Healthcare Organization Commitment

Contact Details

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APSS

What Patient Safety Challenge does your Commitment address?
Challenge 3A - Medication errors

Commitment Name
Adverse Drug Event Reduction - Update - 04.15.2020
How many hospitals are represented in this commitment?

<table>
<thead>
<tr>
<th>Last Report</th>
<th>Current</th>
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<td>21</td>
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Did you download and use the APSS in tandem with your action plan?
No

**Self Assessment Tool**

**Ensure best patient care**

| Create a multidisciplinary team to lead the project, including physicians, nurses, pharmacists, and information technology personnel | Yes |
| Use systematic protocols for medication administration, including checklists for writing and filling prescriptions, drug administration and patient transitions of care, and other quality assurance tools including: | |
| Install the latest safety technology to prevent medication errors, such as: | |
| Medication Management System | Yes |
| A drug library system | Yes |
| Other drug dosing solutions such as a solution for calculating IV & SubQ insulin doses | Yes |
| Use barcoding for identification in the medication administration process | Yes |
| Check patient’s allergy profile before prescribing medication | Yes |
| Ensure appropriate training and safe operation of automated infusion technologies | Yes |
| Distinguish “look-alike, sound-alike” medications by appropriate labeling, package design, and storage | Yes |
Practice the Six Patient Rights on Medications - all care providers should use this simple checklist: right patient, drug, dose, route, time of administration, and documentation | Yes

Follow practices to prevent medication errors during transitions of care | Yes

Engage staff and use data to find areas for improvement

| Use technology to standardize Computerized Provider Order Entry (CPOE), reporting systems and quality assurance reports to audit compliance | Yes |
| Use Clinical Decision Support (CDS) systems where possible (Kane-Gill et al., 2017) | Yes |
| Review monitoring and reporting results at medical staff meetings and education sessions as a part of Continuous Quality Improvement (CQI) | Yes |
| Use patient stories - in written and video form - to identify gaps and inspire change in your staff | Yes |

Boxes Marked Yes:
14

Your Score:
100%

Commitment Details

Commitment Update
We focused on opioid, hypoglycemic and anticoagulant medications in 2019. We continued to hardwire the interventions in our plan. Significant focus on getting strict adoption in the use of Smart Pumps. Our data reported here does not reflect all ADEs but just those associated with our focus areas and high risk medications based on our data and prior performance.

Please describe any best practices your organization has learned through your commitment and share valuable lessons or challenges that were overcome. Capitalize on technology is this area to make it easy to do the right thing and hard to do the wrong thing. Really supports human factor science.

Action Plan
Impact Details

Lives Saved

Predicted Lives Spared Harm
474.14999999999986

For reporting purposes, the number has been rounded up to the nearest whole number. Predicted Lives Spared Harm
475

Acknowledgement
Yes, I acknowledge that this commitment may be used for external communication and publicly announced at the World Patient Safety, Science & Technology Summit. Furthermore, I agree that this commitment may appear on the website of The Patient Safety Movement Foundation or the Masimo Foundation. I also give permission for my commitment to be used in support of the promotion of the World Patient Safety, Science & Technology Summit as well as The Patient Safety Movement initiative.