A Medication Safety Huddle

“#DRUGgle”

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The Goals
Towards zero drug errors

Primary Drivers
Reduced prescription errors
Reduced administration errors

Secondary Drivers
Doctor/Nurse ownership
Culture of drug safety
Pharmacists/team integration

Projects
DRUG-gle
Induction teaching/test
Ward Round chart review
On-ward chart review
Medication Safety Huddles: Teaming Up to Improve Patient Safety

Kerry Wilbur and Kathy Scarborough

INTRODUCTION

The focus on patient safety in health care has intensified over the past 5 years. The 1999 Institute of Medicine report To Err Is Human, which catalogued the alarmingly high rate of medical errors in the United States, mirrored recognition of iatrogenic injury in Australia and the United Kingdom and generated an unprecedented response in health care policy. Many health care organizations launched initiatives to promote patient safety and, in December 2003, the Institute for Healthcare Improvement (IHI) A simple and efficient tool for front-line staff, these small briefings represent an opportunity to share information about actual or potential medication safety problems and concerns on a regular basis. Regular briefing leads to the implementation of suggestions for interventions that are implemented in a timely fashion. Medication safety huddles can be used to identify and address factors contributing to medication errors, educate nursing staff about medications, and promote a culture of change among participants.

• Have you had concerns about medication delivery this week?
• Have you had any errors, near misses, or "good catches" that you would like to share?
Huddling for high reliability and situation awareness

Linda M Goldenhar, 1 Patrick W Brady, 2,3 Kathleen M Sutcliffe, 4
Stephen E Muething 1

ABSTRACT
Background: Studies show that implementing huddles can improve patient outcomes. Yet little is known about the mechanisms through which huddles exert their effects. To help remedy this gap, our study objectives were to explore hospital administrator and frontline staff perspectives on the benefits and challenges of implementing a huddle system and propose a model based on our findings depicting the mediating pathways through which implementing a huddle system may reduce patient harm.
Methods: Using qualitative methods, we conducted semi-structured interviews and focus groups to gain a deeper understanding of the huddle system and its outcomes as implemented in an academic tertiary care children’s hospital with 539 inpatient beds. We recruited healthcare providers representing all levels using a snowball sampling technique (10 interviews) and emails, flyers, and paper invitations (six focus groups). We transcribed recordings and analysed the data using established techniques.
Results: Five themes emerged and provided the foundational constructs of our model. Specifically we propose that huddle implementation leads to improved efficiencies and quality of information sharing, increased levels of accountability, empowerment, and sense of community, which opportunities to stay informed, review events, make and share plans for ensuring well-coordinated patient care.

Studies show that huddles can improve patient safety 1-4 and can reveal factors that contribute to potentially adverse patient outcomes, such as medication errors, near misses and poor hand hygiene. 5 They can provide a venue for raising concerns, increase efficiency of exchanging critical information, and increase staff’s perception of the benefits of face-to-face discussion. 6-8 Moreover, huddle implementation can improve teamwork by enhancing working relationships, increasing trust across departments, and helping staff appreciate and respect others, seeing them as allies working towards a common goal. 2,3 6-8

Missing from the literature is a description of how an integrated system of huddles, developed and structured based on theoretical principles, might work to reach the goal of reducing failures and eliminating patient harm. Thus, we conducted a qualitative study to begin addressing this gap. Specifically, our objectives were to describe the development and implementation of an inpatient huddle system, which was grounded in the theory...
Top 5 reminders for Starfish Drug Charts

1. Remember to write the FLUSH for IVs 0.9% Sodium Chloride 1-5mls IV
2. Prescribe round numbers where possible 118.5mg can become 118mg
3. Avoid prescribing “1 tablet” – use dose Ascorbic acid : 1 tablet = 200mg
4. If you need to change the dose... ...REWRITE the prescription
5. Write legibly in BLOCK CAPITALS

Quiz Answers:
A. Ben Pen prescribed at 118.5mg has the potential for being mis-read as 1185mg; needs to be rounded down to 118mg.
B. Benzyl Penicillin is prescribed QDS but given TDS – this is a drug error and has been reported on DATIX. Best to prescribe times at point of prescribing OR nurses could populate best times according to Frequency prescribed by Doctor.
DRUG-gle

• At end of Grand Round/Handover

• Pharmacist led

• Key interventions from past week

• Summary circulated
# Druggle Feedback list

**Date of Druggle:** 14/11/2017

<table>
<thead>
<tr>
<th>Date of intervention</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>14/11/2017</td>
<td>Please look at the back of drug charts to help ensure all regular medications are being prescribed if appropriate to continue with.</td>
</tr>
<tr>
<td>14/11/2017</td>
<td>For inhalers such as beclomethasone, please state the brand (Clenil or Qvar) and strength of the inhaler required</td>
</tr>
</tbody>
</table>

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**PEARLS**

<table>
<thead>
<tr>
<th>Date of PEARLS</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>14/11/2017</td>
<td>Methylprednisolone injection containing lactose (Solu-Medrone 40 mg) may contain trace amounts of milk proteins. Do not use in patients with a known or suspected allergy to cows’ milk.</td>
</tr>
<tr>
<td></td>
<td>- The injection contains only trace amounts of protein. However, no level of cow’s milk protein is safe in these patients.</td>
</tr>
<tr>
<td></td>
<td>- Solu-Medrone 40mg is the only strength affected, thus other strengths may be used as these do not contain lactose.</td>
</tr>
<tr>
<td>14/11/2017</td>
<td>Rest of trust have now been using a brand of Enoxaparin called Inhixa instead of Clexane 20mg and 40mg. The license for Inhixa is identical to that for Clexane, which is off label use in paediatrics. Both products state that the safety and efficacy of enoxaparin sodium in the paediatric population has not been established. Therefore if Clexane is being used off label in paediatrics then Inhixa could be used in the same way.</td>
</tr>
</tbody>
</table>
CQC questions

1. What division does Pharmacy fall under?

Pharmacy is part of the Clinical Support Division, which includes Radiology, Pathology and the Therapies.

2. What new developments has the Pharmacy department employed this year on the ward for the nursing team?

Nursing Druggle - Weekly on Thursday

3. Where are the CD keys normally kept on the ward?

Keys for the CD cupboard should be held by the Nurse in charge.

The assigned key holder will challenge members of staff who request the keys to ensure that they have a legitimate and acceptable reason to access the CD cupboards and valid identification. Under no circumstances are student nurses permitted to be responsible for Controlled Drug cupboard keys.

The keys for the CD cupboards should not be kept with any keys that may be accessed by staff that are not authorised to hold CD keys.

4. It’s 9pm on a Saturday and the CD keys cannot be found, who should be notified?

   a) The ward sister and ward pharmacist
   b) The bed manager and on-call pharmacist
   c) The police

If the CD keys cannot be found urgent efforts should be made to retrieve them (e.g. by contacting relevant staff who have gone off duty).

The relevant Modern Matron, Ward Pharmacist and Pharmacy Manager should be contacted during working hours. Out of hours the Bed Manager and On-call Pharmacist should be notified.

If the keys are not located within 24 hours the Accountable Officer or their nominated deputy will be informed by the Modern Matron. Depending on the circumstances it may be appropriate to contact the police. This decision will be made by the Accountable Officer. If wrongdoing is suspected the police must be involved.

If access is required, contact the Estates Department who will supply a new lock for the CD cupboard with a new set of keys. The new keys will only be released by security to the Ward manager, Nurse, midwife or ODP in charge, Operational Manager (Bed Manager) or pharmacist.
Local Spread...

• “Let’s do the #DRUGgle”

• #NEOdruggle

• #NURSINGdruggle
National Spread...

Evidence Bites: Drugs

Aug 2

An evidence summary inspired by safety discussions held at the WUTH Safety Days

What is a druggle?
A druggle is a team huddle to discuss medications. The medical and nursing staff meet with pharmacist to review medication harm, risks and near misses, so that processes can be improved.

Who is using druggles?
The druggles emerged from the SAFE programme being run by the Royal College of Paediatrics and Child Health, driven by the use of huddles to embed situational awareness on the ward

Several NHS Trusts are using druggles, led by Leeds Teaching Hospital.

Their Neonatal Unit has a weekly druggle led by the pharmacist. It is a five minute presentation aimed at increasing communication on medicines related topics, highlight areas for improvement and encourage discussion.

It includes a hot topic, an anonymised error of the week (for real time feedback learning), and results from the weekly prescribing standards audit.

Feedback has been extremely positive and there are plans to introduce an award for patient safety.

West Hertfordshire has implemented this, and Gravesham have launched their own weekly medicine newsletter.

How else can the druggle model be implemented?

Meds IQ (a paediatric rests of hate) has been implemented in a number of Trusts.

Does it work?
The literature on the use of druggles in other Trusts suggests it has positive feedback from the pharmacists' intervention.

Further reading

1. Royal College of Paediatrics and Child Health.
3. First winners of new Safe.
5. Westford General case study: medication safety huddle.
# Examples of key messages

<table>
<thead>
<tr>
<th>Type of error</th>
<th>Details</th>
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<tbody>
<tr>
<td>Transcription error</td>
<td>Metolazone prescribed instead of mesalazine.</td>
</tr>
<tr>
<td>Regular medications</td>
<td>Lanzoprazole: Taking 15mg at home; prescribed at 50mg</td>
</tr>
<tr>
<td>Levels</td>
<td>Gentamicin: Reminder levels on day 2 and 5. Day 5 level had been missed</td>
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<tr>
<td>Interactions/effects</td>
<td>Ciprofloxacin and epilepsy: It can reduce seizure threshold</td>
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West Hertfordshire Hospitals

“#DRUGgle”

Acknowledgements

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Alistair Hill

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Neonatal Unit

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