse Mangers distributed the alphabetized spelling list.

Implications for Clinical Practice

Lean methods point to a process called “mistake proofing” which is what the team accomplished with the bundling of three processes.

References

- https://www.omnicell.com/blog/ensuring-medication-safety-through-automation-designed-to-support-ismp-best-practices
- https://www.ismp.org/sites/default/files/attachments/2020-02/2020-2021

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Poster Contact

Erin.mcginnis@salemhelth.org

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