Successful transition to BCMA requires a collaborative effort of many teams in the hospital, particularly nursing and pharmacy departments. BCMA went live in April 2014 at North Shore University Hospital. The pitfalls of BCMA implementation included equipment challenges and missing medications, which make the process time consuming and frustrating, and can lead to workarounds that may potentially compromise patient safety. The Institute of Medicine (2007) reports that hospitalized patients are subject to one medication error per day and the BCMA process has the potential to reduce dispensing and administration errors. Lack of attention to workflows in the pre- and post-go-live periods may result in workarounds due to the challenges with the BCMA process; this can result in non-compliance and, in the process, threatens patient safety (Koppel, Wetternick, Telles & Karsh, 2008).

The BCMA task force was formed with intentions to:

- Support post go-live transition phase by developing a collaborative group staffed with members of the nursing and pharmacy department
- Identify potential problems
- Brainstorm solutions
- Improve compliance
- Improve patient satisfaction and safety

**BACKGROUND**

**PURPOSE**

The BCMA task force was formed with intentions to:

- Support post go-live transition phase by developing a collaborative group staffed with members of the nursing and pharmacy department
- Identify potential problems
- Brainstorm solutions
- Improve compliance
- Improve patient satisfaction and safety

**METHODOLOGY**

- Created an interdisciplinary team consisting of Nurses, Nursing Director, Pharmacists, and Technicians, Assistant Director of Pharmacy, and Site Information Services Manager.

- Identified problems in the BCMA process.

- Created solutions to problems identified by the task force.

<table>
<thead>
<tr>
<th>Identified Problem</th>
<th>Solution</th>
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<tbody>
<tr>
<td>The nursing staff carts have insufficient space to do work.</td>
<td>Smaller keyboards provide more surface room for nurses to do their work efficiently.</td>
</tr>
<tr>
<td>The scanner cords are too long and get caught under the wheels of the cart often and are forcefully pulled out from the scanners or the USB ports.</td>
<td>New coiled wires were selected to provide the necessary reach and to prevent equipment damage.</td>
</tr>
<tr>
<td>The nursing staff was facing issues with non-scannable medications, missing medications, and long waits with medication verification resulting in workarounds.</td>
<td>The nursing and pharmacy staff had an open forum for discussion. Pharmacy made recommendations on how nursing can communicate with them more effectively to receive medications faster, and decrease the duplication of medication requests.</td>
</tr>
<tr>
<td>Issues with compliance of nurses scanning medication was identified.</td>
<td>The managers on each unit review a weekly override report. Individuals were re-educated regarding BCMA process.</td>
</tr>
<tr>
<td>Medications being sent up to the units were frequently misplaced.</td>
<td>CSA’s (Clerical Support Assistants) were given a new role in distributing the medications to their proper locations. Also, CSAs were given access to medication cabinets to distribute medications delivered via pneumatic tube to patient specific bins (4 units have started this).</td>
</tr>
<tr>
<td>The nursing staff found patient specific cart exchanges problematic due to the fact that medication needed for administration during the process were lost or removed.</td>
<td>DO NOT REMOVE MEDICATION bags are currently being implemented on two floors to help in medication cabinet exchange process. The bags allow the staff to safely store the medications needed for the day without fear of losing medication when it is needed.</td>
</tr>
<tr>
<td>Barcode labels are too small on IV medications and are causing difficulties to scan.</td>
<td>Pharmacy is working to have larger print barcodes on the IV labels.</td>
</tr>
</tbody>
</table>

**RESULTS**

**RECOMMENDATION**

Successful transition to BCMA requires:

- Collaboration between nursing, pharmacy, and hospital leadership
- A mechanism for the staff to have an opportunity to suggest small changes and provide feedback to a complex process