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Does medication safety and diversion education improve medication securement practices in SCU compared to current practice?

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Abstract

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This safety quality improvement project began as newly hired SCU2 team members saw an opportunity to improve our medication safety practices and culture. The convenience of having certain medications directly available at bedside was priority. 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 others. Prior to our education, the accepted practice of unsecured medications was rampant: medications were left drawn up or exposed, setting 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. This safety project focused on creating buy-in through multidisciplinary education and analysis; the end goal was to alter the team's workflow habits by increasing diversion and medication safety knowledge and awareness.

SCU2's Medication Safety QI project began by introducing the topic at two March staff meetings. A clinical pharmacist and nurse manager presented the topic of diversion and safe medication handling. The nurse manager then created and posted a translating evidence into practice (TRIP) sheet and PowerPoint for additional educational opportunity. Evidence included >100,000 healthcare workers are dependent or abusing prescriptions each year, medications drawn up and left at bedside have sterility issues, and substance abuse is the number one reason nurses receive disciplinary action by state boards of nursing.

To improve safety, the unit utilized MaineHealth's Operational Excellence program to develop relevant key performance indicators (KPI). The first KPI focused on the entire team reviewing pharmacy and nurse manager's provided education. All PowerPoint presentations were sent out via email in March, and again, in April. All educational materials were also physically posted on unit. A staff sign-off sheet was available once education was reviewed and understood; this knowledge and understanding was self-reported. SCU2's education KPI ended in mid-April 2017, and our "no meds left unsecured at bedside" self-reporting KPI was enacted post-education. Team was encouraged to use MMC's RL Solutions (Risk Management) program to document medication hazards and errors. Current KPI and focus continues to date. Management solicited feedback continually during introduction, education and implementation processes.

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.