Solution: Conducting Face-to-Face Handoff Review of IV Infusions

Organization: Sinai Hospital
Primary Contact: Jocelyn Noel RN, CCRN, ICU Clinical Leader
E-mail: jnoel@lifebridgehealth.org
Phone: 410.601.5226

IDENTIFICATION:
During the process of promoting the directives of patient safety by the Joint Commission, critical issues within the unit surrounding ICU patients with multiple continuous infusions were discovered. There were inaccuracies in the administration and maintenance of IV medication infusions, inconsistent documentation in the EMAR, and discrepancies in patient identification and medication. These issues mandated immediate corrective measures.

SOLUTION:
Interviews were conducted, under the assurance that no repercussions will result from the nurses’ open and honest descriptions of actual practice of medication administration. From these discussions, specific issues were identified, and the leadership team established clear and concrete guidelines with which to address and correct the problems.

1. There were concerns regarding the timely delivery of medicines to the unit, and Pharmacy was asked to improve the turnaround time for medication requests.
2. There was a culture of acceptable behavior that medicines were being borrowed between patients. This totally unacceptable conduct was addressed by nurses being strictly required to follow non-negotiable rules that prohibits using medicines from other patients, filing accurate and timely documentation in CSAR and EMAR, and ordering of IV bags 4 hours before anticipated lapse time to ensure availability.
3. The biggest change that the unit adopted was the face-to-face review at bedside of all hanging IV medications. Both nurses complete a visual check of patient identification on the armband and on the hanging IV medicine, check the accuracy of the drug, its concentration and dose, and expiration date.

No less than strict and full compliance was expected from all the nurses for all these new measures. Shortcuts and cutting corners when it comes to patient safety are all but history.

Outcomes:
It was expected that these new measures would be met with reluctance and opposition due to the change in habits and the seemingly additional time required performing new tasks. Thus, the leadership team performed daily audits to check daily compliance.

One year after implementation, the culture within the unit concerning patient safety has significantly changed. Especially in the case of the face-to-face review, this seemingly time consuming chore from a year ago, have grown deep roots that the nurses consider it as routine as signing up for today’s shift. This transformation of attitude, with the guideline hardwired in each and every nurse on staff, has kept patients safe and nurses safe practitioners.

The results are positive and tangible. There is a raised awareness of medication safety and has allowed a timely identification of medication errors. The morale is no longer clouded with reluctance, but that of acceptance. Audits are now conducted on a monthly basis rather than daily.
The new initiatives promoted not only patient safety by improving accuracy of patient identification and safe use of medications, but has done much to cultivate an improved handoff of communication among our ICU team.