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Opioids Room of Horrors
An interactive learning to improve safety of drug administration

Centre hospitalier universitaire vaudois

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What was done ?

An interactive learning approach with an opioid Room of Horrors was selected, developed and implemented in the geriatric unit to improve safety of drug administration.

Why was it done ?

Adverse events affect 1 in 10 patients in hospital, 20% are due to medication and half of which are preventable[1].

In the CHUV geriatric rehabilitation unit, opioids errors of administration represent a significant part of drug self-reporting incidents (Fig 1).

Prevention with training is a way to reduce these errors. Graduate and continuous educations teach the five rights (5R) rule for a medication with a theoretical approach but remain insufficient.

Objective : Mapping the risk of error of administration in the unit

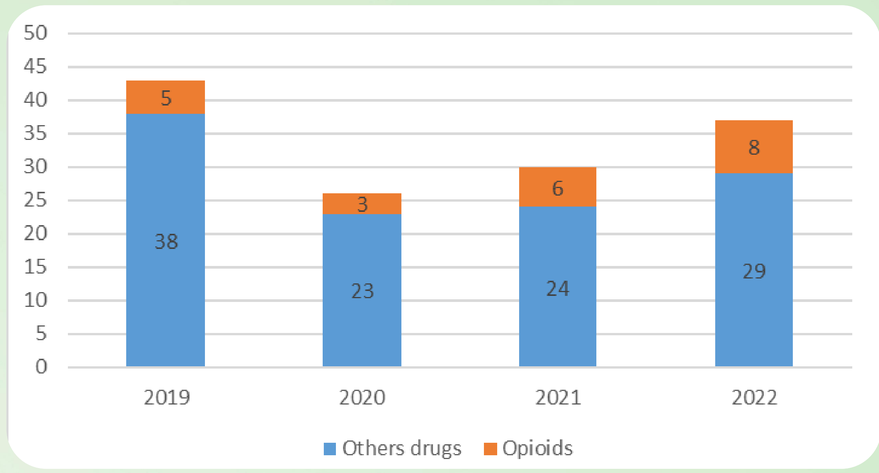
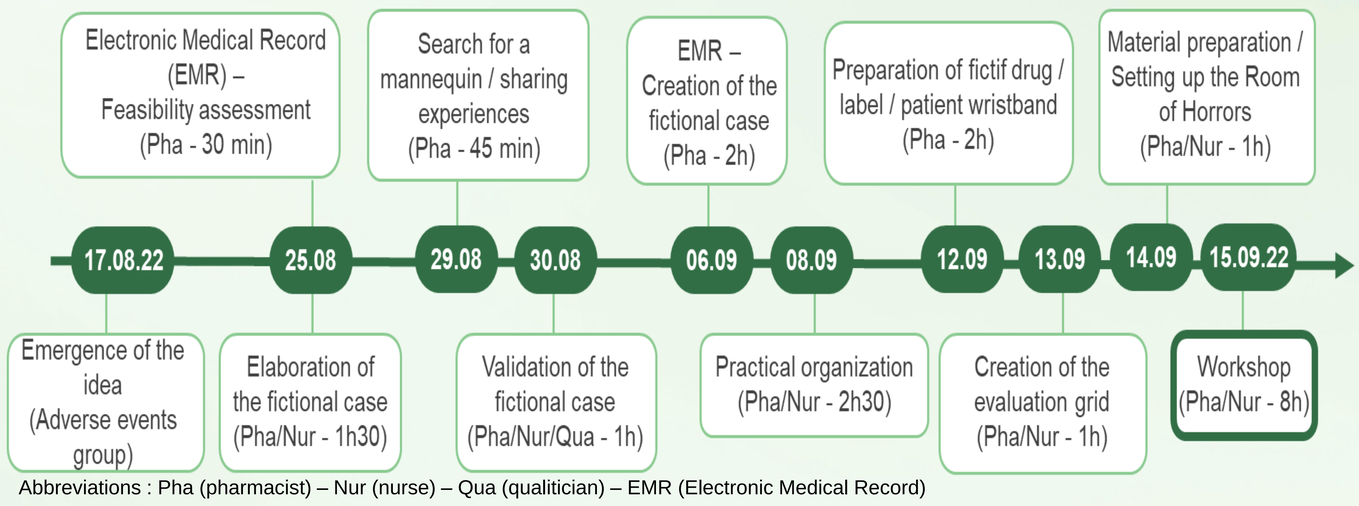


Figure 1 - Number of medication administration errors

How was it done ?

The project

The realization of the project took one month, was deployed following the below steps and required a total of 15 hours to complete it.



Abbreviations : Pha (pharmacist) – Nur (nurse) – Qua (qualitician) – EMR (Electronic Medical Record)

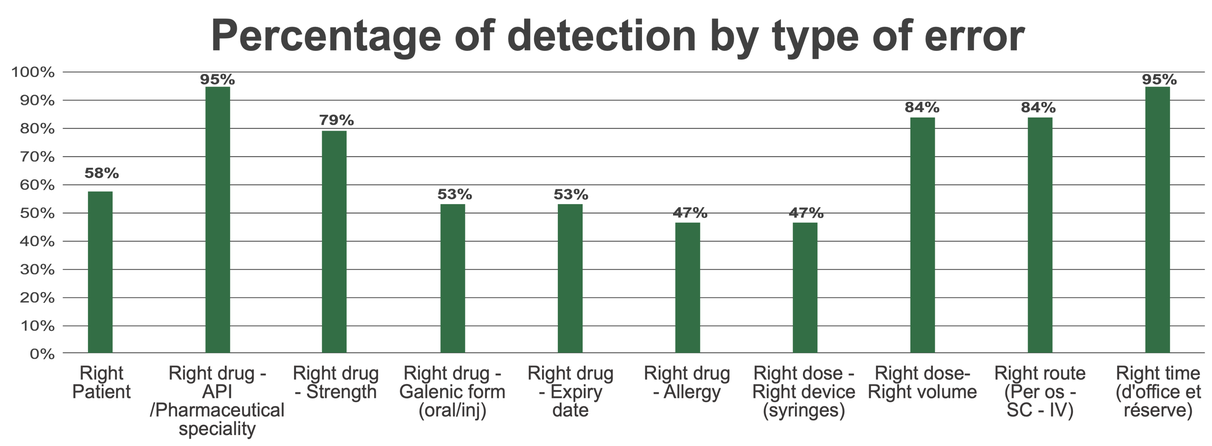
The workshop

- The Room of Horrors took place on the 15th of september 2022, during the world patient safety day.
- 10 errors have been hidden in the room and covered the different steps of the opioid medication circuit.
- The room contained a mannequin, an opioid cabinet, a medical device cabinet, an opioid file for the tracability of the stock, a computer with the Electronic Medical Record.
- Participants were given 20 minutes for the workshop : 5 min for the briefing, 10 min for the simulation and 5 min for the debriefing.
- Participants were searching in pairs (nurse/nurse, nurse/healthcare assistant, physician/physician).
- Two assessors (Pharmacist/Nurse) measured the errors that have been detected

What has been achieved ?

Risk of error mapping – Workshop

Participants : 38 healthcare professionals (19 nurses, 10 healthcare assistants and 9 physicians)



Follow up of the reported incident on opioid administration errors: **0 incident** 3 months after the workshop.

Immediate action:

Reproduction of the workshop based on the turn over of the healthcare professionals

Lessons learned

- **Elaboration of the workshop**
  - Quick creation of the workshop (1 month)
  - Few financial investment was needed
  - Organizer : internal resources
  - Participants attended the workshop during theirs working hours (little time is needed for the exercise)
- **The workshop**
  - Very positive feedback from the participants : fun and impactful experiences
  - Learning with a direct implication and in a long term
  - Extension of the Room of Horror to others drugs at risk or to any healthcare issue identified
  - Rich learning experience for the assessors
  - Promote teamwork (physician/nurse), interaction and sharing expériences

→ ***Give meaning and value to the 5R***

What's next ?

- Reproduction of the Room of Horror in the unit to cover all the employees
- Opioid Room of Horror is available to other department of the hospital
- The Room of Horror is transposable to other drugs at risk or any healthcare issue identified
- The training can be suggested to the training catalogue of the hospital
- Teaching material (video)

Reference : 1. Schwendimann R and al, The occurrence, types, consequences and preventability of in-hospital adverse events - a scoping review. BMC Health Serv Res. 2018 Jul 4;18(1):521

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