Halloween-style drill leads to sweet success for one Virginia hospital

Candy drives home importance of emergency preparation

Editor’s note: This is the second in a two-part series about the pharmacist’s role in emergency preparedness. This month, HPRR focuses on what pharmacists can do in their communities during a disaster. For more information about emergency preparedness, visit www.dhs.gov or www.cdc.gov.

Pharmacy staff at Sentara Norfolk, VA General Hospital found themselves handing out M&M’s® chocolates last year and it was not having a Halloween celebration.

The chocolates were substituted for antibiotics, and the 350 trick-or-treaters were hospital employees doubling as anthrax attack victims.

The scenario was part of an emergency preparedness drill to test the hospital’s ability to quickly distribute medications to a large group of people, says Tim Jennings, PharmD, pharmacy director for Sentara Healthcare, a Virginia health system that includes Sentara Norfolk General Hospital.

“Part of the drill is just to get staff to feel comfortable that we could get people [treated] quickly.”

Educate staff about unapproved drug abbreviation requirements

Use these tips to achieve success during next survey

Take the lead in educating nurses, physicians, and pharmacists about breaking old habits and using only approved drug abbreviations. This will help you achieve compliance and prepare for your next survey.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) released in November 2003 a list of nine dangerous abbreviations, acronyms, and symbols. The list became effective January 1, and hospitals must achieve 100% compliance by the end of 2004.

The accredditor will score a hospital in compliance if staff use the abbreviations less than 10% of the time. For more information, check out the National Patient Safety Goals frequently asked
Emergency preparation

and appropriately,” Jennings says. “The drill could be applied to any situation.”

Get pharmacy staff involved in disaster and emergency-response planning as they will play a crucial role in distributing medications and educating patients during a terrorist attack or major natural disaster.

Be prepared for mass casualties

Staff at Sentara Norfolk treated 100 patients an hour during their anthrax drill, Jennings says. Pharmacists, pharmacy students, and nurses helped distribute medications. The number of drill participants is important because pharmacists should expect to treat a large number of patients during a crisis, says David Teeter, PharmD, emergency management consultant and pharmacist at Wishard Hospital in Indianapolis.

“You might be used to counseling one patient at a time normally,” Teeter says. “You may have 100 people getting antibiotics [during a crisis].”

During Sentara Norfolk’s drill, patients moved through different rooms as part of their treatment. They started in the hospital’s auditorium for an infection-control briefing. Staff educated patients about anthrax. Patients then moved to another room to meet with nurses to discuss their symptoms before moving to the pharmacy to pick up their medications.

Pharmacists explained to patients how to take their medications—or in this case, the chocolates—and outlined any possible side effects, Jennings says. The education component is just as important as distribution of medication during an emergency because it lets patients know how to properly take their medications, he says.

TIP: Use pharmacy students from local colleges to provide you with more manpower during an emergency, Teeter says.

Evaluate the threats in your area

Pharmacists must understand their roles in distributing medications in the event of a disaster, says Fred Massoomi, PharmD, pharmacy operations coordinator at Nebraska Methodist Hospital in Omaha. That role may change depending on the threats in the pharmacist’s community, he says.

Threats near Omaha include Offutt Air Force Base and major events such as the College World Series baseball tournament, which the city hosts every year. Nearby farming communities may also be at risk because terrorists could steal crop dusters to spread chemical agents.

Norfolk is home to Naval Station Norfolk, the world’s largest naval base. This fact has led staff at Sentara Norfolk General Hospital to train to treat mass casualties for the last three years, Jennings says.

Threats could also be natural, such as hurricanes, floods, or tornadoes, depending on a community’s geographic location. If hurricanes pose a threat to your area, make sure you take precautions against flooding, have the ability to access automated medication systems if the power fails, and have enough medications and supplies on hand to treat patients, says Jennings says.

TIP: Work with hospital and local emergency preparedness officials to identify natural and man-made threats in your area.

Get your supplies ready

Once you evaluate the threats in your area, check to make sure your hospital has emergency ordering plans in place so it could function in the event of a disaster, Teeter says. Make sure you will be able to get enough intravenous (IV) fluids and other medications to last until state or federal aid arrives.

Many pharmacies now maintain a just-in-time inventory, stocking only enough medications for day-to-day operations, Teeter says. A just-in-time inventory helps keep costs down because it...
reduces the number of drugs on the pharmacy’s shelves. However, keeping minimal stock could cause a shortage if an emergency creates a rush on supplies.

“We are vulnerable to a situation where we’ll quickly need huge amounts of medications,” Teeter says. “The question becomes, ‘Are you going to stockpile or not?’ ”

Deciding whether to stockpile critical drugs is often a financial matter, Teeter says. Some hospitals may not be able to afford the cost of purchasing and storing extra drugs.

**TIP:** Make sure you have at least a two- to three-day supply of medications for an emergency. Federal assistance may not arrive for up to 72 hours after a disaster, Teeter says.

Federal help could come from the Strategic National Stockpile (SNS), says Teeter. The federal government usually releases the 50-ton shipment of medications and supplies within 12 hours of a state governor’s aid request, but it could take a day or two to arrive and be ready for distribution.

**TIP:** Make sure your state has a plan to receive and store the SNS shipment. Pharmacy technicians can help unload the cargo and set it up for distribution, Teeter says.

**What are your community’s plans?**

Know what your community’s plans are for distributing medications in an emergency, Massoomi says. For example, the Omaha Metropolitan Medical Response System (OMMRS) requires that enough medication is available to treat up to 1,000 chemical-attack victims and all those affected by a biological attack for at least 24 hours or until aid arrives, says Massoomi.

The OMMRS is funded through a grant from the U.S. Department of Homeland Security and allows local law enforcement, fire departments, emergency medical services, hospitals, and public health officials to plan an effective response for the first 48 hours of a public health crisis. Omaha is one of 122 cities in the Metropolitan Medical Response System.

**TIP:** Ask local officials how pharmacies are involved in your community’s emergency plans.

“Do not assume that community plans are complete and set in stone,” Massoomi says. “If a pharmacist has not heard of any formal plans for their community addressing pharmaceutical needs, then more than likely there are none or they are just being developed. This is the opportune time to be involved.”

**Adapt to the situation**

Your pharmacy and hospital emergency plans apply to any situation, not just terrorist attacks. For example, staff at Sentara Norfolk recently treated a meningitis patient, Jennings says. Therefore, exposed staff had to be immunized and treated.

Pharmacy staff had no problems treating those exposed to meningitis because they practiced distributing medication during the anthrax attack drills.

“We just supplanted ‘anthrax’ and put in ‘meningitis’ [in the hospital’s plan]” Jennings says. “It was much less grand [than the anthrax drill] because we only needed to treat 100 or so employees.”

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**Questions? Comments? Ideas?**

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For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978/750-8400.
Publicizing an unapproved-abbreviations policy through e-mails, newsletter articles, poster presentations, and on the Internet helped educate staff at Children’s Hospital of The King’s Daughters in Norfolk, VA. Pharmacy staff began formal education a year ago when the hospital created a list of unapproved abbreviations, and they stepped up the campaign prior to their JCAHO survey in January.

“We’re going to have to continue to put the word out there in e-mails and other forms of communication,” pharmacy director James E. Dice, PharmD, says. “If we don’t, prescribers are going to fall back to old habits.”

Prepare yourself for survey
Surveyors looked closely at the use of unapproved drug abbreviations during the Houston-based Institute for Rehabilitation and Research’s November 2003 survey.

The Institute received a Type recommendation I for its use of abbreviations because surveyors caught too many instances of nursing and physician staff using “QD” (or “qd”) and “D/C,” says Lourdes M. Cuellar, MS, RPh, FASHP, the Institute’s pharmacy director. QD is intended to mean “every day” and “D/C” means “discharge” or “discontinue.”

She was not surprised about the finding because it is nearly impossible to achieve a perfect score in an area where physicians and nurses can no longer write down those familiar abbreviations, acronyms, and symbols.

“I don’t know of a hospital that scored perfectly in this area,” she says. “And I talked to a lot of pharmacy directors about this issue. It just takes time.”

Children’s Hospital started its list with the abbreviations staff would likely misinterpret, says pharmacy manager Becky Shearon, RPh. The hospital had to add “Q/D” and “QOD” (every other day) before its JCAHO survey in January to meet the accreditor’s requirements.

The hospital was one of the first to undergo survey under the new tracer methodology program, which requires surveyors to follow a patient’s medical record from admission to discharge. JCAHO surveyors never mentioned a violation of the hospital’s unapproved abbreviations policy to pharmacy leadership during the patient tracer portion of the survey, Shearon says.

The hospital documented the unapproved abbreviations in its policies, so surveyors did not have a problem with the hospital’s procedure, Dice says.

Get creative with education
The unapproved abbreviations list changes old habits for physicians and nurses. That’s why education is an important tool in achieving 100% compliance.

The Institute for Rehabilitation and Research pharmacy staff upped their education measures to ensure compliance. Cuellar created a “Dear Doctor” letter to educate physicians who continue to use unapproved drug abbreviations. (See the letter on p. 5.)

This tactic impressed surveyors because the letter goes beyond just reprimanding and offers educational details about how people misinterpret these abbreviations, Cuellar says.

In addition to Children’s Hospital’s education campaign, staff placed laminated cards with the list of unapproved abbreviations and acceptable alternatives in each patient’s chart, Shearon says.

TIP: Get nurses and pharmacy staff to work together on education. Nurses often see the medication orders before the pharmacy, so you must ensure that they recognize the unapproved abbreviation and do not simply pass it to the pharmacist to handle.
Sample Dear Doctor letter about using unacceptable drug abbreviations, acronyms, and symbols

Dear [physician’s name],

Your patients’ safety is very important to us at [facility’s name]. One of the many ways [facility’s name] has chosen to improve patient safety is through direct physician feedback. There is evidence that the inclusion of certain information can help prevent errors and provide safer care, while unsafe writing practices or habits have led to serious consequences.

The attached order that you wrote contains one or more of the problems checked below. We also provide a corresponding recommendation for a safer practice. Please review these recommendations.

Thank you,
_________________________________, chair, patient safety committee
_________________________________, chair, pharmacy and therapeutics committee
_________________________________, director of pharmacy

<table>
<thead>
<tr>
<th>Potentially unsafe practice</th>
<th>Misinterpretation</th>
<th>Preferred practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Units” was not spelled out</td>
<td>Regular insulin 5u</td>
<td>Regular insulin 5 units</td>
</tr>
<tr>
<td></td>
<td>The “u” can be misinterpreted as cc, 4, 6, or 0</td>
<td></td>
</tr>
<tr>
<td>A trailing zero was used</td>
<td>Ativan 1.0 mg valium 2.0 mg</td>
<td>Ativan 1 mg Valium 2 mg</td>
</tr>
<tr>
<td></td>
<td>This can be misinterpreted as 10 mg and 20 mg</td>
<td></td>
</tr>
<tr>
<td>A leading zero was not used</td>
<td>Morphine.5 mg</td>
<td>Morphine 0.5 mg</td>
</tr>
<tr>
<td></td>
<td>This could result in a 10-fold overdose of medication</td>
<td></td>
</tr>
<tr>
<td>The medication was ordered by quantity rather than strength</td>
<td>Tylenol 2 tabs</td>
<td>Tylenol 650 mg</td>
</tr>
<tr>
<td></td>
<td>This product is available in varying sizes and strengths</td>
<td></td>
</tr>
<tr>
<td>D/C for discharge or discontinue was used</td>
<td>Premature discontinuation of medications when D/C was intended to mean “discharge” D/C has also been misinterpreted as “discontinue” when followed by a list of drugs</td>
<td>Use “discharge” or “discontinue” or “stop”</td>
</tr>
<tr>
<td>An unacceptable abbreviation was used for the amount of medication</td>
<td>Abbreviations ug, gm, cc, tsp, or tsbl can be misread for something else</td>
<td>Use mcg, mg, g, or ml when possible</td>
</tr>
<tr>
<td>An abbreviation or symbol was used instead of the drug name</td>
<td>MS, MSO4, MgSO4, AZT</td>
<td>Spell out drug name magnesium sulfate, morphine, aztreonam, zidovudine, and azathioprine</td>
</tr>
<tr>
<td>The following medical abbreviation was used:</td>
<td>QD QOD</td>
<td>Q day, daily, every other day</td>
</tr>
<tr>
<td>QD</td>
<td>These are often misread for each other or for qid</td>
<td></td>
</tr>
<tr>
<td>The order was missing an essential element (strength, route, etc.)</td>
<td>Digoxin 0.125 mg daily</td>
<td>Digoxin 0.125 mg po daily Digoxin 0.125 mg IV daily</td>
</tr>
<tr>
<td>Other</td>
<td>Print orders or use preprinted orders and write legibly</td>
<td></td>
</tr>
</tbody>
</table>

Source: Institute for Rehabilitation and Research, Houston. Reprinted with permission.
Permanent markers, self-shredding stickers among simple solutions to getting rid of IV bag labels

If your hospital is struggling to develop a way to properly dispose of intravenous (IV) bag labels, check out the ideas below from your colleagues.

Staff cannot throw IV bag labels into the trash when the bags are empty because that would violate the privacy rules, according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These labels contain protected health information (PHI), such as patient names and other identifiers.

Black out the information
Nurses at St. Michael's Hospital in Stevens Point, WI, carry black permanent markers with them when they remove an IV bag from a patient’s room, says pharmacy director Todd Faulks, RPh. Using the black marker, nurses cross out the patient’s name and any other identifying information, such as an account number or medication type. Each nurse must make sure the information becomes illegible. Then, a nurse places the IV bag into a red biohazard bag, which is sent to an incinerator, Faulks says.

This practice is acceptable under the privacy rule, says Tracy Field, Esq., head of the HIPAA team at Arnall Golden Gregory, a law firm in Atlanta.

“‘You don’t need to buy a shredding machine,’” Field says, “‘HIPAA just says to ‘take reasonable measures,’ but be sure that you adequately erase [identifying information].’”

Your problem too?
Staff at St. Michael’s sometimes forget to cover up patient information with the markers, Faulks says.

That’s why nursing supervisors and charge nurses must now remind all staff to destroy patient identifiers, he says. During the hospital’s original HIPAA training, nurses received education on how to conceal PHI.

“You get the people who were trained last that remember to do it,” Faulks says. “As the shifts go on, they get into the habit. It’s about a month-long phase-in.”

Supervisors also remind staff during annual HIPAA refresher training to conceal PHI with black markers, Faulks says.

Self-shredding products
Faulks says pharmacists should consider new products such as self-shredding labels and present them to their hospital pharmacy and nursing committees.

For instance, Howell, MI–based Tri-State Hospital Supply Corp.’s Centurion Label Systems created a self-shredding label after some hospitals began asking for the company’s help with disposing IV bag labels, says Zane Myers, a company sales representative for the Pacific Northwest region. Centurion initially began selling “blackout labels” that nurses could affix to the IV bag labels. These labels covered any patient information, he says.

But, like the permanent-marker solution, staff must carry stickers and remember to put them on before throwing the original labels in the trash, Myers says. To correct this problem, the company created a self-shredding label that obliterates patient information when torn off the bag.

Some hospital pharmacies have sent Centurion a sample of the label they use, noting the exact location where they print PHI. Centurion custom-designed self-shredding tags for these pharmacies.

When the pharmacy prints a label, the patient information appears across a perforated area. Once the bag is empty, a nurse peels the label off the bag,
shredding the PHI, Myers says. The nurse can then throw the label in the trash.

**Monitor compliance**

Whatever system you use, conduct an ongoing audit to make sure staff comply with HIPAA’s privacy rule, says Kate Borten, CISSP, president of The Marblehead Group, a consulting firm based in Marblehead, MA.

“There are too many hospitals that have written policies and that’s it,” Borten says. “That’s not enough to be HIPAA-compliant, and that’s not going to be good for security.”

Be a HIPAA detective

Develop a checklist, Borten says. Adapt the following to your needs:

1. Search for violations. On a periodic basis (i.e., monthly), have your hospital’s security officer and other managers check to see whether papers with PHI are out in the open, and whether identifying information is just thrown in the trash instead of being shredded or obliterated.
2. Document results of these periodic monthly audits.
3. Follow up any HIPAA violations with education and disciplinary action, if necessary, according to your hospital’s policy.

**JCAHO standard of the month—MM.6.20**

**Group therapy: Use monthly forums to discuss adverse events and reduce medication errors**

Break down communication barriers with staff forums to discuss potential or actual medication errors and adverse drug events.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) medication standard MM.6.20 requires hospitals to respond to adverse drug events and medication errors that have or could have resulted in patient harm. Holding a “tell-a-story” forum will allow you to learn about events that have or may have occurred and what you can do to prevent them in the future, says Rita Shane, PharmD, FASHP, FCSHP, pharmacy services director at Cedars-Sinai Medical Center in Los Angeles.

Pharmacy and nursing staff from each patient care unit began meeting once a month last year to talk about medication issues at the unit level, Shane says.

The goals were to discuss issues from as many units as possible, identify errors and any near misses—errors that could have resulted in injury but someone corrected before reaching the patient—and identify opportunities for improving medication systems.

“It’s remarkable, to listen to the types of situations that nurses and pharmacists encounter,” Shane says. “Having open dialogue that focuses on errors for half an hour is one of the best ways to learn about factors that can contribute to medication errors. After a while, it becomes a really rich dialogue.”

**Standard MM.6.20 at a glance**

The organization responds to adverse drug events that do or may result in patient injury.

Requirements for MM.6.20

1. The organization has a process to respond to adverse drug events.
2. The organization takes appropriate action when an event occurs, including calling for outside assistance, if necessary.
3. The organization complies with reporting requirements, including internal systems and reporting to the U.S. Pharmacopeia, Food and Drug Administration, and Institute for Safe Medication Practices.
Explain your side of the story

The forums allow staff from various disciplines to learn about each other’s roles in medication administration and safety, Shane says.

For example, a nurse mentioned a delay in delivering drugs to a patient with kidney disease. The JCAHO requires that the pharmacist review all medication orders unless there is an emergency. In this case, the pharmacist needed to contact the physician to have the dose changed because the kidneys could not process a large amount of the drug.

A significant delay in giving out medications is considered an error, but the forum gave pharmacy staff a chance to explain to the nurse why they reviewed the medication order before sending it to the floor, Shane says. “The delay is built in to protect the patient,” Shane says. “The reason for it is to protect the patient from getting a toxic dose.”

Get smart: New IV pump technology helps reduce medication errors, improve administration accuracy

A patient is supposed to receive 5.1 mcg/kg/minute of dopamine through an intravenous (IV) feed. The nurse, in a hurry, accidentally programs the IV pump to give the patient 51 mcg/kg/minute of dopamine.

Without any alert from the pump, the patient could receive a fatal dose, all because the nurse simply missed the decimal point.

The Institute of Medicine’s Keeping Patients Safe: Transforming the Work Environment of Nurses, published in November 2003, noted that 34% of preventable adverse drug events occurred while administering the drug. Many of those errors were caused by nurses miscalculating drug doses because of stress and fatigue, according to the report.

“The highest level of severity in medication errors generally occur with IV medications. When something is wrong with an IV, it can result in a sentinel event,” says Elaine Levy, RPh, system pharmacy director at Sharp HealthCare in San Diego. “If the error slips through the pharmacy and gets up to the nurse at the bedside, it’s probably going to get to the patient.”
Smart infusion pumps are one way to solve IV dosing problems, says Timothy Vanderveen, PharmD, MS, executive clinical director of San Diego–based ALARIS Medical Systems Center for Medication Safety and Clinical Improvement.

Smart pumps allow the hospital to establish minimum and maximum dose ranges for medications. The pump will alert nurses if the dose they program into the pump is outside the hospital's range.

Emerging technology
ALARIS Medical Systems developed the Medley™ Medication Safety System in 2001, and approximately 75 hospitals in the country now use it. Using ALARIS' Guardrails® Safety Software, the Medley Medication Safety System allows hospitals to create drug libraries with minimum and maximum dose ranges programmed into the pump.

The pharmacy can download data to see how many times the pumps alert nurses that the doses they entered were outside the acceptable range.

"The pharmacy has a responsibility for medication safety practices," says Claudia Russell, RN, MBA, ALARIS vice president for marketing and strategic development.

"At the point of care, the impact of pharmacy is immediately felt. The pharmacy now has access to clinical data at the point of care."

Set your own limits
Pharmacy and therapeutics (P&T) committees establish upper and lower dosage limits based upon their hospitals' practices, says George Reid, PharmD, pharmacy director at Spartanburg (SC) Regional Medical Center. Nurses may override those limits if an alert occurs while programming the pump, but they must call the physician to alert him or her that the order is outside of the hospital's parameters. "It puts that extra safety factor in there," Reid says.

The P&T committee can look at that information to see whether the minimum and maximum dose range needs to be changed for certain medications, Levy explains.

For example, she says if nurses continually override an alert saying that 10 units/ml of heparin is too high, the P&T committee might consider either more education for the nursing staff or raising the concentration level in the pump's drug library.

Going wireless—with bar codes
Both ALARIS and Baxter Healthcare Corp. of Deerfield, IL, have developed new wireless systems that will allow pharmacy staff to download data without having to physically go to each pump.

Nurses can scan bar codes on patients' wristbands and medications. The computer system checks the information against the physician's orders, and if the medication or the patient does not match the order, the computer will alert the nurse.

Baxter's Patient Care System allows nurses and pharmacists to receive real-time data from each pump through a radio signal, says Joseph Mase, Baxter group marketing manager.

Nurses and pharmacists through a handheld computer can verify that the infusion settings on the IV pump are correct, receive alarms and alerts, and monitor the pump with real-time information for multiple patients.

"There are many opportunities for errors to happen," Mase says. "Now we have systems with these checks and balances in place."

The bar-coding technology will allow the pharmacy to discover which nurse is programming.
the pump. Smart pumps without bar codes only allow the pharmacy to determine when a dosing error occurs. “We have all accountability built in,” Mase says. “If you didn’t have bar coding, a lot of this [real-time data] wouldn’t happen, including making sure the patient receives the right drug, at the right time, via the right route of administration, and at the right dose.”

ALARIS developed its bar-code system by combining the Medley system and wireless communication with healthcare manufacturer McKesson’s handheld computers, Vanderveen says.

B. Braun USA also offers bar coding with its Outlook system, according to the company’s Web site, www.bbraunusa.com. B. Braun representatives were unavailable for comment at presstime.

Good for survey
Sharp HealthCare of San Diego began converting its infusion pump system to ALARIS smart pumps in January 2003, before two of its facilities were up for a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey, Levy says. Sharp experienced mechanical problems with the old pumps, which did not prevent free, or uncontrolled, flow of medication, something the JCAHO now requires in its National Patient Safety Goals. Programming errors also occurred with the old pumps but often went unnoticed, says Levy.

“We knew we had some medication errors associated with IVs. Some of it was simply human error in programming. We had nothing in place to help nurses at the bedside.”
—Elaine Levy, RPh

“Look, I know we’re understaffed and you’re working tons of overtime. Don’t worry about your appearance. Grunge is in.”

Quick turnaround
ALARIS can install the pumps and train staff to program them in 57 days, Russell says. Training staff is relatively simple, Levy adds, because staff are able to use a computer-based education system as part of the learning process.

The ALARIS Medley Medication Safety System costs approximately $1.5 million for a 350-bed hospital, Russell says, or about $8,000 for a single-channel pump, according to ECRI, a nonprofit health research agency. Baxter Healthcare Corp.’s Colleague CX smart pump costs $7,050 per single-channel pump, according to ECRI. Levy says she believes the pumps are worth the money because they will pay for themselves in the future.

“We knew we had some medication errors associated with IVs,” Levy says. “Some of it was simply human error in programming. We had nothing in place to help nurses at the bedside.”

The smart pumps pleased the JCAHO surveyors, Levy says. “We were able to demonstrate Sharp’s focus on patient safety. It went over well. It was something to tout [during survey].”

“For the sake of patient safety, I believe people will realize it is worth the cost,” Levy says.

Editor’s note: ECRI tests and rates different infusion pumps on the market. For more information about ECRI and its medical-device rankings, go to www.ecri.org.

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Fresh idea for National Patient Safety Awareness Week

Get pharmacy staff involved in patient education

Pharmacists at one Ohio hospital bring patient safety to the forefront, making sure they know about every prescription a patient takes.

Doctors Hospital in Columbus will hold a brown-bag session March 10 for the public to bring in their medications so pharmacists can look for possible interactions and discuss adverse drug effects, says clinical pharmacist Tammy Young, PharmD. Patients may call the pharmacy to set up a half-hour appointment with a pharmacist.

The brown-bag session is part of the hospital’s National Patient Safety Awareness Week, which runs March 7–13. The week is endorsed by the National Patient Safety Foundation and began in March 2002, according to the foundation’s Web site, www.npsf.org.

Pharmacists meet with patients one-on-one during the appointments, taking them into a quiet room near the hospital’s lobby, Young says. The relaxed atmosphere makes patients feel more comfortable and willing to ask questions about their medications, says senior staff pharmacist Mike Boyd, RPh.

“Patients may feel they are imposing on a pharmacist if the pharmacy is busy,” Boyd says. “This is more relaxed, and we have a specified length of time to meet.”

Most people who meet with pharmacists at Doctors Hospital take several different medications and worry about possible interactions, Young says. Pharmacists urge patients to bring all of their medications, including over-the-counter drugs and herbal supplements.

“We had a patient last year who had a bag full of medications,” Young says. “There were at least eight or nine medications and some herbals, and there were some interactions. We make sure everything they take is safe.”

Many patients fill prescriptions at more than one pharmacy, Boyd says. That poses some potential problems because one pharmacy might not know about potential interactions with a drug purchased at another.

“In an ideal world, the patient would get all prescriptions filled at one pharmacy,” Boyd says. “The information one pharmacy has [about the patient] may not be complete. Hopefully we’re offering a backup.”

For more ideas on what to do during National Patient Safety Awareness Week, visit www.npsf.org/html/psaw.html.

Upcoming events

Audioconferences:

3/18/2004—JCAHO’s 2004 ongoing records review standards

3/23/2004—Simplify the JCAHO's medication management standards

3/24/2004—2004 Outpatient Prospective Payment System

3/24/2004—How to manage mold in your facility: Risk, removal, and requirements

Call customer service at 800/650-6787 to register.
Quick tip: Have pharmacists review medication orders for ED boarders

Pharmacists should review medication orders for patients temporarily boarded in the emergency department (ED) or other units to comply with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) medication standards.

Boarded patients are those admitted to the hospital but placed in beds in the ED or other units, such as post-anesthesia care, until an inpatient bed becomes available. Although the requirement for a pharmacist’s review of medication orders does not apply for most ED patients, it does apply to those admitted to the hospital but housed in ED beds, says Bud Pate, REHS, consultant for the Marblehead, MA–based The Greeley Company, a division of HCPro, Inc.

The ED is a physician-controlled environment and most medications are taken from floor stock, so the JCAHO does not require a pharmacist’s prior review of medication orders. But Pate says admitted patients housed in the ED during a prolonged wait for an inpatient bed are technically inpatients, so medication standard MM.4.10 requires a pharmacist’s review of medications before staff give them out.

ED staff must make sure they follow the same rules as an inpatient unit once they begin the prolonged care for admitted patients.

**TIP:** Have ED staff or pharmacy generate an inpatient medication administration record (MAR) once the patient becomes a boarder—inpatients are considered boarders if they remain in the ED longer than two hours after admission—or the admitting physician makes a significant change in the medications regimen, Pate says.

If the MAR is hand written, it can be faxed to the pharmacy to bring together all medications for review.

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