Date:	Conducted by:
Location:	
Participants:	

Walkarounds Introduction:
This tool can be completed by any member of the healthcare team including: ethics and compliance officers, pharmacy, nursing, physicians, healthcare leaders, risk management, patient safety officers, quality managers, etc. Each section time commitment is approximately one hour. Getting started: 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.

Section 1	Quality Processes and Risk Management	Discipline	Responses
1a.	Have you reported a medication event in the past 90 days?		
1b.	What could have been done to prevent this close call(s)? Did your leadership team or manager follow up with you regarding the event to identify solutions?		
2.	What do you think are reasons that clinicians do not report events with medication errors or close calls?		
3.	If you make or report an error, are you concerned about personal consequences?		
4.	Have you developed any personal practices to specifically prevent making a medication error?		
5a.	What opportunities are there to revise standardized policies to further reduce/prevent medication errors? (examples: high alert medications, look alike-sound alike medications, insulin or heparin protocols)		
5b.	Where do you think standardization could be implemented: a) storage and procurement, b) ordering/prescribing, c) transcribing and verifying, d) preparing, dispensing and delivering, e) administering, and f) monitoring and reporting?		
6.	Please provide an example where technology has contributed or could potentially contribute to medication errors?		
7.	What do you predict the next medication error will be?		
8.	Are discrepancies with medication counts and waste addressed at the time of discovery?		
	Patient Information and Education		
9.	How are you ensuring that the patient understands his/her medications before being sent home?		
10a.	Are patients being asked about over-the-counter medications and supplements they currently take during the medication reconciliation process?		
10b.	Where is this information documented?		
	Drug Standardization, Storage, and Distribution		
11a.	Are ready-to-use concentrations being utilized (nursing does not have to perform manipulation before administration)?		
11b.	If not, give some examples where ready-to-use concentrations could be used.		
	Medication Device Acquisition, Use, and Monitoring		
12a.	How often are you removing medications from medication dispensing cabinets (e.g., Pyxis) via the override function?		
12b.	How often and who reviews both controlled substance and non-controlled substance medication overrides?		
12c.	How is this data analyzed and reported to the Medication Safety Committee or P&T Committee for process improvement or appropriate determinations?		

13.	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 to identify how pharmacy can assist to limit this process.)		
	Medication Device Acquisition, Use, and Monitoring	**Discipline**	**Responses**
14.	What is the standardized process for loading medication dispensing cabinets (e.g., Pyxis)?		
	Communication of Medication Orders and Other Information		
15a.	Can you describe how communication between caregivers enhances safe medication use?		
	Can you describe how communication between caregivers inhibits safe medication use?		
15b.	What are areas for improvement?		
	Communication of Medication Orders and Other Information		
16.	In what situations are medication orders not being screened by the pharmacy before administration?		
	Environmental Factors, Workflow, and Staffing Patterns		
17.	What aspects of your environment are likely to lead to medication errors?		
	Closing		
18.	What other medication safety concerns do you have that have not been addressed during this walkaround?		
19.	What patient safety concerns keep you up at night?		

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

Other notes:

Operational Considerations:

- **Groups of 2-3 pharmacy/nursing/MD colleagues**
- **Prepare to spend 1-2 hours with observations and discussions.**
- **Methods of how to conduct: Engage the unit-based team in discussion and observe actual practice**

Section 2	Medication Management Audit and Observations	Discipline	Responses
1.	Is your policy for look-alike/sound-alike (LASA) medications updated and reviewed regularly to consider new medications added to formulary or close calls that have occurred?		
2.	How are high-alert medications being identified and differentiated from other medications?		
3a.	Please give me examples where medications, even for short time periods, are not stored under proper temperature control or secured appropriately.		
3b.	What is the process to ensure medications are stored properly?		
4a.	How and how often are refrigerator temperatures monitored?		
4b.	Is this a consistent process?		
5a.	Is the smart pump library standardized for pediatric and adult dosing?		
5b.	How often do the standard drug concentrations NOT match the drug library?		
5c.	How often are smart pump guardrails bypassed when they should not have?		
6.	Are the number of drug concentrations available limited? Examples: Number of norepinephrine strengths made, number of dopamine concentrations purchased		
7a.	Are all expired, damaged, and/or contaminated medications removed and stored separately from medications available for administration?		
7b.	How often are drug storage areas inspected and where are the inspections documented?		
8.	What are examples where physicians order concentrated electrolytes a la carte and not our standard commercially available products?		
9.	Do medication labels clearly provide formulation and route of administration to nursing for medication administration (e.g., formulation = capsule, tablet, oral liquid; route = oral, IM, IV)		
10.	Are there difficulties with ordering complex IVs (e.g., concentrated electrolytes should have diluents)?		
	Nursing Practice		
11.	What two patient identifiers are being used to verify that the right patient is being given a medication?		
12.	Is the patient's electronic medication administration record (eMAR) being reviewed prior to medication administration?		
13.	Are patients being counseled on first doses of all of their medications?		
14.	Are patient weights being measured, converted to metric units if applicable, and documented in metric units?		
	Medication Dispensing Cabinets Observations		
15a.	Are the medication dispensing cabinets (e.g., Pyxis) located in areas with minimal distractions?		
15b.	Due to patient load, how often and when do you remove medications for more than one patient during a single visit to the medication dispensing cabinet (e.g., Pyxis)?		
15c.	How do you transport the medications to each patient?		
16a.	How are look-alike/sound-alike medications being differentiated?		

16b.	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.		
17a.	How and how often are refrigerator temperatures monitored?		
17b.	Is this a consistent process?		

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.*