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Long-Term Care Survey Alert

Quality of Care: Don't Let Phone Orders Dial Up IJ Citations

Write off med errors with the right strategies.

Phone medication orders can be a liability trap ready to snap shut on your facility if you don't error-proof the process at every step.

Start by taking note of just how wrong a phone order can go.

Real-world example: An LPN at a nursing home that had a reputation for good care took a phone order for what she believed to be concentrated potassium IV, relays **Myra Peskowitz, RN, MBA**, of the **Peskowitz Group** in Shelter Heights, NY. "The physician later said he gave an order for [oral] potassium via G-tube, using the abbreviation for gastrostomy," she says. Another nurse ended up giving the patient concentrated potassium IV instead of potassium by G-tube, which killed the resident.

A root-cause analysis of the deadly error unveiled a chain of missing safety checks. For one, "if the nurse had read the order back to the physician and clarified the G-tube abbreviation, that might have stopped the error," says Peskowitz. Secondly, "the nurse had to get the potassium solution from the supervisor who didn't question the order either," she adds. "And the order appeared to be intended for oral administration given the dosage--and the fact that the physician didn't include instructions for diluting the IV potassium."

Head Off Med Errors

The good news: You can take steps to head off medication errors at the receiving end. Consider these expert strategies:

1. Ensure licensed nurses know and follow the state practice act for nurses taking phone orders and administering medications. A number of states prohibit LPNs from taking phone orders, observes **Janet Feldkamp, RN, BSN, LNHA, JD,** an attorney with **Benesch Friedlander Coplan & Aronoff LLP** in Columbus, OH. Or the state practice act may impose restrictions on LPNs taking such orders or administering IV medications, she says. Under Pennsylvania law, for example, an LPN can take a phone order in a nursing home if an RN is in the facility, notes **Alan Rosenbloom**, who is president and CEO of the **Pennsylvania Health Care Association.**

Strategies for success: Develop policies requiring the LPN to check phone orders for medications with the RN, just to make sure there are no obvious problems with the orders, advises Rosenbloom. "The facility should also have a procedure and audit process to ensure physicians sign off on the orders, which can be done by fax, within a reasonable amount of time," he adds. That process can also detect incorrect medication orders.

2. Implement and enforce strict rules requiring the nurse to write the phone order down and read it back to the physician for validation. "The nurse should clarify any incomplete order--for example, one that doesn't specify timing of medication administration or dilution instructions for IVs," says Peskowitz. If the LPN had done that in the tragedy involving the potassium order, she may have caught the fact that the physician intended the potassium to be given by G-tube, Peskowitz notes.

3. Insist physicians never use abbreviations in phone orders. That's especially important given that "today more nurses and physicians speak English as a second language--or they come from different cultures," notes Peskowitz. "And use of abbreviations makes it even more likely that misunderstandings will occur." Facilities that use abbreviations for written physician orders should develop a standardized list so everyone knows what they are, she adds. (See the **Joint**

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Commission on Accreditation of Healthcare Organization's list of "do not use" abbreviations later in this issue.)

Ask the physician to spell similar-sounding medications, such as Celexa and Celebrex. Or ask him to give both the trade and generic names for all medications.

Resource: You can order a free poster and a laminated, quick-reference card of confusing drug name sets from the U.S. Pharmacopeia by calling 1-800-487-7776.

4. Implement a strict "print only" rule for nurses transcribing phone orders to the medical record, including medication orders. That tactic will help prevent common medication errors caused by someone transcribing a semi-legible order from the chart to the medication administration record, according to **Robert Davis, CEO** of **OneTouch Technologies Inc**., an Irvine, CA-based company offering an electronic medical record and medication software program. The **Centers for Medicare & Medicaid Services** and the **Agency for Health Care Research & Quality** are testing the impact of the electronic approach on medication errors and quality of care in nursing homes (for details, see the December 2005 Long-Term Care Survey Alert).

5. Explore alternatives to phone orders for managing medications. With the new Medicare Part D drug benefit coming on line Jan. 1, facilities may want to consider more interactive real-time methods of ordering--for example, personal digital assistants or other electronic media, suggests **Marie Infante,** an attorney with **Mintz Levin** in Washington, DC.

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