Long-Term Care Survey Alert

Quality Assurance: Stop Common Med Errors In Their Tracks

5 ways to help the medicine go down-safely.

Dispensing pills looks relatively simple--and therein lies the problem. Complacency about this routine but critical nursing task paves the way for major medication errors.

Instead, implement the following field-tested methods to make sure no one can accuse your facility of being asleep at the medication cart.

1. Provide ongoing pharmacology education for nurses to distill critical information and capture attention. To administer medications safely, nurses have to use critical thinking, emphasizes **Myra Peskowitz, RN, MBA**, a consultant in Shelter Heights, NY. "For example, the nurse needs to know the major side effects, the consequences of missing a dose--and the intended therapeutic outcomes for administering medications," she says. But the sheer amount of information can be overwhelming.

Solution: Use a "drug of the month" approach, selecting common drugs that can cause significant safety problems. One facility provides inservices on the selected meds and also conveys information in attention-grabbing ways, such as colorful posters in the medication room, as well as newsletters and postcards that nurses can carry with them on the medication cart, Peskowitz relays.

As part of inservice training, present clinical and survey scenarios outlining the consequences of failing to assess patients appropriately before administering certain medications. For example, one facility found itself with a fistful of G-level F tags for each instance where a nurse didn't check or document residents' blood pressures as ordered before administering antihypertensive drugs.

2. Target "high-alert" drugs for special safety precautions. The Institute for Safe Medication Practices (ISMP) defines high-alert drugs as those that "bear a heightened risk of causing significant harm when used in error." The list includes Coumadin (warfarin), low-molecular weight heparin, subcutaneous or IV insulin and oral methotrexate (for non-oncological use).

Read the entire list at www.ismp.org/Tools/highalertmedications.pdf.

Beware this potentially lethal drug dose error: In a palliative care setting, nurses can easily miscalculate the dose for liquid morphine (Roxanol) which comes in a solution providing 20 mg per ml. "The typical dose for a hospice patient may be 2.5 or 5 mg," says nurse attorney **Janet Feldkamp** in Columbus, OH. "So if you are giving 5 mg and have 20 mg/ml, you'd give 0.25 cc--not 2.5 cc's, which would be 50 mg."

Solution: Work with the long-term care consulting pharmacist to identify medications, such as Roxanol, where the nurse should double-check the dosage with someone before administering them. "Nurses should also have the authority and autonomy on a unit to flag any medication that they believe deserves more than the minimum safety checks," Feldkamp maintains. "That might include any kind of drug that's unusual for the patient population or something requiring reconstituting or administering in a nonstandard manner."

3. Work with the consulting pharmacist and medical director to develop a best-practice protocol for mixing insulin, suggests **Stuart Levine, PharmD,** informatics specialist for the ISMP. As a general rule of thumb, you draw up short-acting insulin followed by long-acting, Levine says.

The problem: Some nurses rely on the fact that short-acting insulin is clear and long-acting cloudy to determine the order in which they draw them up in a syringe. "But there are now long-acting insulins coming to the market that are also clear," cautions **Carla Saxton, PharmD,** with the **American Society of Clinical Pharmacists.** "There are also some types of insulins that you shouldn't mix together, so nurses should check a reference prior to mixing unfamiliar or new insulins."

Tip: Don't mix insulins from different manufacturers, adds Saxton. For one, manufacturers don't provide instructions for doing so--and they use varying buffering agents, she says.

Continuing education resource: To review how to mix insulin in a single syringe, watch the demonstration at www.bddiabetes.com/us/demos/injecting.asp.

Watch what you say: When surveyors confronted a nurse that she was mixing insulin incorrectly, the nurse replied, "But I've been doing it this way for 12 years,'" which just added fuel to the fire. "Surveyors put the nurse's exact quote on the CMS 2567," cautions Feldkamp.

4. Perform an internal medication pass observation regularly based on your medication error rate. "You can do this either through the facility's own QA process or with the consulting pharmacist," says Feldkamp. Provide extra QA monitoring for staff who make medication errors or display competency issues, she adds.

5. Take a systemic approach to analyzing medication errors. Do a root-cause analysis of medication errors and "near misses" to figure out where the system broke down in a particular case--and what needs fixing. (See the story later in this issue about a facility's near miss involving failure to perform ordered lab testing to check a patient's coagulation status on Coumadin therapy.)

Learn from others' errors: Stay on top of sentinel alerts issued by the **Joint Commission on Accreditation of Healthcare Organizations** on medication-related issues. "Use of abbreviations is a good example of how sentinel alerts tie into the Joint Commission's national patient safety goals," says **Marianna Grachek, RN, MSN**, executive director of long term care for the accrediting organization (see the JCAHO list of verboten abbreviations later in this issue).

Editor's note: For an inside look at a new point-of-care technology for nursing homes that helps prevent resident misidentification and common medication errors, see the December 2005 Long-Term Care Survey Alert.