Closed Loop Medication Management Nursing Workaround Information Session

MHA Capstone Project
Feb 2022

SOURCE: Poland, H., Black, A. & Diogo, I. (2023). Enhancing Patient Safety by Mitigating Nursing Medication Administration Workarounds. *Canadian Journal of Nursing Informatics, 18*(1). https://cjni.net/journal/?p=10862

Land Acknowledgement

I acknowledge with gratitude that I live and work on the traditional, ancestral and unceded territories of the Coast Salish peoples – the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh Úxwumixw (Squamish), and sə̓lilwətaʔɬ (Tsleil-Waututh) First Nations.

About Me…

→ RN- worked in Ontario, then at BCCH x 3 years

→ CIS- helping with CST roll out

→ Completing Masters of Health Administration at UBC

→ Interest in Quality Improvement & Professional Practice

About my team…

Academic Supervisors

Agnes Black
Isabel Diogo

CW Supervisors

Julie Thiessen
Karen Pike

BCCH Leadership

Rebecca Euverman, Quality & Risk Lead
T6, T7, SH Managers, Educators & Peer Mentors

Providence HEALTH CARE

BC Children's Hospital

Privacy & Confidentiality

- Participation is VOLUNTARY
- NOT taking attendance or collecting any personal info
- Not sharing surveys responses with Leadership
  - Results will be analyzed and summarized
  - Will share report with Leadership- and with you if you're interested!

Agenda

01 **Pre- Presentation Survey**

02 **Review of CLMM**

03 **Case Study**

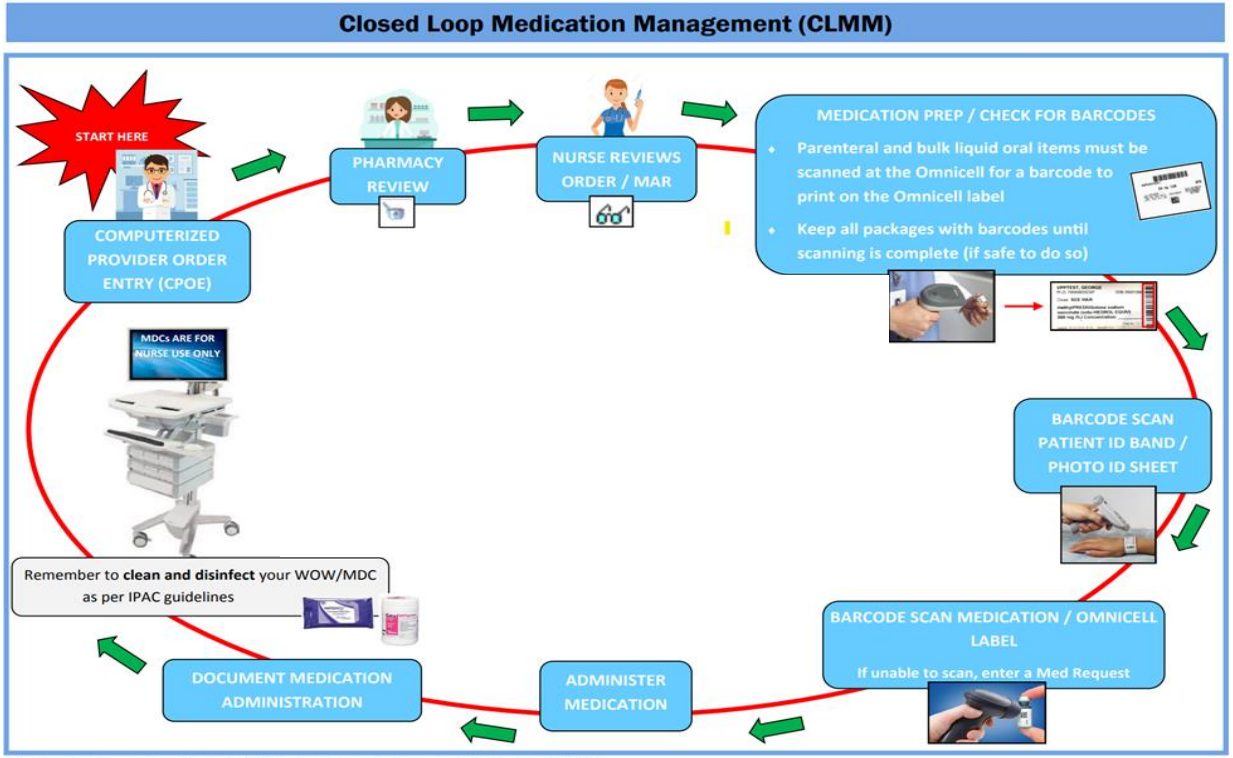
04 **Discussion**
Including Q & A

05 **Post- Presentation Survey**

Survey

Complete the first 13 questions and then pause!

Review: Closed Loop Medication Management



Bar Code Medication Administration [BCMA] is part of Closed Loop Medication Management [CLMM]

Case Study Background

Madison, RN, has been working on the Pediatric Medical- Surgery Unit for the past 5 years. The 12 bed unit is filled with complex kids ranging from Newborn to 16 years. Normally there are 3 nurses working per shift. Diagnosis are widely variable, there happens to be 4 sick septic patients receiving the same medications at the same times on the floor today.

Context...

Last year, Madison's hospital rolled out CST Cerner, including Closed Loop Medication Management Workflows- and Bar Code Medication Administration

WiFi has been notoriously poor since the CST roll out. The Nurses have had to adopt a "trick" to scan the medication and an extra patient band in med room instead of at the bedside. This allows "timely" medication administration and avoids any trouble from management

Once Upon a Time...

Madison starts the day by finding out her co worker has called in sick and Gloria, the replacement, will not make it in until 9 or 10 am. Her other co worker Kelly has a patient in critical condition being transferred to PICU. Madison will have to complete the 8 am medication round for 7 patients.

Madison

In order to save time, Madison, scans all the 8 am medications and extra patient bands in the medication room- then stores the medications in the separate medication drawers in the WOW

Madison rushes and is able to administer all the 8 am medications to all 7 patients

Gloria

Gloria arrives at 9 am to find Madison frazzled but with the morning rush completed!

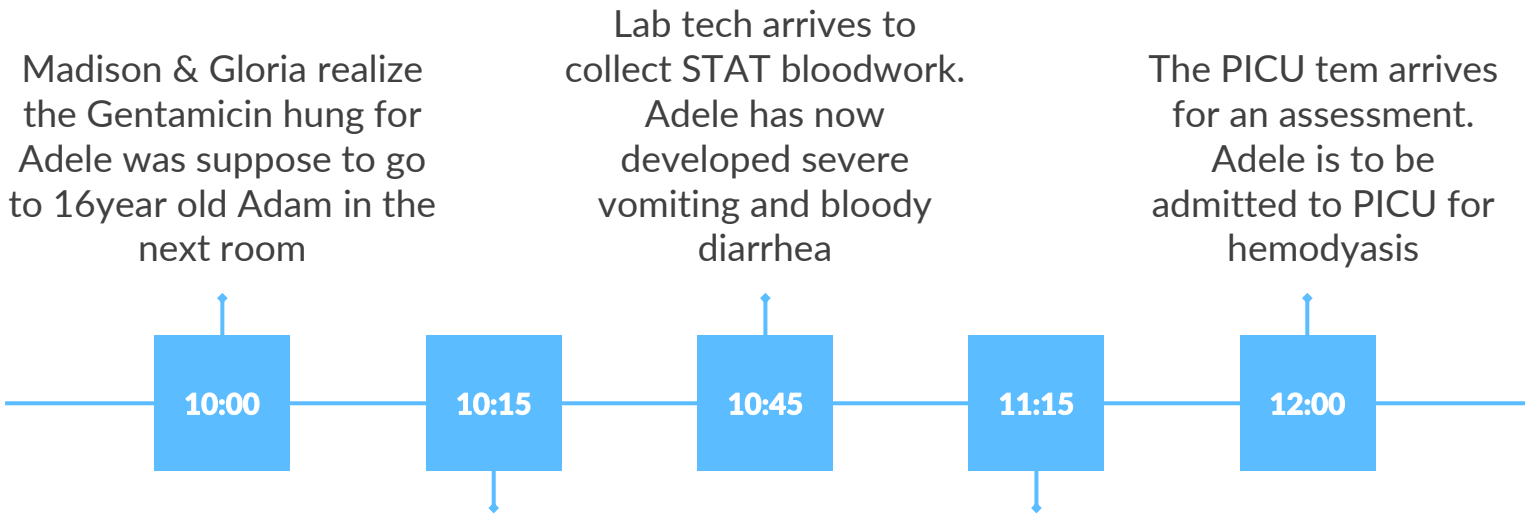
She thanks her co worker and proceeds to complete her morning Head to Toe assessments on her patients

And then...

Gloria assesses 2 year old Adele last. When checking her site to source, Gloria notes a large empty secondary bag of Gentamicin. The label notes a very large dose.

On assessment, Adele complains of new, sharp abdominal tenderness & severe nausea

“It all happened so fast…”



Discussion

What was the workaround?

How could we have prevented the poor outcome?

What can we apply to BCCH?

What is a Workaround?

Definition

"informal and/or temporary behaviors or actions that 'fix' perceived workflow hindrances to meet a goal or to achieve it more readily"

"Gaming"

In addition to workaround, user "pretends" to follow the formal workflow steps, in order to avoid repercussions

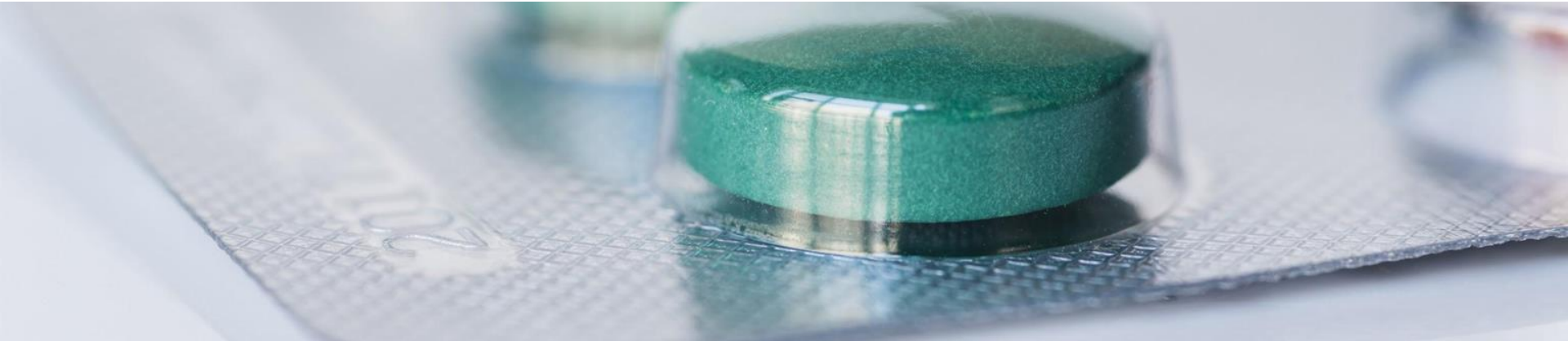
Why?

- Inflexibility
- Time stress
- Lacks Situational Awareness
- Leadership relations
- Culture

Prevention

In order to truly prevent something, we must find the ROOT Cause.
In this Case Study:

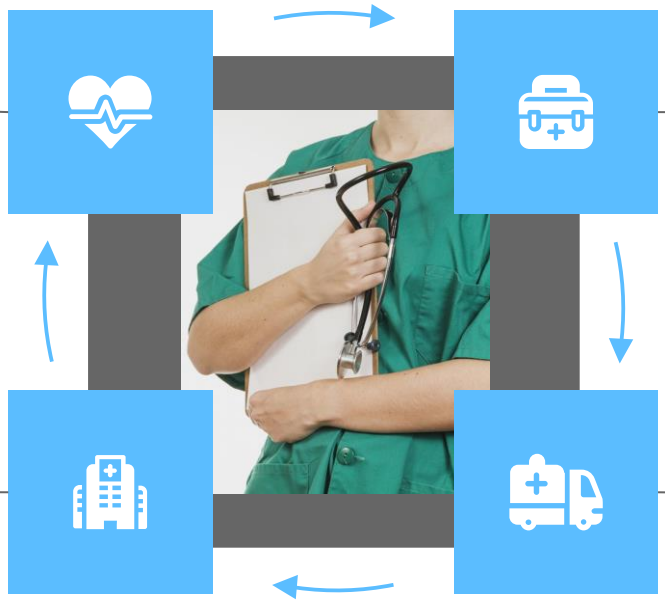
Short Staffed	Stress	Workaround	Gaming
Difficult to prevent at unit level	Can reduce but not eliminate	… but what is causing the workaround? The poor WiFi!	… but what is causing the gaming? Don't want to get in trouble! ? Unit culture



Prevention Options

Madison adheres to BCMA scanning workflows- even though it's slow

Madison can manually check patient arm band to MAR & Med label- even though this still means opening Powerchart



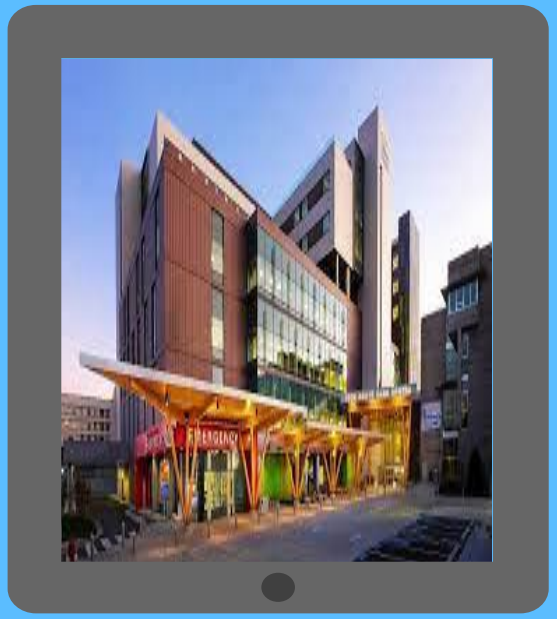
Madison- or any of the unit nurses- report the slow WIFI which is leading to the workaround

Madison calls for help from leadership &/or refuses 7 patient workload

What does it mean for BCCH?

- Root cause of workaround behaviour includes the *unaddressed* slow Wifi and unit culture
- Found that the gaming **added** a significant amount of risk to the initial workaround…
- Root cause of the gaming includes difficulty approaching leadership, fear of repercussions and unit culture

These are the things BCCH can try to prevent!



HOW?

need YOUR feedback!

PSLS provides way to report Closed Loop Medication Management Workflow issues

ANONYMOUSLY

- ✓ More convenient way to communicate with leaders
- ✓ Anonymous- can't get in trouble
- ✓ Familiar program ensures all relevant info is collected
- ✓ Quality Leads monitoring PSLS, able to trend reports
- ✓ Also a way to share SAFE workarounds

Quality & Risk Lead can make a RedCAP Survey where staff can report issues

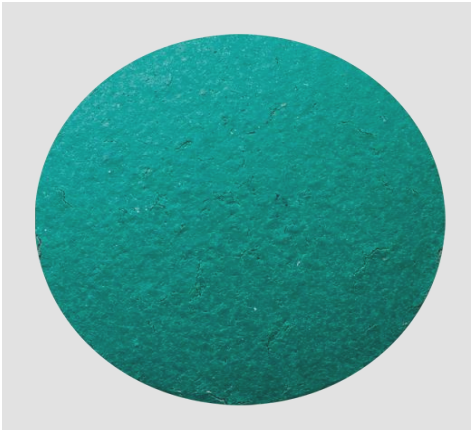
ANONYMOUSLY

- ✓ More convenient way to communicate with leaders- from your cellphone!
- ✓ Anonymous- can't get in trouble
- ✓ Familiar program ensures all relevant info is collected
- ✓ Quality Leads monitoring RedCAP, able to trend reports
- ✓ Also a way to share SAFE workarounds

Safe Workarounds?

NOT always unsafe

Sometimes even better than the original workflow!



Frontline Staff

INTEGRAL to reportiing ineffectual workflows and innovating feasible solutions

Already in Place

CST has created and implemented workarounds to adjust for system limitations

Take Aways

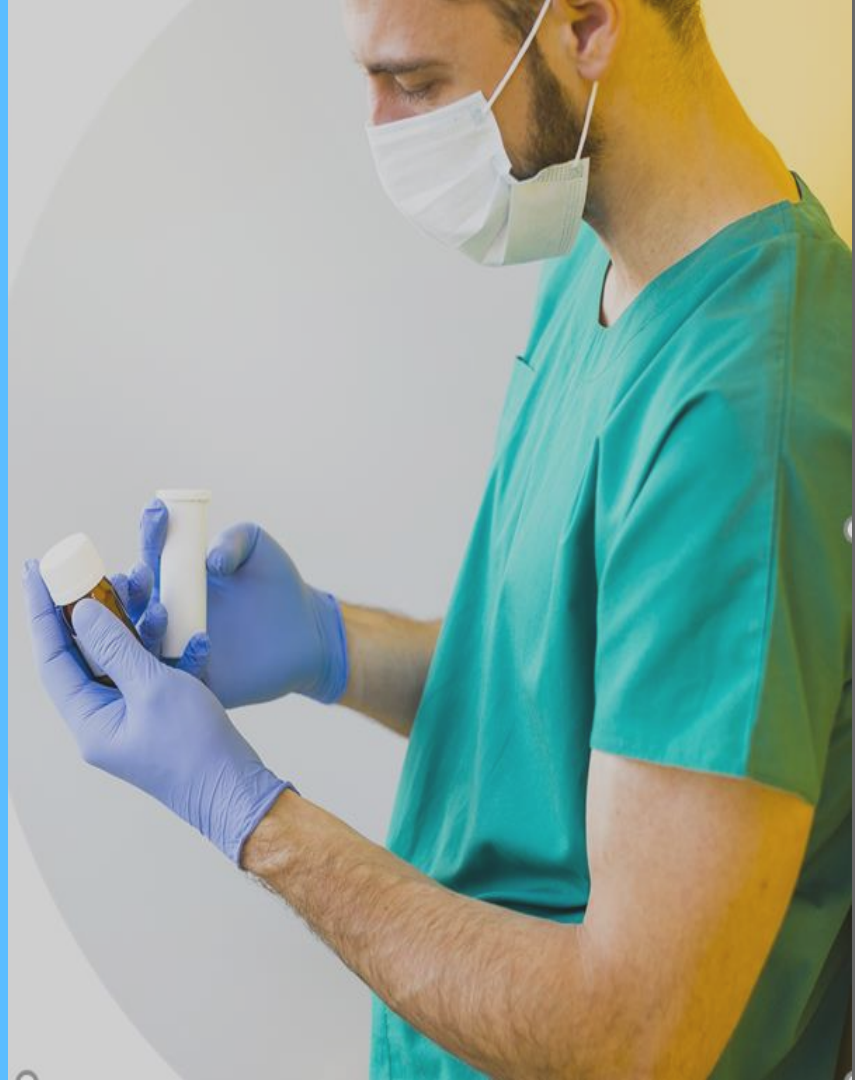
- Workarounds should always be reviewed to ensure safety
- Workarounds may indicate need for change
- Unit Culture & Leadership play an important role
- CLMM & BCMA will feel slow at first
- Gaming doesn't fix anything
- Partnership in change is needed

Survey

Re-open pervious survey

&

Complete the final 6 questions



Next:

Go Live!

Receive a follow up surveys in April

Reach out if you want to participate in Post Go Live interviews

Thank you!

Do you have remaining questions?

OR

Want to participate in one-on-one post Go Live Interviews?

Email: heather.poland@cw.bc.ca


slidesgo