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How Near Miss Events Helped to Improve the Reliability of the Medication Processes at Texas Health Recovery Wellness Center (THRWC).





Objectives

- 1) Participants will understand how to use safety and near miss events to identify process issues.**
- 2) Participants will learn how near misses can be used to track and trend the effectiveness of performance improvement initiatives.**
- 3) Participants will gain insight into how safety event data, near miss event data, and other HRO methodology can be used to get leadership buy in for investing in equipment and technology to advance the reliability and safety of care processes.**

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Situation

Safety Event Reports Helped Make Improvements in Medication Processes at Texas Health Recovery Wellness Center (THRWC).



Background:

Texas Health Recovery Wellness Center (THRWC) is a Residential Treatment Facility(RTC) that provides care to clients experiencing substance use disorders.

THRWC does not have a pharmacy and relies on outside pharmacies to provide medications for clients.

Medication
Carts



Background:

February 2022- Nursing staff reported issues with the outside pharmacy fulfilling medication orders timely and was causing delays in clients receiving medications.

THRWC's Leadership and System Behavioral Health Leadership issued a START THE CLOCK to address issues with medications.

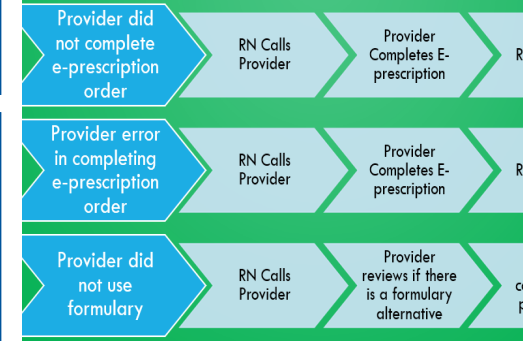
Developed a "Medication Escalation Protocol" for nursing staff to use.

- Focused on how to respond in different scenarios and when to enter issues as a safety event.
- Standardized what was considered an early sign of a potential delay in a medication.

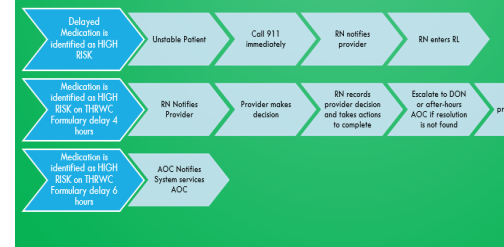
THRWC Leadership, Behavioral Health Patient Safety and Risk, and Texas Health Behavioral Health VP and Texas Health Behavioral Health CNO and COO would meet every morning Monday-Friday to review issues and events from the previous day.

Near misses were key in uncovering and understanding all process issues that were contributing to the medication delays and other medication related processes.

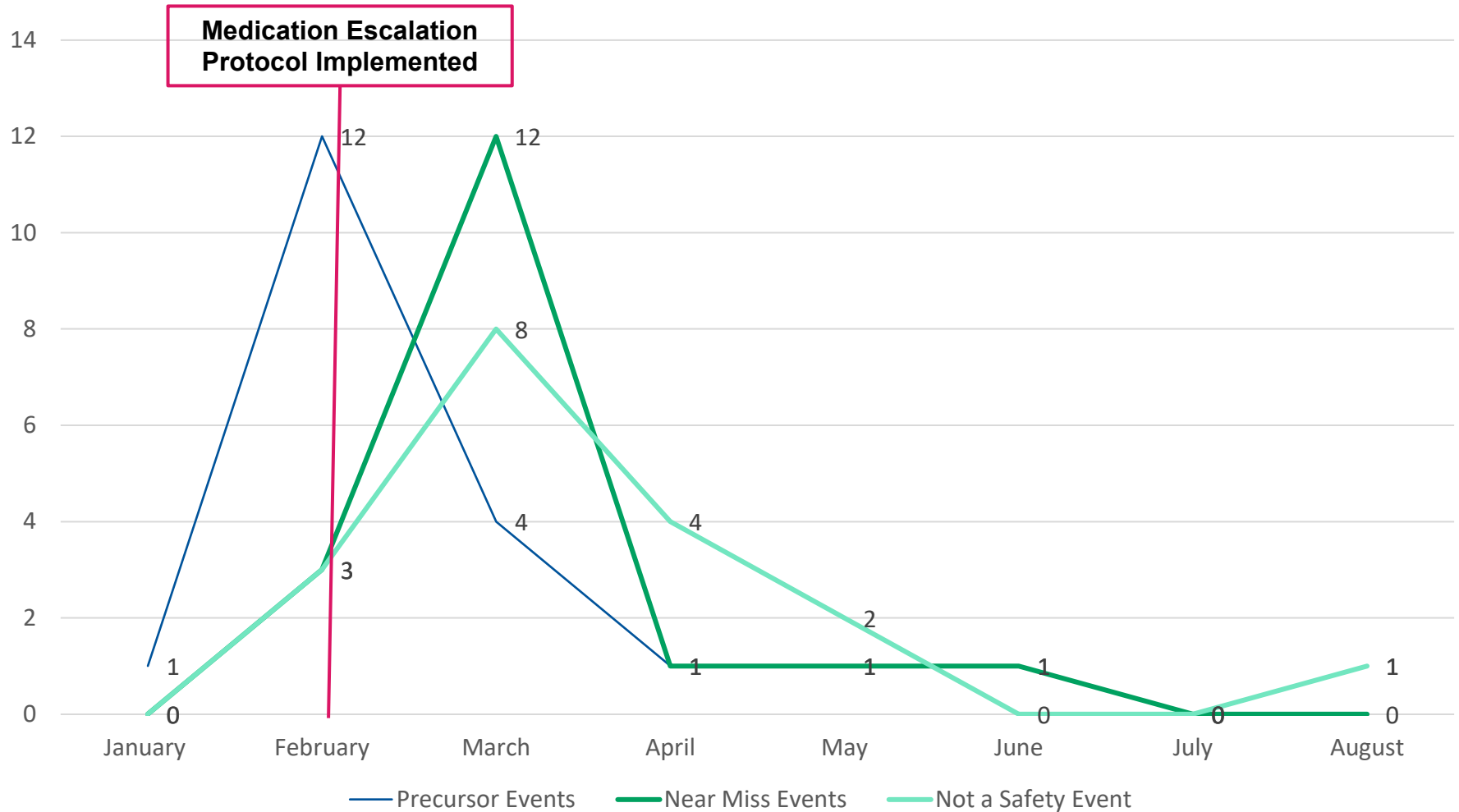
THINGS THAT GO WRONG - PROVIDER



THINGS THAT GO WRONG - CRITICAL



Assessment





Recomendations

Keys to our Success

Simplified issues and identified solutions.

Defined for staff when a medication was at risk of being delayed.

Explained to staff the “WHY” behind the importance of reporting near misses.

Emphasized the What's In It For Me (WIFM) in reporting.

Closing the loop with staff on what was happening based on what they were reporting.

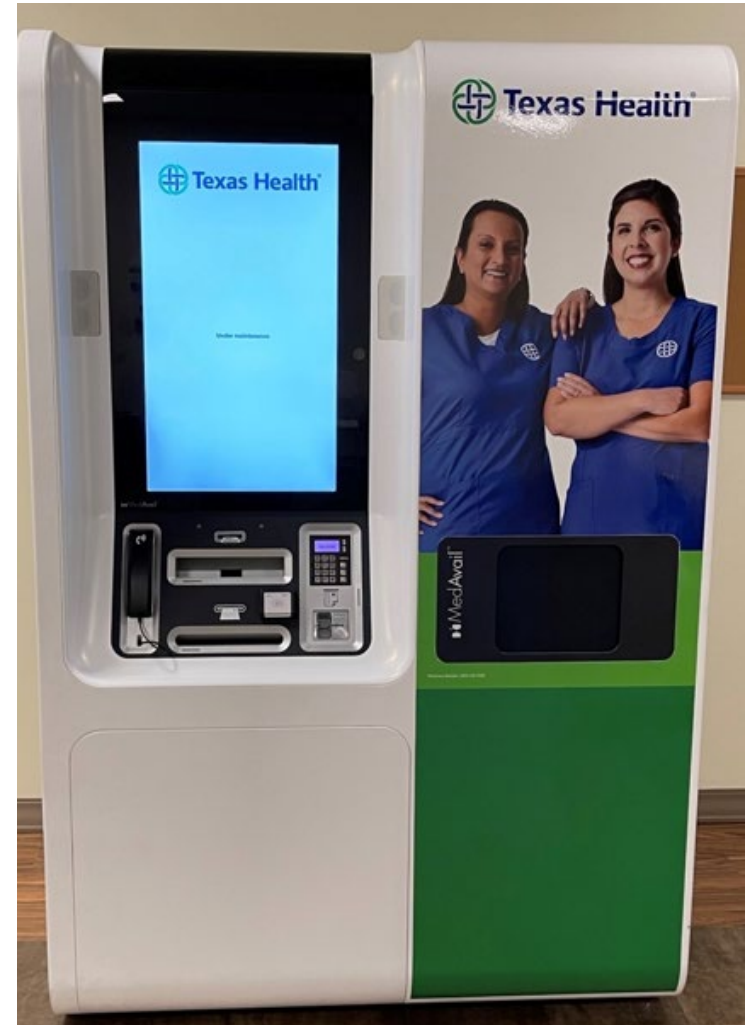
Recommendations

Entity and System Behavioral Health Leadership was involved in the entire process and attended every “Start the Clock” meeting.

When barriers were encountered it was communicated up through the chain of command. This resulted in leadership all the way up to the top being aware of the situation.

Data from near miss events, precursor events, and information from our barrier analysis provided fact-based information to make the case for the need for more advanced medication equipment.

THRWC know has medication kiosks on site and has 3 Pyxis machines on the way!!!



Questions

