

Implementing Best Practice Acts

Medication Safety Best Practice Acts

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A Toolbox of Solutions for Rural Challenges
October 11, 2006

Medication Errors

- Medication errors are one of the leading causes of injury to hospital patients
- Over half of all hospital medication errors occur at the interfaces of care
- Poor communication of medical information at transition points is responsible for as many as 50 percent of all medication errors and 20 percent of adverse drug events
- Medication history—in most cases there is no clear owner or standardized process

I Take a Blue Pill!

If a patient cannot remember their medications:

- Obtain a detailed description of the medication from the patient or family member—dosage form, strength, size, shape, color, markings
- Talk to any family members present or contact someone that could possibly bring in the medication or read it over the phone
- Try calling the patient's pharmacy to obtain a list of medications they have been regularly filling
- Contact the patient's physician/physicians to try and get an accurate listing of current medications

Medication Reconciliation

- Defined as a formal process of obtaining a complete and accurate list of each patient's current home medications—including name, dosage, frequency and route—and comparing the physician's admission, transfer, and/or discharge orders to that list. Discrepancies are brought to the attention of the prescriber
- Remember to ask about OTC, herbal, and meds purchased out of the country

Medication Reconciliation

The process involves three steps

- Verification (collection of medication history)
- Clarification (ensuring that the medications & doses are appropriate)
- Reconciliation (documentation of changes in the orders)
- A decision needs to be made as to who owns the process

St. Peter Community Hospital Medication Reconciliation Team

Multidisciplinary team consisting of:

- Two med-surg RNs (work different shifts)
- One transcriptionist
- One health unit coordinator
- One ER RN (works nights)
- One rad tech
- One staff person from Health Information
- One physician from each clinic (2 MDs)
- One pharmacist

Best Practices Blanket Orders

Prohibit use of Blanket Orders

- “Continue previous medications”
- “Resume preoperative orders”
- “Resume orders from floor”
- “Discharge on current medications”
- Orders previously written must be written in their entirety
- Consider use of “order sets” for standardization

Best Practices Faxed Orders

- Order forms and prescriptions should have margin lines to indicate areas beyond which writing is not permissible
- Avoid fax orders if possible and move to electronic transfer
- Print for improved legibility
- No cross-outs or overwrites. Order must be rewritten

Best Practices High Alert Medications

- High-alert medications bear a high risk of causing significant harm such as chemo agents, IV potassium chloride, IV&SQ insulin, IV heparin, IV thrombolytics, TPN etc. Each hospital should set up their own list
- Reduce the risk by limiting access to these medications, using auxiliary labels, standardizing the ordering, preparation and administration of these products
- Employ “double checks” when feasible

Best Practices Leading or Trailing Zeros

- **Do Not Use Trailing Zeros**
- Trailing zero after a decimal point (e.g., 1.0 mg mistaken for 10 mg if decimal not seen)
- **Use Zero Before a Decimal Point** when the dose is less than a whole unit (e.g., .5 mg is mistaken for 5 mg if the decimal point is not seen)
- Drug name and dose run together (especially for drug names that end in “l” such as Inderal 40mg and Tegretol 300mg). Use adequate space between name and dose

Best Practices Leading or Trailing Zeros

- Large doses without properly placed commas (e.g., 100000 or 1000000 mistaken as 10,000 or 100,000). Use commas or write out thousand or million
- No “Do Not Use” abbreviations
- Legible

Best Practices Tall Man Lettering

- “Tall Man” lettering should be used to mark drug containers to help differentiate the products (e.g., EPINEPHrine, ePHEDrine)
- Other methods—highlight, coloring, circling, font usage, not storing next to each other

Best Practices

Look-Alike or Sound-Alike Drugs

- Develop a policy for look-alike or sound-alike drugs
- Review with nursing and physicians annually to raise awareness and add any new drugs
- Do not keep in the same proximity
- Keep an updated copy of these “confusing” drugs at the nurses stations

Best Practices

Look-Alike or Sound-Alike Drugs

- Determine the purpose of the medication before dispensing or administering medications. Most (not all) look-alike/sound-alike drugs are for a different purpose
- Accept verbal or telephone orders only when necessary, read back all orders, spell the name when appropriate, and state its intended use
- Use preprinted order sets whenever appropriate to minimize chances for error
- For further confusion—the same brand name drug can contain a different active ingredient in a different country

Best Practices Verbal Orders

- Try to avoid verbal orders
- Do not accept verbal orders for chemo drugs
have lab work done before MD rounds to
avoid dosage adjustment over the phone
- Orders should make sense—if something
doesn't sound right it probably isn't—check
- Have a second person listen to the order if
possible
- Record the order directly on the order sheet to
eliminate another chance for error

Best Practices Verbal Orders

- Receiver should sign, date, and time the order.
The prescriber should verify, sign and date the
order within a predetermined time frame
- Allow no verbal orders when physician present
- Limit verbal orders to formulary drugs
- Spell back the drug name and repeat all orders
back to the prescriber

Best Practices Approved and Do Not Use Abbreviations Lists

- Create a list of confusing abbreviations that cannot be used due to potential for error and misinterpretation
- Create a list of approved abbreviations—general, laboratory, obstetrics, physical therapy, and surgical

Summary

- Medication safety practices are everyone's responsibility
- Involve the medical staff at their meetings
- Have them approve policy to gain their buy-in
- Bring administration to the table on safety and quality issues to raise their awareness and send the message of its importance
- Create a non-punitive reporting environment