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