ISMP Medication Safety Alert!®

Nurse Advise-ERR®

Educating the healthcare community about safe medication practices

August 2008 ■ Volume 6 Issue 8

Patient safety should NOT be a priority in healthcare!

Part I: Why we engage in at-risk behaviors

"Patient safety must be a priority in healthcare." Most practitioners and patients would certainly agree that this is true. In fact, many healthcare organizations and patient advocacy groups have fashioned mission statements, or even safety slogans, that embody this principle. ISMP is no exception. So it may come as a surprise to hear us say that patient safety should NOT be a priority in healthcare.

Labeling patient safety a "priority" implies that its order in a long list of other very important initiatives can be rearranged. It's human nature to constantly shift priorities according to circumstances and competing concerns. So, patient safety should NOT be a priority that potentially can be reordered based on the demands of a particular day or focus on a particular dimension of quality, such as expediency, productivity, efficiency, and cost effectiveness. Instead, patient safety should be a *value* associated with every healthcare priority, linked to every activity, and an enduring constant that is never compromised.

How do you make patient safety part of your value system? If practitioners voluntarily follow safe procedures consistently for every job, working safely will eventually become part of their value system. Unfortunately, this advice is not easily followed because working safely may not come naturally to people. It's often much easier to take risks than to work safely. Because taking risks are consistently rewarded with convenience and saved time, and rarely result in patient injuries, the perceived benefits create a vicious cycle of repeating the behavior or taking even more risks; thus, "at-risk" behaviors are developed and become habits.

While ISMP has always urged practitioners to abandon "It won't happen to me" thinking when it comes to harmful medication errors, it's been difficult for many to truly embrace this when, patient injuries really do seem to happen to "other people." This helps explain the ongoing struggle to motivate people to always choose the safest way to work. Human behavior runs counter to patient safety efforts because the rewards for risk taking are often immediate and positive, and the punishment for risk taking is remote and unlikely. As a result, even the most educated, diligent, and careful practitioners may learn to master dangerous shortcuts.

We learn at-risk behaviors through our ongoing experiences. Remember when you first learned to administer medications? Most likely, you were a bit nervous and carefully followed all the safety procedures you were initially taught. You gave your undivided attention to the procedure at hand; sought out information on unfamiliar drugs; prepared one patient's medications at a time; always checked the patient's weight and allergies; educated patients about their drug therapy; asked other nurses to double-check your work; and so on.

But as the years went by, you likely drifted from the safe practices you first learned. Many of the initial precautionary measures fell by the wayside, and you may have developed some unsafe habits and at-risk behaviors. For example, if you're an experienced nurse, you may believe it's acceptable to maintain unauthorized stashes of medications on patient care units, prepare IV admixtures instead of waiting for pharmacy to dispense them, and administer medications to patients

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Double Trouble

Double Trouble

Treating the "flu." A physician assistant (PA) entered "fluoxetine 100 mg PO BID" into a computerized prescriber order entry system for a newly admitted patient. A pharmacist tried to call the PA to discuss the unusually high dose, but the PA had left for the day. The nurse told the pharmacist that the patient stated he was taking this dose at home, as prescribed by an out-of-state psychiatrist. The drug and dose were also listed on the patient's history and physical form. Still concerned, the pharmacist asked the patient's wife to bring in the prescription bottle. It contained fluvoxamine 100 mg. The on-call physician corrected the order. Both fluoxetine and fluvoxamine are used to treat obsessive-compulsive disorder, increasing the risk of mix-ups between these look- and sound-alike medications. Although a brand product for fluvoxamine is not available, using the brand name **PROZAC** with fluoxetine will reduce the risk of mix-ups with fluvoxamine. Do not administer any drug until all questions identified during the medication reconciliation process are resolved.

"Next" mix-up. A physician wrote an order for **NEXAVAR** (sorafenib) 200 mg, 2 capsules (400 mg total) BID for a patient with unresectable hepatocellular carcinoma. The pharmacist misinterpreted the order as **NEXIUM** (esomeprazole) 20 mg, 2 capsules (40 mg total) BID. At this hospital, Nexium was routinely substituted with **PROTONIX** (pantoprazole), so the pharmacist rewrote the order as Protonix 40 mg PO BID. The patient received two doses of Protonix before the physician detected the error while reviewing the patient's medication administration record. To help prevent mix-ups, match the drug's indication to the patient's condition. Electronic prescribing and 24-hour chart checks to verify recent orders also help prevent and identify mix-ups before they can harm patients.

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before pharmacy has reviewed the orders. You may borrow another patient's medications for quick administration to your patient or leave medications at the bedside. You may no longer bring the patient's medication administration record to the bedside if you are just administering a *prn* medication. You may no longer take the time to label all self-prepared syringes or have dose calculations checked.

It's frightening how quickly we learn to take these and other important medication-use processes for granted. In no time at all, we have moved from a safe and controlled environment, as first learned, to an unsafe and automatic process where risk is increasingly tolerated. The positive rewards for taking shortcuts rapidly foster continuance despite the knowledge on some level that behavior could risk patient safety. In fact, taking shortcuts may even be labeled as efficient behavior. Yet, at-risk behaviors often emerge because of system-based problems.

In part II of this feature (to be published in next month's newsletter), we will suggest ways to uncover the underlying system-based causes of at-risk behaviors, and offer recommendations to begin the cultural transformation of making patient safety a value, not a priority, in your organization.

Yellow means caution: Do not use epidural tubing for IV solutions

FLOLAN (epoprostenol sodium), used to manage primary pulmonary hypertension, must be infused continuously through a dedicated central venous access device. The drug has a very short half-life, so interrupting the flow for even a few minutes could result in life-threatening effects. Because it is incompatible with other IV medications, tubing used to administer Flolan should not have a Y connector.

Patients normally receive Flolan at home via an ambulatory infusion pump. When admitted to the hospital, the patient is often switched to the facility's standard infusion pump, which is more familiar to nurses and may employ important safety features such as dose-checking capabilities.

We recently learned nurses in a hospital were using Hospira Plum infusion pumps along with administration sets typically used for epidural solutions to administer Flolan. While the epidural administration set has no Y connectors, it has a yellow stripe running the length of the tubing to identify it as epidural tubing. Although the tubing package label says it's a "Primary I.V. Plumset," a yellow package label states "Epidural Line Only" (see Figure 1). Hospira will be changing the label to make it clear that the tubing is for epidural use only.

Because of the risk of confusing an IV line with an epidural line, yellow striped tubing should only be used for epidural infusions. Hospira provides Plum administration sets without Y connectors and without a yellow stripe.

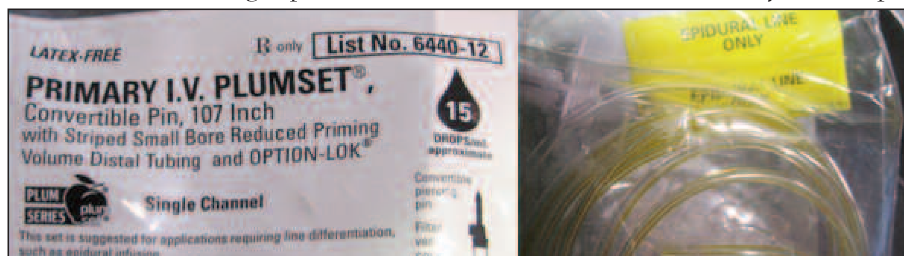

Figure 1. Fluid administration set package label (L) mentions "IV," but the package itself (R) contains yellow striped tubing and labels stating "Epidural Use Only." Labeling changes are underway.

*safety*wire

"Daily" double. Since The Joint Commission banned use of the abbreviation "QD" for "daily," some prescribers have been using "Qday," but this abbreviation poses problems, too. "Qday" has been misread as "Today," and "Today" has been misread as "Qday." (Sounding alike, these terms could be misheard as well.) For example, written orders for "Coumadin today" were misinterpreted as "Coumadin Qday," meaning daily. After receiving daily doses of warfarin, several patients developed elevated INRs. When prescribers were notified of the elevated INRs, they didn't know their patients were getting daily doses of warfarin; so they didn't think they needed to write orders for "no warfarin today." But the errors were recognized and more serious outcomes associated with elevated INRs were avoided. The only safe way to communicate "daily" is to print out the whole word.

Special Announcements

Maximize the effectiveness of your medication safety team! ISMP will hold a two-part **teleconference series** to help healthcare organizations meet the challenges involved with creating a successful medication safety team. This dynamic teleconference series will be offered on **September 17** and **October 23, 2008.** For details, visit: www.ismp.org/educational/teleconferences.asp.

CNO Leadership Congress. If you are a nurse executive who is interested in learning about innovative ways to improve safety and quality, please join us **September 15-17** at the 4th Annual Nursing Leadership Congress, **Driving Patient Safety Through Transformation**, in Scottsdale, AZ. This **free** conference is sponsored by the American Association of Nurse Executives, National Patient Safety Organization, ISMP, McKesson, and Intel. To register, visit: www.nursingleadershipcongress.com/nlcReg/.

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One hour of **free CE credit** covering the January-June 2008 issues is now available at: www.ismp.org/nursingce.

11TH ANNUAL ISMP CHEERS AWARDS

It's a Family Affair!
Help Us Cheer for the Medication Safety Stars

2008 Cheers Awards Dinner

Join us on Tuesday evening, **December 9, 2008**, in Orlando, FL, at Maggiano's Little Italy for a gala dinner as we honor this year's ISMP Cheers Awards recipients.

Even Aunt Clara will be there!

Keynote speaker

Peter B. Angood, MD, FRCS(C), FACS, FCCM, Vice President and Chief Patient Safety Officer, The Joint Commission, and lead for the international World Health Organization's Collaborating Center for Patient Safety Solutions

Submit a Nomination

The ISMP Cheers Awards are one of the most prestigious ways to recognize innovators in the field of patient safety. The awards honor individuals, hospitals, health systems, community pharmacies, or companies that have made extraordinary advances in medication safety in the past year. Nominations will be accepted until **September 12, 2008**.

Nominations also are being accepted for the 2008 *ISMP Medication Safety Alert!* Subscriber Award, which honors an organization that widely distributes the ISMP newsletters and uses the information to reduce the potential for medication errors.

The awards acknowledge excellence in all areas of healthcare, including acute, long-term care, home care, and community settings. Nominations are welcomed from physicians, pharmacists, nurses, administrators, and allied health professionals. Self-nominations are strongly encouraged.

Winners receive an award, national recognition for their work, and a travel stipend to attend the annual ISMP Cheers Awards gala dinner. To submit a nomination online, go to: www.ismp.org/Cheers.

Support the Awards

The ISMP Cheers Awards would not be possible without the generous support of committed sponsors. We need your help to continue spotlighting heroes and trendsetters in the prevention of medication errors. Consider helping to ensure the future of the awards and the continuation of ISMP's lifesaving work by making a donation.

For more information about supporting the Cheers Awards, please visit ISMP online at: www.ismp.org/Cheers or call 215-947-7797.