

The Department of Pharmacy Services welcomes you to FSH!

Operations Overview
Medication Safety
Donna Bohannon, R.Ph.

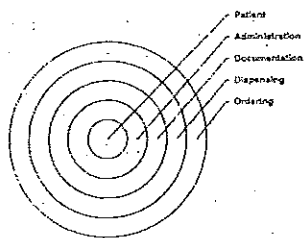


Orientee's Guide to Medication Safety

1. Get acquainted with the pharmacy services
2. Write/understand the components of a complete medication order
3. Recognize and apply the medication related national patient safety goals
4. Discuss the need to report occurrences to enhance safe processes.



Medication Management



National Patient Safety Goals related to medications

- 2B Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.
- Goal 3 Improve the safety of using medications.
- 3C Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.
- 3D Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.
- 3E Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.
- Goal 8 Accurately and completely reconcile medications across the continuum of care.
- Goal 9 Reduce the risk of patient harm resulting from falls.

Ordering -The Evidence

- The Institute of Medicine has reported that 1.5 million preventable adverse drug events arising from a medication error occur each year of which between 44,000 and 98,000 people die.
- The Institute for Safe Medication Practices have noted that error prone abbreviations have been frequently misinterpreted and involved in harmful medication errors
- Franklin Square Hospital Center identified through the Failure Mode Analysis process that incorrect/illegible orders are a lethal risk to the organization that had no quick resolution.

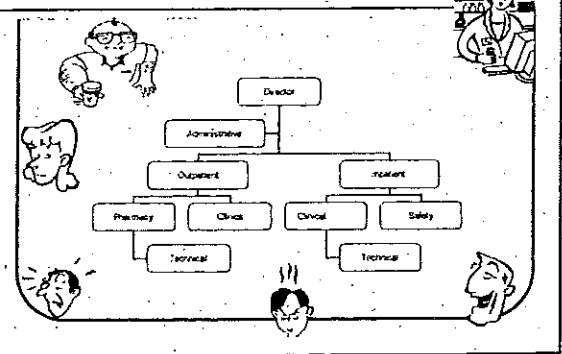
Medication Reconciliation

- A process to assist in minimizing adverse drug events while the patient is in the hospital by:
 - Compiling a complete list of the patient's home medications and
 - Reconciling the home medications with those the patient is taking while in the hospital at
 - Every transition of care (admission, transfer and discharge).

Dispensing – The Evidence

- At FSHC, dispensing errors account for 13% of all reported occurrences.
- As with all errors, dispensing occurrences can be exogenous or endogenous
- Technology while beneficial, has inherent potential for error built in.

The Pharmacy Department



Important Names and Numbers

- General Pharmacy Number x7374
- Operations- Carol Ross x7313
- Medication Safety x7948
- Pyxis /Pyxis Connect 1-800-727-6102



Inpatient Services

- Full Service 24/7/365
- IV,PO,TPN
- Drug Information
- Pharmacist on units
- Pain Management
- Antibioqram
- Pyxis
- Pyxis Connect
- Deliveries
- Medication Safety
- Formulary on-line
- Occurrence reporting on-line

Pharmacist on Unit

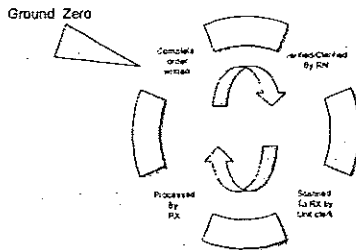
- Multi-disciplinary approach to care
- Order processing on patient care unit
- Accessibility to drug information



Medication Review

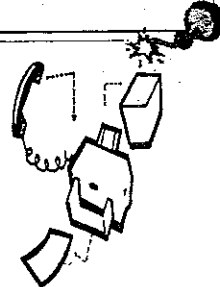
- Reduction in Polypharmacy
- Elimination of therapeutic duplication
- Dosing adjustment
- Evaluation for falls risk

How should I process my order?



Faxes are Dead!!!

- Utilize Pyxis Connect
- Scan Face Down, Bottom edge first with Optio label attached.
- Problem orders are printed back to the unit for clarification
- Technical problems – 1-800-727-6102 Pyxis Connect option 5



Administration – The Evidence

- Administration, nationally and at FSHC is the node in which most errors occur.
- The nurse is the patient's last defense against medication error.
- Utilizing independent double checks of medication and patient identifiers significantly decrease errors.

Minimizing high risk medications High Risk Medication Policy

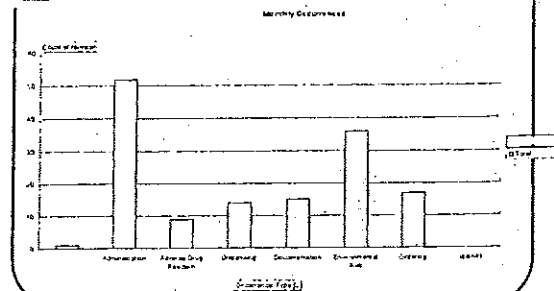
- Standard concentrations
- Look alike / sound alike medications
- Dispensation only from pharmacy
- Reduce variety, e.g. insulin
- Mandatory use of order sets for Medication Reconciliation, Heparin, PCA, and Insulin.
- Independent double checks

See High Risk Medication policy Online

Preventing Harm from Anticoagulation (2008)

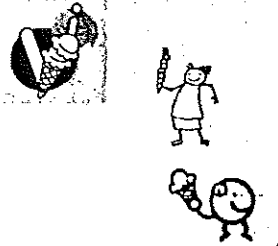
- From admission to discharge, the patient should be appropriately anti-coagulated
 - Admission
 - Routine lab testing ordered (APT/PTT/ INR)
 - Anticoagulation medication reconciled
 - During stay
 - Patient appropriately bridged
 - Reversed appropriately as needed
 - Prevent adverse events (HIT)
 - Discharge
 - Patient receives appropriate follow-up when discharged on anticoagulant

Medication Occurrences



How does FSH handle medication Occurrences?

- On-line reporting
- Actual events
- "Near- Misses
- Adverse Drug Reactions



What happens with this information?

- Quick resolution
- Analysis for trending and tracking
- Focused Case Reviews
- Root Cause Analysis



CONTINUOUS IMPROVEMENT IN SYSTEMS AND PROCESSES

Prevent Adverse Drug Events

Errors resulting in preventable ADEs occurred most often at the stages of **ordering** (56%) and **administration** (34%); transcription (6%) and dispensing errors (4%) were less common.

Errors were much more likely to be intercepted if the error occurred earlier in the process: 48% at the ordering stage vs 0% at the administration stage.

Prevent Adverse Drug Events

- **CONCLUSION**--Adverse drug events were common and often preventable; serious ADEs were more likely to be preventable. Most resulted from errors at the ordering stage, but many also occurred at the administration stage. Prevention strategies should target both stages of the drug delivery process
- **Incidence of adverse drug events and potential adverse drug events. Implications for prevention.** ADE Prevention Study Group.

Bates DW.



In a Nutshell...

- Best Patient Care
- Innovatively
- Safely
- Together



Questions?