Unit Based Pharmacist-Medication Safety Walkarounds Tool

Date: **Conducted by:**

Walkarounds Introduction:

Introduce yourself. I am interested in hearing from you about how we can make the patient care environment safer by focusing on systems, not people. The questions are broad so consider medication errors, adverse drug events, close call/good catches, etc. Also utilize elements of observation and audit to look for opportunities.

ID	Quality Processes and Risk Management	Location	Discipline	Participant(s)	Responses
1	What do you predict the next medication error will be?				
	Drug Standardization, Storage, and Distribution				
2	When are ready-to-use concentrations not being utilized (Is there opportunity for pharmacy to purchase or prepare the product for nursing to avoid manipulation on the care unit)?				
3	Where are patient home medications stored? Are they secured and clearly labeled?				
4	Where are medications placed that are expired or need to be returned to pharmacy? Are they segregated from other medications?				
	Medication Device Acquisition, Use, and Monitoring				
5	How often are medications removed from medication dispensing cabinets (e.g., Pyxis) via the override function? (Run override report to ask nursing colleagues why and when the situations occur.)				
6	How is medication event data (errors/close calls) utilized for change? How many events for that unit were reported? Was there a trend? How was the identified gap closed?				
7	Perform a tracers on heparin and insulin from order, storage, automated dispensing cabinent removal, administration, pump setting, nursing documentation, and monitoring. What gaps where identified in this process? Share findings with medication safety committee and interdisciplinary team for ideas of improvement.				
8	How are high-alert medications being differentiated? Review access to neuromuscular blockers (NMB) for the unit. Is it appropriate to have this medication on this unit? Is there clinical decision support for nursing in the ADC? Refer to standard HCA guidance.				
	Environmental Factors, Workflow, and Staffing Patterns				
9	What are unit BCMA scanning rates on the unit? Review outliers with nursing colleagues for challenges with barcodes.				
10	Ask nursing, patients, families, or physicians: What aspects of your environment are likely to lead to medication errors?				

Closing Remarks: *Thank you very much for sharing your responses. Your comments will be used to consider system changes to improve patient care.*

Notes:

Note To User: *One way to improve the Culture of Safety is to follow-up with anyone that you interviewed on substantial changes or workflow improvements that were created as a result of their feedback.*