COASTAL
BEHAVIORAL HEALTHCARE, INC.

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Medication Variations Performance Improvement Project 2002-2003

Crisis Stabilization Units

CBH

- Coastal Behavioral Healthcare, Inc., is a not – for–profit community based corporation that provides an integrated system of mental health, substance abuse, criminal justice, prevention and intervention treatment services to children, adolescents, adults, and seniors. A continuum of care is provided within 58 programs, in 21 different locations covering 6 counties in SW Florida.

CBH Mission Statement

To offer affordable behavioral healthcare that exceed customer expectations for quality, availability, and satisfaction.

QA & RISK MANAGEMENT

- QUALITY ASSURANCE: a program for systematic monitoring and evaluation of various aspects of a project, service or facility to ensure that standards of quality are being met
- RISK MANAGEMENT: A program that focuses on the reduction of loss, injury, and liability

CBH's QI and RM Program

- **Historical Healthcare Practice – QI and Risk separate departments and functions**
  - Quality Improvement is proactive
  - Risk Management is reactive
- **CBH – a proactive collaborative approach**
  - A **c**ontinuous **q**uality **i**mprovement process where QI and Risk work collaboratively as a department. QI/RM work in a team fashion with all CBH departments to increase our timeliness in identifying and responding to opportunities to improve our performance in any company related service or function while simultaneously minimizing risks within the company.

INCIDENTS/QUALITY OF CARE

- CBH encourages reporting – systems approach to reviewing – staff accountable but not blamed
- Incidents are reviewed by QI and RM and categorized by actual incidents or those occurrences that reflect a quality issue that while not an incident if not addressed could potentially lead to one in the future.
- Incidents and quality of care occurrences may be analyzed and trended by:

Type	Shift
Location	Diagnosis
Program	Activity

5 Rights For Medication Administration

Right Patient

Right Medication

Right Dosage

Right Route

Right Time

Medication Variations Performance Improvement Project

RIGHT SIZE SYRINGE!

Medication Variations Performance Improvement Project

- PURPOSE: To reduce the potential risk for medication errors and provide for a safe, effective and efficient medication administration practice.

- OBJECTIVES:
  - Assess current system to identify patterns of problematic practice
  - Establish plan of action to address weaknesses
  - Implement short and long term strategies to strengthen process
  - Evaluate outcome

PDCA - Shewart

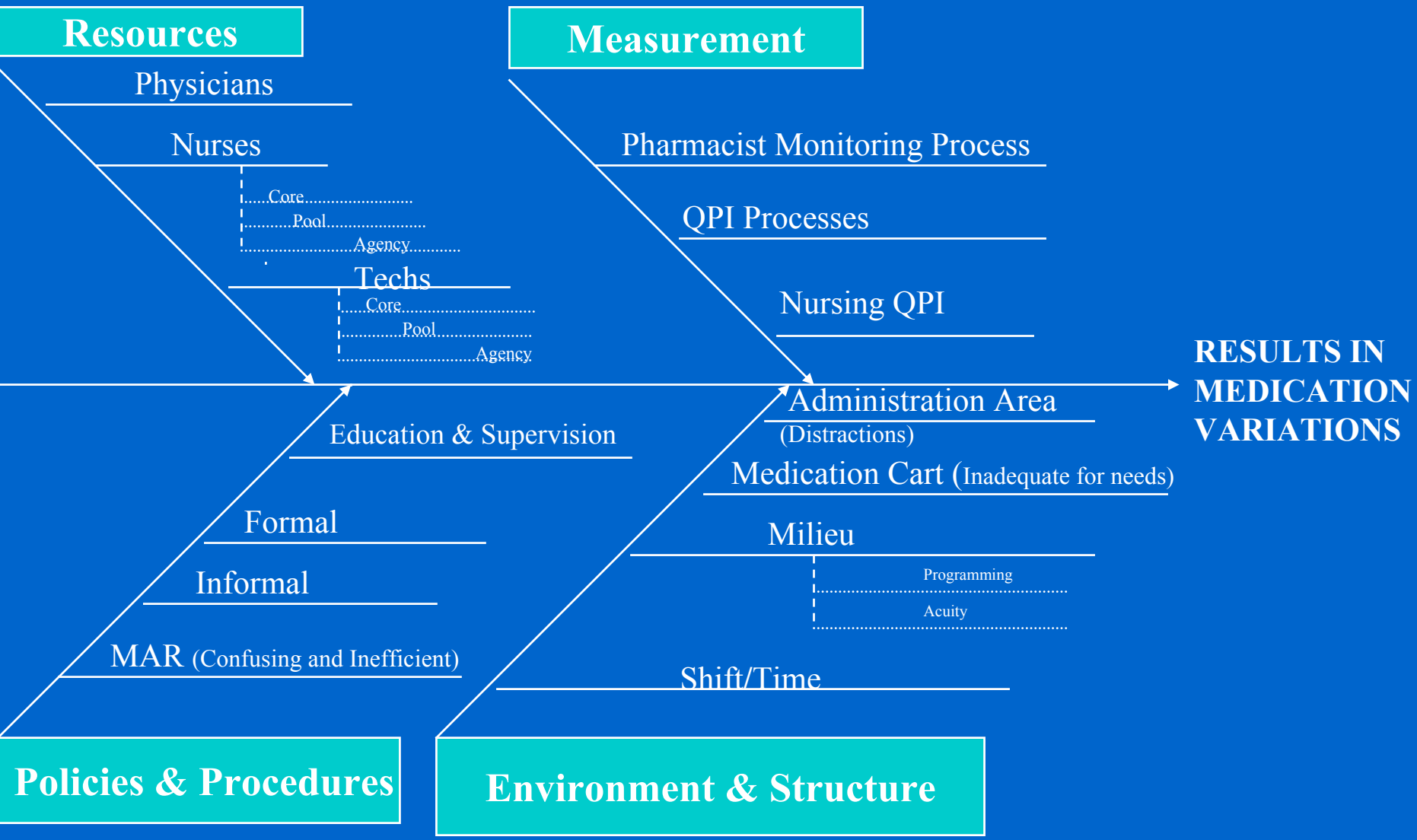
- **Plan** = Define process in need of improvement and design the changes needed and how to measure success
- **Do** = Set these changes in place
  - Implement the changes
- **Check** = Gather information about changes and measures of success
  - Use measures and gather information
- **Act** = Evaluate and redesign if necessary
  - Reviews measures of success and plan further changes if needed

CSU MEDICATION ADMINISTRATION

- PLAN
  - Literature Review: Root causes of medication errors
    - » Findings:
      - IOM reported 7,000 deaths a year due to medication errors
      - Most medication errors are due to multiple system failures
      - Blame-free reporting can decrease medication errors
  - Assess Current System – identify patterns of problematic practice
    - » System Review Activities (Cause and Effect Analysis)
      - Staff feedback and input
      - People (staffing)
      - Policies and Procedures
      - Measurement
      - Environment and Structure

Cause and Effect/Ishikawa Diagram

ANALYSIS OF CSU MEDICATION ADMINISTRATION PROCESS



CSU MEDICATION ADMINISTRATION

- DO
  - Staff
    - » Physicians
      - Stabilized coverage
    - » Nurses
      - Retention:
        - salary surveys
        - salary adjustments for current staff
        - improved schedule consistency
      - Increased number of core staff:
        - increased recruitment effort (increased starting pay, advertised at local educational institutions, marketed CBH benefits)
    - » Techs
      - Retention
        - created additional opportunities for advancement (Tech Supervisor and Lead Tech positions)
        - improved range of salary
        - salary adjustments
        - pool staff – CBH centralized “float” techs

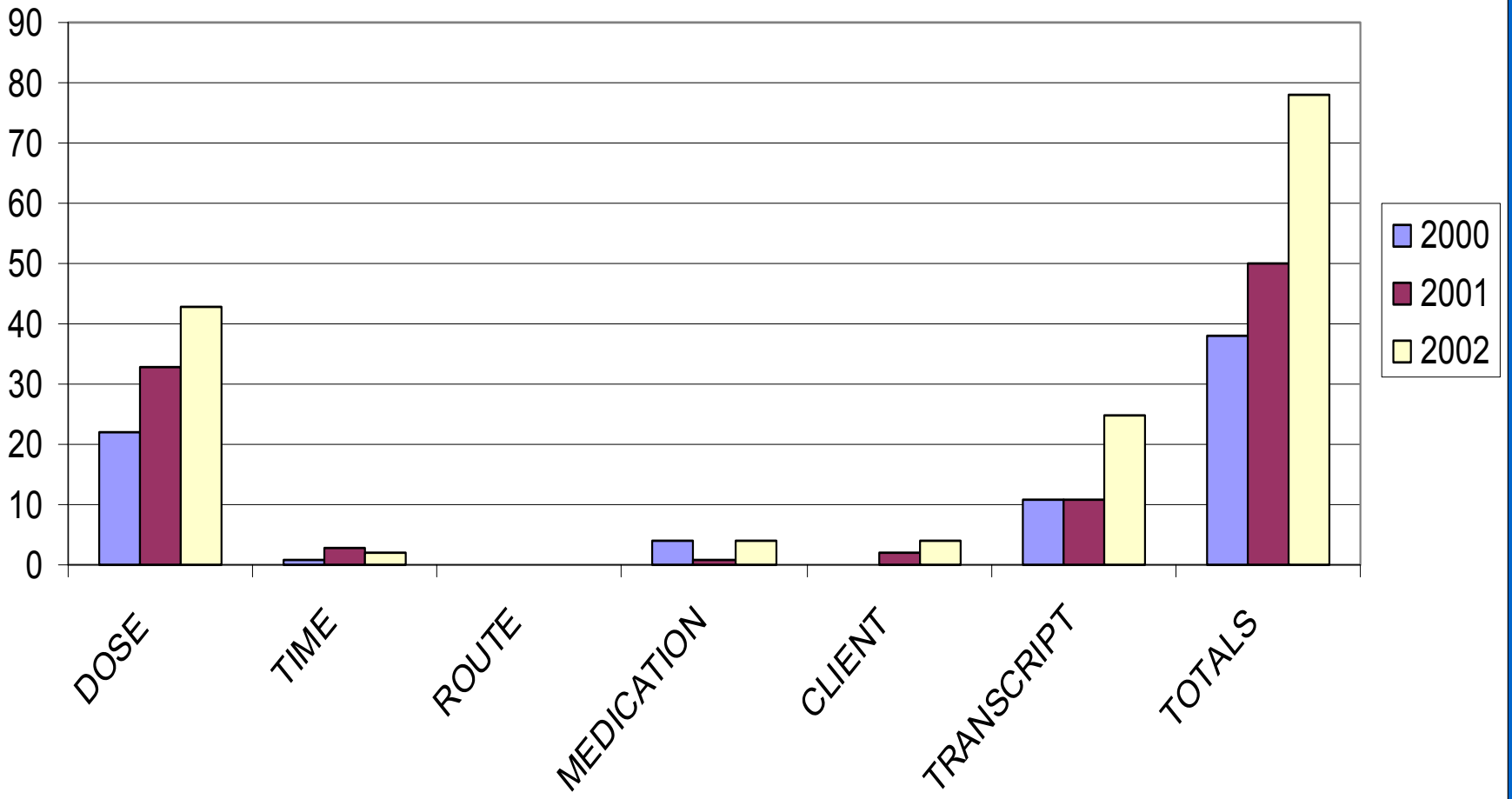
CSU MEDICATION ADMINISTRATION

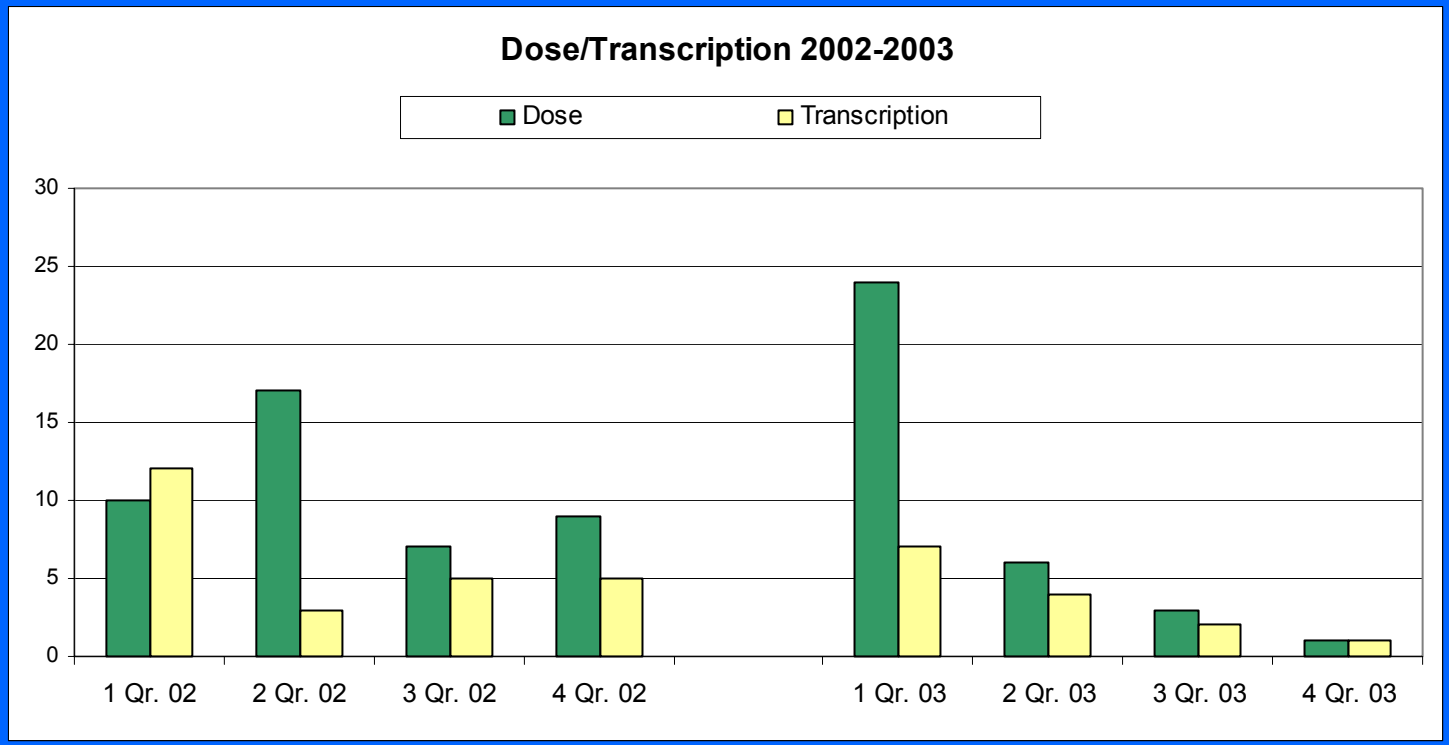
- DO
  - Policies and Procedures
    - » Reviewed, revised and created new P&Ps
    - » Revised MAR
    - » Created protocols
    - » Education and Supervision
      - Reviewed, revised and drafted new P&Ps and forms and discussed in QI committees and staff meetings
      - Standardized procedures – discontinued informal procedures and forms
      - Improved orientation – lengthened, mentors, competency
      - Implemented monthly staff meetings

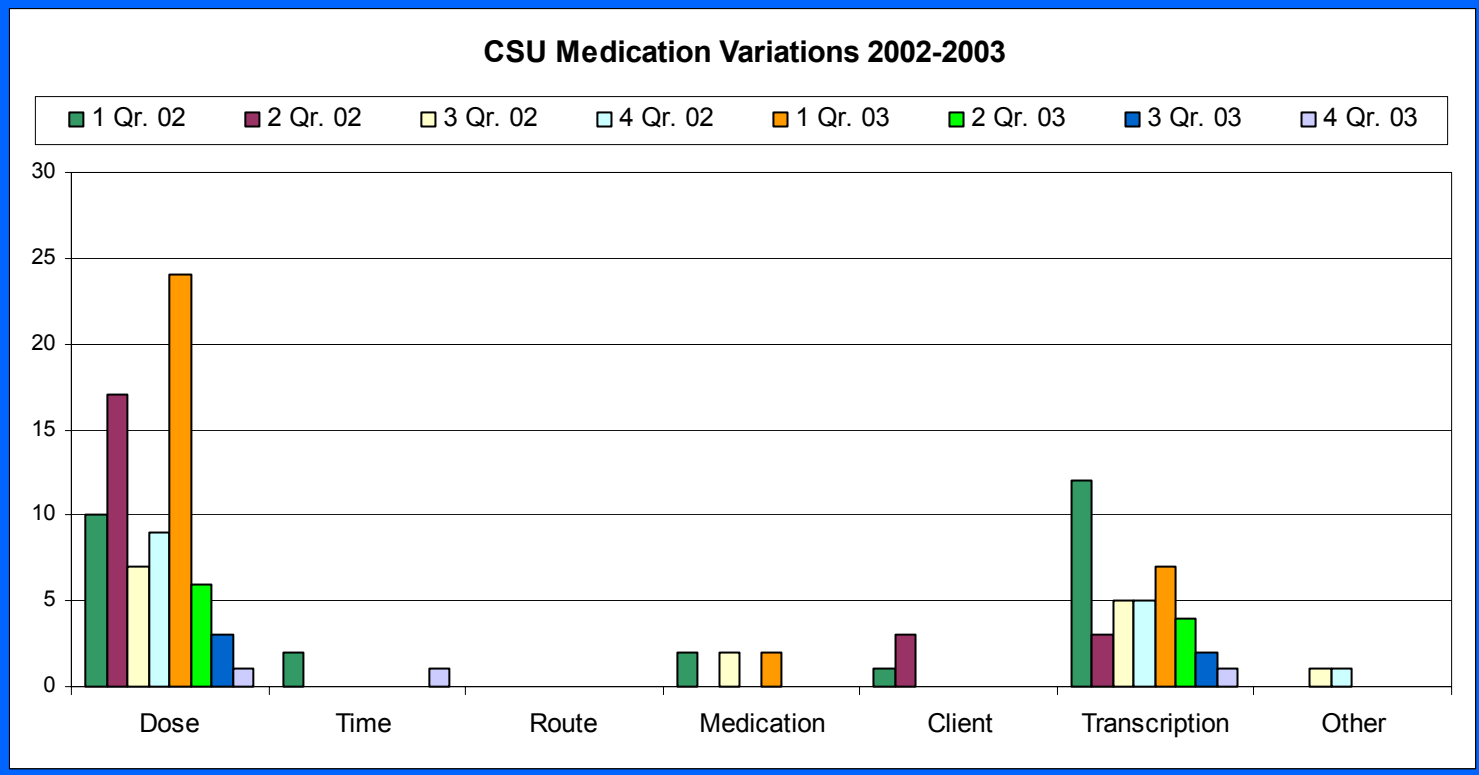
CSU MEDICATION ADMINISTRATION

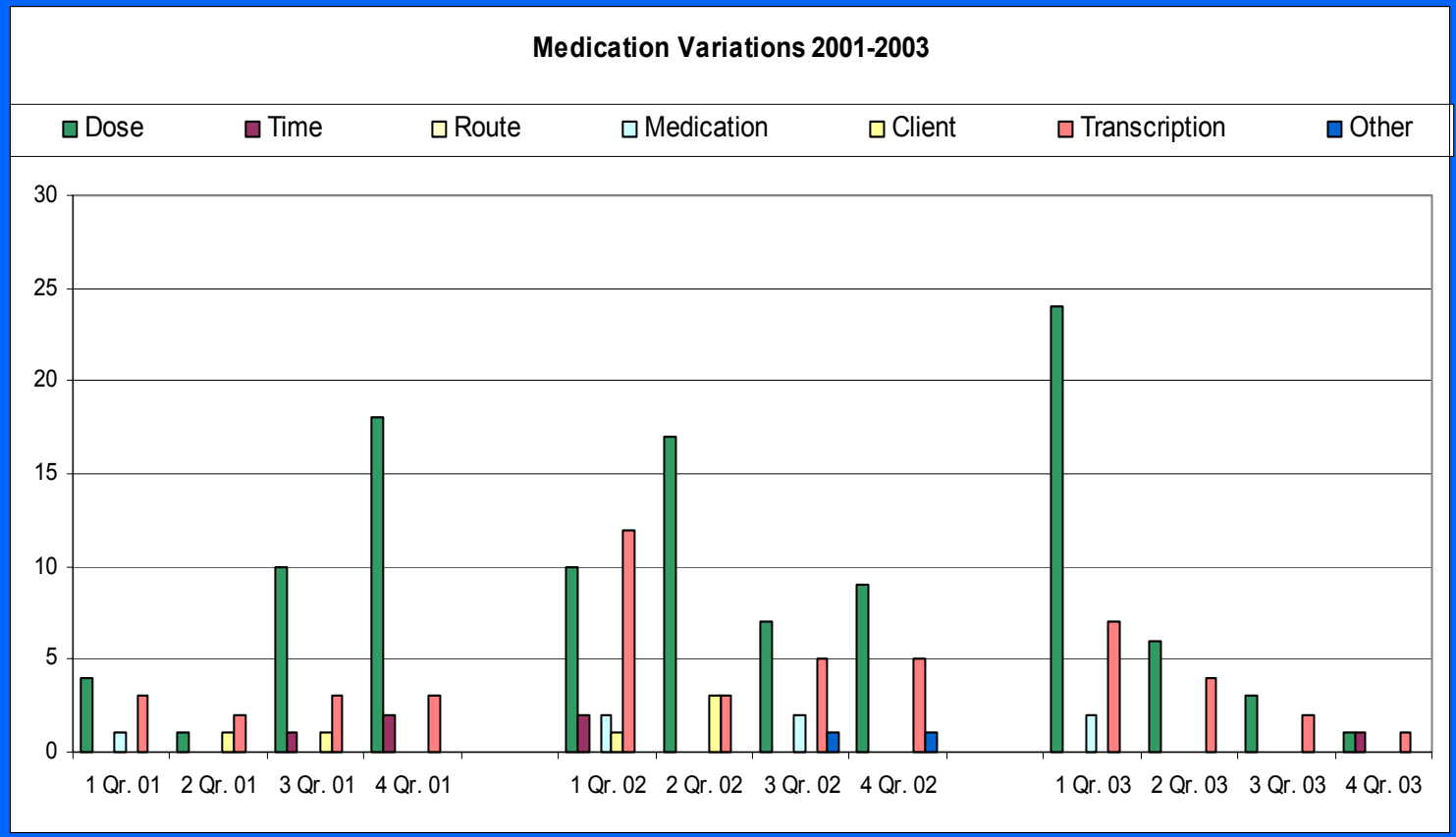
- DO
  - Measurement
    - » Utilized data from Pharmacist's review (weekly, monthly, quarterly)
    - » Utilized data from QI/RM
    - » Implemented Nursing QI re: review of nursing medication process – shift checks monitored – identify and correct problems timely in order to prevent medication errors
    - » Implemented medication administration competency evaluations – quarterly

QPI MEDICATION VARIATIONS




Dose/Transcription 2002-2003
Dose
Transcription
30
25
20
15
10
5
0
1 Qr. 02
2 Qr. 02
3 Qr. 02
4 Qr. 02
1 Qr. 03
2 Qr. 03
3 Qr. 03
4 Qr. 03


CSU Medication Variations 2002-2003
1 Qr. 02
2 Qr. 02
3 Qr. 02
4 Qr. 02
1 Qr. 03
2 Qr. 03
3 Qr. 03
4 Qr. 03
30
25
20
15
10
5
0
Dose
Time
Route
Medication
Client
Transcription
Other


Medication Variations 2001-2003
Dose
Time
Route
Medication
Client
Transcription
Other
30
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5
0
1 Qr. 01
2 Qr. 01
3 Qr. 01
4 Qr. 01
1 Qr. 02
2 Qr. 02
3 Qr. 02
4 Qr. 02
1 Qr. 03
2 Qr. 03
3 Qr. 03
4 Qr. 03

CSU MEDICATION ADMINISTRATION

- DO
  - Environment and Structure
    - » Administration Area
      - Temporary solution implemented – designated space for medication nurse in unit station
      - Planned physical modification to unit station- providing decreased distractions and improved checks prior to administration
    - » Medication Cart
      - Conducted a review of available styles of medication carts, model choice, plan for capital expenditure in FY 2002-2003
    - » Milieu
      - Reviewed programming
      - Core staff
      - Revised staffing patterns
      - Client ID bracelets
    - » Shift/Time
      - Second shift issues reviewed/analyzed
      - Planned times for team meetings

CSU Medication Administration

Physicians Order

Written Order **Verbal Order**

Charge Nurse

1. Picks up and Signs off order
2. Obtains written consent/client signature
3. Medication education/client signature

Medication Nurse

1. Transcribes order onto MAR/Co-sign
2. Checks availability
3. Review medication teaching with client
4. Administer medication/initial

Second Nurse

1. Checks orders for accuracy of transcription on MAR
2. Initials MAR

Night Nurse

1. Checks orders with transcription on MAR
2. Checks medication administration
3. Initials MAR

CBH M.A.R. MONITORING TOOL

DATE: REVIEWER: SERVICE:

MIS NUMBER		
MEDICATION		
REGULAR/PRN	Regular PRN	Regular PRN
MAR		
■ Accurately Transcribed		
■ PRN Response Documented		
■ Second RN Initials		
■ Night Nurse Initials		
ORDER SHEET		
■ Specific Order Review		
■ Type (verbal/written)		
NURSES		
COMMENTS:		

CSU MEDICATION ADMINISTRATION

- Check
  - Pilot revised MAR - feedback
  - Nursing QI Monitoring Tool
    - » Analyzing and trending data
  - QI data (Pharmacist and QI/RM)
  - Quarterly Medication Administration Competency Evaluations
    - » Analyzing and trending data
  - Review and analyze data with staff in meetings

CSU MEDICATION ADMINISTRATION

- Act
  - Revised MAR based on staff feedback multiple times
  - Retrained Nurses on transcription process
  - Ordered and using medication cart since May 2003
  - Revised nursing QI review
  - Designed and received cost estimates on renovations to nurses station – set-up interim medication delivery area

CQI……

- Continue medication administration performance improvement project for 2004:
  - Assess results of actions taken
  - Recommendations:
    - » Continue to educate nurses on new JCAHO medication standards
    - » Start renovations to nurses station
    - » Implement revised M.A.R. QPI Tool
    - » Continue to discuss and assess actions taken in staff meetings and the appropriate QPI Committees

RESULTS

- 2002-2003
  - –Originally anticipated a 20% decrease in medication errors at the CSU for 2003
  - –Final percent decrease = **36.3%** reduction in medication errors

SUMMARY

- BLAME-FREE REPORTING AND ACCOUNTABILITY
- SYSTEMS APPROACH
  - MANAGEMENT SUPPORT
  - COMPANY STRUCTURE
    - » RESOURCES
    - » ORGANIZATION
    - » EDUCATION
- Benefits:
  - Improved patient safety
  - While process is intensive – benefits have been lasting and have also addressed issues that were not originally part of the initial focus
  - Multi-site system: helped one of our sites and their staff feel more connected and supported by the the “corporate” team
  - Staff empowered, involved in the process, improved morale
  - Increased scores client satisfaction (MHCA) – stabilized staffing
  - Educational/training process – can be replicated for a variety of PI and risk prevention activities