

# Pharmacy and Nursing Collaborative: A Multidisciplinary Approach to Patient Safety

STACI ADEN, RN, BSN, CMSRN

ANGELA DANGLER, PHARMD



## Kaizen Committee

The purpose of the Kaizen Committee is to provide amazing service by enhancing patient care and safety through improvement of the medication management system.

Kaizen Committee currently has 40 interdisciplinary active members, many with over 5 years of service. Membership consists of inpatient and ambulatory nurses, pharmacists and respiratory therapists.

Care areas represented include Med-Surg, ICU, Operative Services, Ambulatory, Pharmacy, Pyxis, Medication Safety, Nursing Informatics, Educator Council and Nurse Manager Council.

## Kaizen Philosophy

Kaizen is a Japanese word meaning gradually and orderly, continuous improvement. The Kaizen Committee strives to provide continuous quality improvement through the combined efforts of a multidisciplinary team.



## Kaizen Committee Responsibilities

Kaizen Committee's annual activities and responsibility to the hospital include:

- Review and approval of medication-related policies
- Review and approval of Automated Dispensing System (Pyxis®) Medication Override List
- Review, approval and implementation of physician order sets
- Other medication related initiatives
  - ✓ Do Not Tube List
  - ✓ MINI-BAG Plus Diluent Chart
  - ✓ Multi-dose Vial Labeling Guidelines

## Kaizen Committee Actions

Kaizen Committee co-chairs create a "Monthly Tip Sheet" following each committee meeting to ensure that members accurately share meeting actions with staff. Formal minutes and other handouts are posted on the Committee website.

## Kaizen Bulletins

**改善 Kaizen**

"CONTINUOUS QUALITY IMPROVEMENT THROUGH THE COMBINED EFFORTS OF NURSING AND PHARMACY"

DATE: 05/11/2011  
 FROM: PHARMACY AND PHARMACY CARE TEAM MEMBERS  
 TO: HOSPITAL WIDE  
 SUBJECT: Required Drug Information Study

The reference books have been identified on the required list only. Requests for items to be added to the list, or changes to the list, must be submitted to the pharmacy department for review by the University of Colorado Hospital. These list of reference books may be modified from time to time.

Alaris® SmartPump and other infusion devices are available for purchase by the hospital.

Required Reference Available at the Aurora Medical Center Bookstore  
 • The Infusion Handbook: A Handbook for Nurses and Health Professionals  
 2010, Elsevier  
 • The Infusion Handbook: A Handbook for Pharmacists  
 2010, Elsevier  
 • The Infusion Handbook: A Handbook for Respiratory Therapists  
 2010, Elsevier  
 • The Infusion Handbook: A Handbook for Physicians  
 2010, Elsevier

In addition, CDMP® "Reference" and the CDMP Handbook are key references that are available on the CDMP website. These references are available for downloading. No personal reference will be allowed within the CDMP system unless they are one of the above references.

Kaizen Committee is guided by the hospital's shared leadership model. One method used to communicate practice changes affecting staff is through Kaizen Bulletins.

AURORA, CO



**University of Colorado Hospital**  
UNIVERSITY OF COLORADO HEALTH

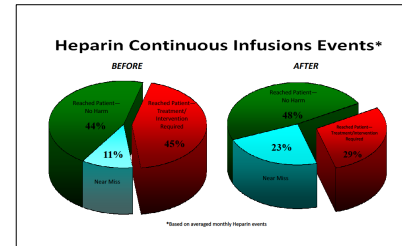
## Medication Safety Initiatives

### Initiatives to decrease incidence of heparin-related medication errors

Kaizen Committee provided input on the following actions:

- New "Independent Double Check" policy approved
- Implementation of the internal "6 Rights in 6 Months" campaign highlighting one medication administration "right" per month
- PTT results displayed on the Medication Administration Record (MAR) to decrease PTT-related errors (see below)

Since implementation of PTT results displaying on the MAR, there have been **ZERO** PTT-related medication errors reported.

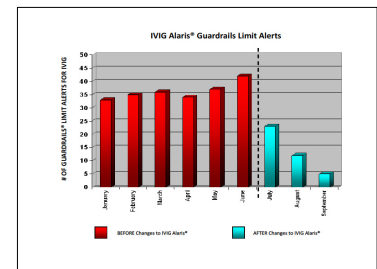


## Medication Safety Initiatives

### Alaris® SmartPump Technology: Intravenous Immunoglobulin (IVIg) pump administration changes and outcomes

Kaizen Committee provided input and staff education regarding a change to how IVIG was built in the Alaris® SmartPump. This change resulted in a decrease of pump alerts and improper pump programming.

Drug	RATE	DOSE	VOLUME	DOSE	RATE	VOLUME
IVIg	100 mL/hr	1000 mg	1000 mL	1000 mg	1000 mL	1000 mL



The authors would like to acknowledge Sondra May, PharmD and Sylvia Park, RN, BSN for their contributions to this poster.

**University of Colorado Hospital**  
UNIVERSITY OF COLORADO HEALTH