Medication Safety: “Bolus from the Bag”

Problem

- Lack of standardization of process led to variation in medication administration via smart infusion pumps
- Costs were incurred from nursing time and single dose medication use when boluses were given from individual vials rather than the running infusion bag of the same medication

Background

- The organization supports high reliability processes and efforts to improve outcomes
- The Clinical Nurse Specialist (CNS) role at Aurora St. Luke’s Medical Center is one of leadership, collaboration, education, and implementation of evidence-based practice to achieve improved patient outcomes. The CNS’s on this project were part of an inter-professional leadership team whose goal was to improve process and outcomes
- Smart infusion pumps incorporate safety guardrails and had the ability to bolus a medication from an existing IV infusion, but the bolus functionality was not being utilized
- The electronic medical record (EMR) did not currently support documentation of administering a bolus of medication from a running intravenous (IV) infusion
- Root-cause analysis of a safety event revealed variation in medication administration of many intravenous drugs, including lidocaine
- Analysis revealed workarounds in nursing practice and documentation
  - Nurses administered appropriate bolus doses through smart infusion pumps but did not document appropriately, leading to diversion investigation

Setting & Population

- 938-bed acute care urban medical center
  - Six intensive care units and 18 inpatient units
  - One hospital as part of a large integrated health system utilizing an EMR for documentation
- The CNS role is unit-based and works within a dyad team model consisting of the unit Nurse Manager and CNS

Methods

- Plan
  - Inter-professional team, led by two CNS’s and a Pharmacist, collaborated to leverage and align current technology
  - This collaboration led to a proposed change in current process of medication administration and EMR documentation
  - Proposed change, at the system level, was to allow nurses to administer medication boluses in adult patients through the existing IV line on the infusion pump
  - Prior to implementation, the smart infusion pump technology had 32 medications with bolus from bag options that were not being utilized
- Do
  - A time study on the current administration process was done in an intensive care unit to evaluate initial nurse workflow efficiency with administration of IV push fentanyl
  - June 2017, the team met with stakeholders involved and proposed change-system teams included informatics, nursing, pharmacy, system shared governance council, and system medication safety committee
  - Proposed alignment of new workflow with concurrent Joint Commission titratable infusion project
  - August-December 2017, EMR build including building Medication Administration Record (MAR) orders to allow for charting of bolus from the bag
  - December 2017-January 2018 — training for nursing done by unit based CNSs and Nurse Clinicians
  - Go-live date of January 25, 2018
- Study
  - Provides clear medication instructions to the nurses on how to administer bolus dose
  - Ensures bolus is administered within safety guardrails
  - Prevents workarounds
  - Allows easier complete documentation
- Act
  - Effective process change as evidenced by resource utilization and efficiency measures

Findings

- Fentanyl infusion utilization in Aurora Health Care Emergency Departments, Operating Rooms, and Intensive Care Units included 1,969 patients and 10,082 bolus doses during January-June, 2018
- Before go live 10,082 IV fentanyl doses were estimated to take a nurse 10 minutes for each administration. This equated to a total of 1,680 nursing hours or $67,213.00 in nursing time
- After go live fentanyl from the bag doses were estimated to take 1.5 minutes per dose. This equated to a total of 252 hours or $10,080.00 in nursing time compared to the same number of doses utilized
- If nurses had given the same volume of doses in the pre and post time frames, difference of spending 1,680 hours and $67,213 instead of 252 hours and $10,080
- With the additional 30 medications added to the EMR bolus from the bag functionality, this has resulted in 12,433 bolus from the bag doses utilized
- Annualized to a cost savings of over $110,000

Conclusions

- Bolus from the bag functionality ensures boluses are administered within safety guardrails
- New functionality has translated to financial savings
- Standardization of workflow and process eliminated variation present before implementation
- Allows for accurate documentation and improves medication safety with elimination of previously identified workarounds
- New process contributed to cost savings from decreased RN time per dose, improving workflow and efficiency
- Implementation of best practice can be difficult when proposing system level changes. Overcoming these challenges through leadership commitment to zero harm and high reliability (Chassin & Loeb, 2013) were instrumental to the success of this project
- CNS leadership of this project was instrumental to identifying high risk processes and developing workable solutions for improving patient safety
- Technological functionality via Smart Pumps available to end users should be leveraged to improve patient safety

References


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