

HOSPITAL CHARACTERISTICS

## **BRONSON METHODIST HEALTH**

- Kalamazoo, MI
- 370 beds
- www.bronsonhealth.com

### S.T.E.E.E.P.



SAFE

Medication errors were reduced.

## TEAM MEMBERS

#### Diana Allor, RN

Nurse Manager, Pediatrics/PICU

#### Janine Black, RN

Risk Management

#### Heather Dietz, RN

Staff Nurse, NICU

#### Rob Germaine, RN

Staff Nurse, PICU

#### Kari Kloosterman, RN

Staff Nurse

#### Cheryl Knapp, RN

Vice President of Quality and Safety,

Executive Sponsor

#### Peg Malnight

Outcomes Coordinator, Clinical Operations Improvement

#### **Dave Montgomery**

Decentralized Pharmacist

#### **Eduardo Osorio**

Project Coordinator, Process Management

#### Jennifer Pawelek, PharmD

Decentralized Pharmacist

#### Chris Rosey, PharmD

Pharmacy Clinical Coordinator

#### **Chris Selles**

Director of Pharmacy

#### **Dave Short**

Director of Pharmacy

#### Jacqueline RF Wahl, RN

Team Leader, Executive Director

#### **Cherie Woodhams**

Pharmacy Educator

#### Mary Woodhouse, RN

Unit Coordinator/Nurse Manager,

Pediatrics/PICU

# PROTECTING PEDIATRIC **PROBLEMS**

#### The Problem

Bronson's patient safety committee appointed a task force to look at medication errors in pediatric patients. The team looked at all medication errors that occurred in patients 17 years and younger. There were 162 errors in the previous year with a rate of occurrence at 7.39 per 1,000 patient days. While this rate was lower than the adult population (8.67/1,000 patient days), the team decided to delve deeper and look for best practices in medication safety.

#### The Solution

The team selected 47 best practice methods from research on medication safety. Some of the best practices were already implemented and a part of the pharmacy routine. There were recommendations for pharmacy, nursing, physicians and educators. Some of the methods implemented included:

- » Standardized pre-printed order forms including a calculation of medication dosage based on weight of the patient and visible on the order;
- » Pediatric orders sent to the pharmacy are automatically flagged to alert the central pharmacist;
- » One pharmacist on the evening shift assigned to process all pediatric orders;
- » Pediatric based pharmacists offering monthly education to residents and nursing staff.

#### Results

» Bronson saw a 44 percent reduction in medication errors for pediatric patients from August 2008 to December 2008 (4.23/1000 patient days). The previous rate from November 2006 to October 2007 was 7.39 per 1000 patient days.