Barcoding in the ED: Who Said it Couldn't be Done?

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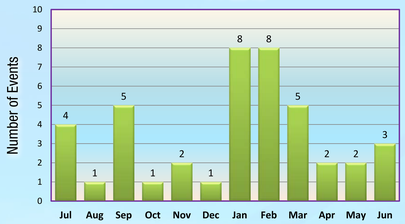
Evidence Statement

One of the most common care areas where medication errors take place in Pennsylvania healthcare facilities is the Emergency Department (ED). While it is impossible to completely eliminate medication errors in any healthcare setting, this unique barcoding initiative improved patient safety.

A busy 40 bed ED acknowledged the need for constructive intervention.

Medication Errors, ED-Muhlenberg
FY 2013



Barriers

- Nurse skepticism/ "buy-in"
- Barcode scanning issues: "old habits die hard"
- Limited availability of electrical outlets
- Insufficient amount of equipment
- Computer-Assisted Physician Order Entry (CAPOE) delays
- Communication delays with Pharmacy: "medication approval"

Strategies

1. **Interprofessional Team***
   - Unit Leadership (Director, Unit Educator, Nurse Manager)
   - Registered Nurse (RN) Superusers
   - ED RNs
   - Nursing Informatics Representative
   - Pharmacist
   - Physician Assistant (mid-level provider)

   **Increasing the involvement of the pharmacy department, as well as instituting a multidisciplinary approach to patient care in the ED proved to be an extremely effective strategy to decrease medication errors in the ED.*
2. **Equipment Analysis - computers, outlets, wireless scanners**
3. **Staff Education via eLearning modules**
4. **Informational signage posted throughout department**
5. **Superuser support at go-live**
6. **Compliance data displayed on visibility boards**

Outcomes

Goal: Decrease the number of medication errors through barcoding in the ED

Next Steps

Expand Barcoding Process to:

- Emergency Behavioral Health Unit
- Additional EDs within Network

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