

HOSPITAL CHARACTERISTICS

**ALBERT EINSTEIN  
MEDICAL CENTER**

- ▶ Philadelphia, PA
- ▶ 700 beds
- ▶ www.einstein.edu

**S.T.E.E.E.P.**



**SAFE**

Developing a pharmacy practice bundle requires a shared goal to improve safety



**EFFECTIVE**

Medication events associated with order entry were reduced by 52 percent

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# THE MEDICATION BUNDLE

## The Problem

Medication safety is a strategic imperative in the organization. Each aspect of the medication-use cycle-prescribing, dispensing, administration and monitoring-is vulnerable to error. Hospitals operate in a transitional environment of paper and electronic records. At AEMC, the pharmacists enter physician orders into a clinical documentation system for online nurse charting. The goal was to eliminate possible errors in medication order entry and standardized the pharmacy process bundle. The rationale was to build safety redundancies through the execution of bundles that heighten checkpoints in the medication delivery system, which is often complex and vulnerable to human error.

## The Solution

Chunking key elements or practices together, as a list of essential steps to make a process more reliable is known as a bundle. Clinical bundles are comprised of standardized practices that are evidence based. This initiative examines the role of bundles in response to medication errors in a network pharmacy consisting of a tertiary teaching acute care hospital and its subsidiary entities encompassing multiple pharmacy practice sites. This initiative explores the merits of applying a consistent and standard process bundle in the practice of pharmacy.

With recent medication errors trending upwards, the pharmacy team was willing to explore the best practice of bundles and adapt them in the pharmacy domain in efforts to improve the medication process and patient safety.

A front-line team of pharmacy staff familiar with the medication process was formed and the group's charge was to develop the best way to implement a novel pharmacy practice bundle in efforts to reduce medication errors. The front-line team traced all the steps in the medication workflow process and identified four key redundant steps that needed to happen each time to ensure overall success of the process. The pharmacy practice bundle was unveiled at staff meetings. The pharmacy team was eager to pilot the practice bundle in response to recent medication errors

## Results

- » Medication events associated with order entry were reduced by 52 percent from April 2008 to March 2009. The medication event reductions have sustained for 9 to 2 months since the bundles initiative was implemented in the pharmacy
- » Medication events associated with dispensing were reduced by 48 percent from April 2008 to March 2009.
- » The medication event reductions have sustained for 9 to 2 months since the bundles initiative was implemented in the pharmacy