Intimidation, verbal abuse harm patient safety, study says

Pharmacists at the forefront of problem

Editor’s note: This is the first of a two-part series about workplace intimidation and its effects on patient safety. This month highlights the results of a recent survey that focuses on intimidation’s effects on pharmacists. Next month, check out some tips to reduce intimidation and abuse.

The Institute for Safe Medication Practices (ISMP) found that 10% of 354 pharmacists surveyed reported that they were involved in a medication error where intimidation played a role within the past year.

“Intimidation impacts patient safety,” says Judy Smetzer, RN, BSN, an ISMP vice president who conducted the survey. “It was a real eye-opener to see that respondents said they asked colleagues to help interpret an order rather than call the provider.”

JCAHO medication standard MM.5.10 requires you to communicate with the patient and other healthcare providers if you have concerns about treatments.

Medicare update

Prescription for savings: Help patients choose drug card

Give patients resources to sort through the confusion of the new Medicare-approved drug discount cards. With more than 60,000 drugs, 73 discount cards, and 75,000 participating pharmacies, confusion is bound to exist.

The Medicare-approved prescription drug discount cards, an 18-month transition to the Part D prescription drug coverage to begin January 1, 2006, allow seniors to receive discounts on certain drugs. Card sponsors may select which drugs they cover, but all therapeutic classes must have coverage.

The discount cards became effective June 1 and may cost beneficiaries up to $30. Low-income beneficiaries also received a $600 annual allotment—the Transitional Assistance Program—to help pay for prescriptions.

Many patients don’t know which cards to choose and are turning to pharmacists for advice.
Intimidation

Intimidation can hinder your compliance with this standard.

Survey results
The ISMP sent the survey to 10,000 subscribers of its Nurse Advise-ERR newsletter; Smetzer says. It also sent the survey to its Medication Safety Alert! newsletter subscribers.

The November 2003 survey found that 83% of pharmacists surveyed encountered a reluctance to return phone calls when they sought clarification about an order. Fifty percent said they encountered strong verbal abuse from other healthcare providers.

Sixty percent of 2,095 healthcare workers overall said they often or sometimes encountered reluctance by a physician or other prescriber to return phone calls or answer questions. Seven percent overall reported that they were involved in a medication error where intimidation was involved.

“The numbers are staggering,” says Roberta Barber, PharmD, MPH, RPh, the incoming pharmacy services director at Maine Medical Center in Portland, ME. “To some degree, I would say surprising in today’s push to a changed culture. I applaud the ISMP for taking a stance on this.”

Protect the patient
When it comes to order clarification, 69% of healthcare workers said a prescriber responded, “Just give what I ordered.” Eighty-four percent of pharmacists or medications. Intimidation can hinder your compliance with this standard.

Survey results
The ISMP sent the survey to 10,000 subscribers of its Nurse Advise-ERR newsletter; Smetzer says. It also sent the survey to its Medication Safety Alert! newsletter subscribers.

The November 2003 survey found that 83% of pharmacists surveyed encountered a reluctance to return phone calls when they sought clarification about an order. Fifty percent said they encountered strong verbal abuse from other healthcare providers.

Sixty percent of 2,095 healthcare workers overall said they often or sometimes encountered reluctance by a physician or other prescriber to return phone calls or answer questions. Seven percent overall reported that they were involved in a medication error where intimidation was involved.

“The numbers are staggering,” says Roberta Barber, PharmD, MPH, RPh, the incoming pharmacy services director at Maine Medical Center in Portland, ME. “To some degree, I would say surprising in today’s push to a changed culture. I applaud the ISMP for taking a stance on this.”

Protect the patient
When it comes to order clarification, 69% of healthcare workers said a prescriber responded, “Just give what I ordered.” Eighty-four percent of pharmacists

### Reports of intimidation from 2,095 healthcare workers

<table>
<thead>
<tr>
<th>Potentially intimidating behaviors</th>
<th>By physicians/prescribers</th>
<th>By others (e.g., pharmacist, nurse, supervisor)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Often</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Reluctance or refusal to answer questions/return phone calls or pages</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Condescending language or voice intonation</td>
<td>28%</td>
<td>39%</td>
</tr>
<tr>
<td>Impatience with questions</td>
<td>25%</td>
<td>41%</td>
</tr>
<tr>
<td>Strong verbal abuse</td>
<td>6%</td>
<td>16%</td>
</tr>
<tr>
<td>Negative or threatening body language</td>
<td>5%</td>
<td>15%</td>
</tr>
<tr>
<td>Reporting you to your manager (actual or threat)</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td>“Just give what I/the attending ordered.”</td>
<td>12%</td>
<td>25%</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Key: Often=more than 10 times this year; Sometimes=3–10 times this year; Rarely=1–2 times this year; Never=no occurrences.

Source: The Institute for Safe Medication Practices. Adapted with permission.
reported a similar response—this was a combination of those who responded that they receive answers like this “rarely,” “sometimes,” and “often.”

Barber says she saw that happen at a hospital where she used to work. One example involved a physician who told a pharmacist to dispense the drug despite warnings that it could cause an adverse reaction, she says.

The patient did have an adverse reaction as a result, Barber says.

“We found [pharmacists] felt powerless at that point in time,” Barber says. “One of the things we found helpful was to provide support to staff members.”

Pharmacists have a responsibility to protect the patient, says Tim Benedict, RPh, assistant executive director of the Ohio State Board of Pharmacy. That includes not giving the medication whenever pharmacists have concerns. “If they feel that the drug should not be given, they should not dispense the drug, period,” he says.

Why the hostility?
Benedict says he is surprised hostility still exists between physicians and pharmacists because physicians have worked hard to shrug off their God complexes and take the time to do things correctly.

Pharmacists are more likely to encounter intimidation because they interact with nearly all physicians on staff, Smetzer says. Nurses, for example, may not interact with as many providers because of their specialty areas.

<table>
<thead>
<tr>
<th>Potentially intimidating behaviors</th>
<th>By physicians/prescribers</th>
<th>By others (e.g., pharmacist, nurse, supervisor)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Often</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Reluctance or refusal to answer questions/return phone calls or pages</td>
<td>19%</td>
<td>44%</td>
</tr>
<tr>
<td>Condescending language or voice intonation</td>
<td>21%</td>
<td>40%</td>
</tr>
<tr>
<td>Impatience with questions</td>
<td>21%</td>
<td>39%</td>
</tr>
<tr>
<td>Strong verbal abuse</td>
<td>3%</td>
<td>15%</td>
</tr>
<tr>
<td>Negative or threatening body language</td>
<td>2%</td>
<td>10%</td>
</tr>
<tr>
<td>Reporting you to your manager (actual or threat)</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>“Just give what I/the attending ordered.”</td>
<td>19%</td>
<td>32%</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Key: Often=more than 10 times this year; Sometimes=3–10 times this year; Rarely=1–2 times this year; Never=no occurrences.
Source: The Institute for Safe Medication Practices. Adapted with permission.
Medicare update

Kathleen Cantwell, JD, director of federal legislative affairs and government affairs counsel for the American Society of Health-System Pharmacists. Unfortunately, pharmacists may not know the answer.

"I don't know that even the pharmacist is sure which card is the best," Cantwell says. "It's the normal confusion of any new program. This is a real benefit, especially for low-income beneficiaries. They get that $600. It's not much, but it's better than nothing."

Information overload

The Centers for Medicare & Medicaid Services (CMS) hotline, 800/MEDICARE, received 1.7 million calls within one week after the enrollment period began May 3, causing wait times and disconnecting some callers. The hotline received six million calls total in 2003, CMS official Michael McMullan said during a Kaiser Family Foundation question-and-answer session May 25.

Many patients have skipped the phones and gone to their pharmacists for advice. Pharmacists at Lahey Clinic in Burlington, MA, have fielded questions about the cards for the past four weeks, says pharmacy director Ernest Anderson Jr., MS.

"The big thing is that we don't want our patients to be left out in the cold, but by the same token, we can't tell them which prescription card to sign up for," Anderson says.

Lahey Clinic staff prepared a list of frequently asked questions to give to both patients and healthcare providers. (Check out a sample list of questions on pp. 5–6.) Your staff can use this as a guide to help address patients' concerns about the drug card.

More than one tool available

Most information about the drug card program is online at the Medicare Web site, www.medicare.gov. “It’s as easy as one, two, three,” CMS Deputy Administrator Leslie Norwalk said during a June 10 press conference. “First, know your ZIP code. Second, know your drugs and dosages, and third, know your income if you want to apply for transitional assistance.”

After plugging in their information, beneficiaries can get a list of Medicare-approved drug cards accepted in their area.

Beneficiaries can also compare how much they will save with the different cards based on the drugs they take.

Tip: If beneficiaries do not have Internet access, have them call the Medicare hotline at 800/MEDICARE (800/633-4227) or their state health insurance counseling and assistance program.

Check for cheaper drugs, alternate therapies

Patients may not realize that they can save money without the discount cards. Cheaper generic versions of a brand-name drug may exist and may save a patient money, Anderson says.

Tip: Review a patient's drug regimen. Check to see whether less expensive, generic versions of certain drugs exist to help the patient save money.

Choose wisely

Many pharmaceutical and insurance companies offer their own discount cards. For example, Eli Lilly and Company has its LillyAnswers card to cover certain drugs it sells and Pfizer offers the Pfizer for Living Share Card.

Medicare beneficiaries may still use any discount cards they had in the past, but they may only have one Medicare-approved discount card, and they may only use one card at a time.

"That's why they need to choose wisely up-front and choose the one that will give them the best discount," Anderson says.
Medicare beneficiaries will have questions about the Medicare-approved discount cards and which one is the best for them. Lahey Clinic in Burlington, MA, supplied patients and healthcare providers with the following list of frequently asked questions.

**Q: What is a Medicare-approved discount card?**
A: A Medicare-approved discount card is a temporary card designed to help Medicare recipients pay for their medications until the new Medicare prescription drug coverage becomes effective in 2006. Enrollment for the cards began May 3, and the discounts for approved cardholders began June 1. Medicare-approved discount cards will have the Medicare-approved seal imprinted on the card.

**Q: Who is eligible to sign up for a Medicare-approved discount card program?**
A: Anyone enrolled under Medicare Part A or B who is not receiving outpatient prescription drug benefits through Medicaid is eligible. Patients who are enrolled in a state pharmacy assistance program (not Medicaid) may still be eligible. Patients with unanswered questions concerning eligibility should contact 800/MEDICARE (800/633-4227).

**Q: What is a Medicare managed care plan?**
A: Medicare managed care plans (also known as Part C) are health maintenance organizations (HMOs) or health plans that Medicare-eligible patients may elect to join in addition to Medicare Part A and B to help pay for prescription drug coverage.

**Q: Can someone sign up for more than one Medicare-approved drug discount card?**
A: No. A person may enroll in only one Medicare-approved drug discount card at a time.

**Q: Are there opportunities for people to switch discount card plans if they are not satisfied with their current choice?**
A: Yes, however a change in plan coverage can only occur from November 15 through December 31.

**Q: If married, should each spouse enroll in a Medicare-approved discount card plan?**
A: Yes. Each person must submit separate applications.

**Q: What level of discounts do the Medicare-approved discount cards provide?**
A: The Medicare-approved discount cards will offer up to a 40% discount off prescription medications. Low-income Medicare recipients may qualify for additional assistance.

**Q: Can prices change during this program?**
A: Yes. Periodic manufacturer price increases may occur. These price increases will affect the discounted retail price offered by all cards.

**Q: Are any type of drugs not discounted by the Medicare-approved cards?**
A: Yes. The cards do not cover some weight-loss drugs, fertility drugs, cosmetic drugs, drugs to relieve coughs or colds, vitamins (except prenatal), barbiturates, benzodiazepines, over-the-counter drugs, and medications that can be covered under Medicare Part B.

**Q: Would there be a difference in price between using the cards at [your pharmacy name] or another pharmacy?**
A: There may be a difference, as each pharmacy individually negotiates pricing with the card sponsors.

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.
Medicare FAQ

Q: How can I help a patient who asks for pricing or information on a Medicare discount card?
A: You can refer the patient to Medicare’s Web site at www.medicare.gov or 800/MEDICARE (800/633-4227). Patients may also contact their state health insurance counseling and assistance program.

NOTE: The Medicare Web site and toll-free number will only provide the highest possible price within a demographic region that will be charged when using a card. The customer may call the card sponsors directly for specific pricing at individual pharmacies.

Q: How long does a patient have to wait after applying for a card before being able to receive a discount on prescriptions?
A: It will take about three weeks for applicants to receive their cards in the mail. Discounts will begin on the first day of the month after the customer has been approved for the program.

Q: How much does a Medicare-approved discount card cost?
A: Each Medicare-approved discount card may have an annual fee of up to $30. Fees may vary from card to card. However, low-income applicants may qualify to have the enrollment fee paid by the government as part of the Transitional Assistance Program.

Q: What is Transitional Assistance and who is eligible?
A: Transitional Assistance is a government-funded subsidy to the Medicare discount card plan. Patients whose income is below 135% of the federal poverty level ($12,569 single; $16,862 married) may be eligible for Transitional Assistance. Transitional Assistance includes having the annual fee paid by the government and also includes a $600 subsidy applied to the patient’s card each year.

Q: Where can patients find their income level that is used to determine Transitional Assistance eligibility?
A: The income level used can be found on their 2003 tax return, line 34 of Form 1040. Single is less than or equal to $12,569 and married is less than or equal to $16,862.

Q: What happens to the $600 Transitional Assistance subsidy if a senior does not use it all in 2004?
A: Any unused amount of the 2004 $600 benefit will roll over to 2005, and the patient will receive another $600 for 2005 as well ($1,200 total for both periods).

Q: Can patients enrolled in a pharmaceutical manufacturer assistance program such as the Pfizer for Living Share Card, LillyAnswers card, or TogetherRx card apply for a Medicare-approved discount card?
A: Yes. These programs will continue to provide patients with low-cost medications until they enroll in the Medicare Prescription Drug benefit in 2006. Some Medicare discount cards will be able to coordinate the manufacturer’s discounts with the discounts offered by their card and pass the total benefit to the patient.

Source: Lahey Clinic, Burlington, MA. Reprinted with permission.
Revisions to National Patient Safety Goal #3 (posted at www.jcaho.org) require you to identify a list of look-alike and sound-alike drugs used in your organization and prevent errors that may occur by confusing the drugs.

Look-alike and sound-alike drugs have posed problems in the past. The U.S. Pharmacopeia’s (USP) MEDMARX error-reporting database received 31,932 reports related to look-alike and sound-alike drug names between January 2000 and March 2004, packages, and labels, says John Santell, MS, RPh, USP director of educational program initiatives. Of those errors, 2.6% resulted in harm to the patient.

Check out three ideas from your colleagues to solve the look-alike, sound-alike drug problem.

1. Red alert
   Red bins keep pharmacy staff on the lookout for potential drug mix ups at Warren Hospital in Phillipsburg, NJ.

   The colored bins dotting the pharmacy shelves alert staff to double-check any medication that may look or sound like another drug. In addition to improving patient safety, the method has helped workflow because staff do not have to separate the drugs and place them in another area of the pharmacy, says Priti Merchant, PharmD, the hospital’s clinical pharmacy coordinator.

   “It makes it easier instead of segregating the drugs,” Merchant says. “People have pointed out, ‘Oh, look, this is easy to miss.’ We’re glad it’s working.”

2. Make them visible
   Use current data and resources to create educational material to remind staff about the potential for confusion. USP Quality Review #79, published in April, contained a list of almost 800 pairs of drugs with similar looking or sounding names.

   “It’s a good resource for hospital pharmacists to take a look at their own list and compare it against this list,” Santell says. “Eight hundred pairs are quite a lot. This is just a starting point.”

   Tip: Conduct a Failure Modes and Effects Analysis (FMEA)—an analytic tool used to identify potential problems before they occur—to categorize look-alike and sound-alike drugs in your organization.

   Hang posters and charts with the look-alike and sound-alike drug pairs in the pharmacy and each medication room, Santell says.

3. Use tall-man lettering
   Warren Hospital pharmacy staff label the red bins with tall-man lettering, Merchant says. Tall-man lettering involves capitalizing certain letters in drug names to differentiate similar-looking and sounding drugs.

   For example, the Institute for Safe Medication Practices recommends the following spellings to identify these two drugs:
   - PredniSONE
   - PrednisoLONE

   Tip: Use tall-man lettering in computer systems, especially if they list drug names alphabetically, Santell says. This will eliminate the potential for selecting the wrong drug by confusing the names.
Case study

MA hospital eliminates paper with CPOE system

One Boston health system spent $2.5 million to establish computerized physician order entry (CPOE) and eliminated almost 50% of errors from the medication system in the process.

Beth Israel Deaconess Medical Center reduced transcription and call-back errors and has not used a handwritten order since 2001, when it put CPOE in place, says John Halamka, MD, chief information officer for CareGroup health system and Harvard Medical School.

CareGroup includes Beth Israel Deaconess Medical Center in Boston, Beth Israel Deaconess Hospital-Needham, Mount Auburn Hospital in Cambridge, and New England Baptist Hospital in Boston.


Why did they do it?

CareGroup began planning its CPOE system in 1999, around the same time the Institute of Medicine came out with its report To Err is Human: Building a Safer Health System, which noted that medication errors cause 7,000 deaths annually. However, the system did not experience any medication errors that prompted the movement toward CPOE, Halamka recalls.

The chief executive officer said CPOE is part of the medication-error reduction strategy, Halamka says. “That’s the goal. We’re going to reduce errors.”

The hospital spent 18 months developing its own system before going live, Halamka says. Beth Israel Deaconess used electronic medication administration records as far back as the 1980s, and it needed an entirely Web-based system, something that a vendor would not be able to provide, he says.

Here’s how the system works:

• The physician enters an order
• The pharmacist reviews the order for any interactions or allergies
• The pharmacist enters the order into the automated medication storage cabinet
• The nurse types in the patient’s name to get the medications from the automated cabinet

Beth Israel Deaconess spends almost $500,000 a year to maintain the system, Halamka says.

Meet with a POET

Halamka credits the hospital’s success with CPOE to the work it did in the years and months prior to launching the system. Beth Israel Deaconess created a provider order entry triage (POET) committee, a team of 35 physicians, nurses, pharmacists, and other providers, to determine what components the CPOE system should have.

The interdisciplinary team is crucial to the success of a CPOE system, Halamka says, because staff will feel comfortable using a system they helped design.

“The system came from the users,” Halamka says. “They’re not saying, ‘Look what administration did to us.’”

For example, Cedars-Sinai Medical Center in Los Angeles developed a CPOE system and began using it in October 2002, Halamka says. The hospital took the system offline in January 2003 because of staff resistance.

One problem was that Cedars-Sinai planned to sell its CPOE system as a product, he says. Administrators need to make staff understand that the end goal of CPOE is patient safety, not profit, he says.

The POET group continues to meet monthly to review new clinical data to add to the medication list or new screens that may enhance the system, Halamka says. The pharmacy director maintains a log of morbidity and errors to determine whether
the group needs to change certain screens or ordering steps to improve performance.

**Tip:** Create a collaborative effort to design the CPOE system and have the group review it once it becomes operational. Include all disciplines that will use the system.

Make it easy
The CPOE system holds nine million patient records. The large volume creates a need to design a system that is easy to use and navigate, Halamka says.

One common concern about CPOE is that physicians must click on too many screens to order a drug. Beth Israel Deaconess solved that problem with one-step ordering, allowing a physician to click on the desired medications when placing an order.

A patient’s allergy information appears on the screen for physicians. Prescribers can override any drug interaction alerts that may appear, he says. The pharmacist will see both on the screen.

**Tip:** If a pharmacist notices an alert override with the order, he or she should call the physician. Ask why the physician chose to override the warning.

Another CPOE-related concern is that prescribers may select the wrong patients because they have similar names. Prescribers at Beth Israel Deaconess can select screens that show only the patients on a particular unit, narrowing the patient population on the screen.

The CPOE system includes every patient report, such as electrocardiograms, and physicians can access it from anywhere in the world. Make sure you use CPOE as an aid to help the way staff handle workflow, Halamka says. Do not attempt to change workflow after you begin using CPOE or you will have trouble getting staff to buy in to the technology.

**Tip:** Change any relevant medication or ordering policies before you implement CPOE.

Roll out and train gradually
The day the hospital launched CPOE, it began to train staff at each nursing station, Halamka says. Information technology staff spent three weeks at each station training physicians, nurses, and other providers how to use the system.

The gradual roll-out through each station helped ease the hospital’s transition into CPOE, Halamka says. The hospital did not train physicians and staff before implementing CPOE because physicians and others wouldn’t attend the training, he says.

Editor’s note: Check out the enclosed insert for examples of what CPOE screens look like at the hospital.
Pharmacy staff only saw them a couple times, Dipboye says, and the visits were limited.

“If it didn’t have something to do with the tracer, they didn’t come in,” he says.

Teamwork pays off
Surveyors liked Sparks’ interdisciplinary documentation form, Dipboye says. The form has a section that shows all patient problems. Different departments can see each problem and determine who can best help the patient.

Sparks’ pharmacy staff make rounds of the floors, so they can look at the problem list and adjust treatments accordingly. For example, Dipboye says pharmacists can adjust vancomycin treatments depending on certain notations written on the form.

The form also includes a physician communication sheet. The sheet remains in the patient chart, and pharmacists can make suggestions to a physician, Dipboye says.

“You can say, ‘I’ve noticed this problem. What do you think of this treatment?’ ” Dipboye says.

Multimedia education
To prepare for the survey, staff received copies of questions surveyors asked at other hospitals through the hospital’s contract with Novation, a group purchaser, Dipboye says. Staff were able to read the questions during their free time to get a sense of how the survey might go, he says.

Staff also watched medication management and tracer methodology videos, Dipboye says, and the hospital held organizational meetings to update staff about new standards and any other changes.

**About the facility:** Sparks Regional Medical Center is a 450-bed hospital in Fort Smith, AR. It became Arkansas’ first hospital in 1887. It serves almost 250,000 residents in an 11-county area of northwestern Arkansas. The hospital has 24-hour pharmacy coverage seven days a week.
**Tip:** Make staff available to answer survey preparation questions that other employees may have.

Sparks’ staff spread out survey preparation over several months, Dipboye says. The education sessions totaled nearly six hours per staff member.

**Keep current with a steering committee**  
A JCAHO steering committee also helped Sparks’ staff prepare for the survey. Make sure your committee has a pharmacy representative so you can keep current on any new standards.

The steering committee at Sparks met weekly until the survey. The hospital leaders hope to reconvene for monthly meetings to discuss JCAHO compliance issues, Dipboye says.

“Be sure to prepare on a daily basis,” Dipboye says. “If we see a place where we’re lax or weak, we can step in.”

The JCAHO steering committee stays abreast on the latest standards changes or National Patient Safety Goal revisions, Dipboye says. Department heads or representatives can then pass that information on to staff members.

All clinical directors have seats on the committee, Dipboye says.

The steering committee can also tackle major issues that could affect patient care and JCAHO compliance. For example, bar coding is one topic the committee can investigate, from potential vendors to what system the hospital needs, Dipboye says.

“That’s not something one department can do on its own,” Dipboye says. “That’s something the committee can meet about.”

The committee will also be able to determine the hospital’s compliance with bar-coding requirements, especially if it becomes part of the 2005 National Patient Safety Goals. The JCAHO is expected to vote on the proposed revisions this month.

---

**Survey at a glance**

**Hot spots:** Respiratory therapy medications, chemotherapy orders, interdisciplinary documentation.

**Critical advice:** Control respiratory therapy medications as you do with other medications. The JCAHO will focus on how you control them and how you review their orders.

**Survey tip:** Create a JCAHO steering committee and make sure the pharmacy has representation on it. The committee can help prepare the hospital for the survey and keep staff updated on JCAHO news.

**Quote of note:** “If it didn’t have something to do with the tracer, they [surveyors] didn’t come in.”
Quick tip: Keep this number handy for poison emergencies

Post the national poison hotline number in your pharmacy and call it in the event of a poison emergency, such as pharmacists accidentally ingesting poisonous substances or patients taking the wrong medicine.

The toll-free number—800/222-1222—connects callers directly to their local poison-control center, says Chris Falk, spokesperson for the American Association of Poison Control Centers (AAPCC). Each poison-control center still has a local number, but patients can take the number with them and get access to the nearest center anywhere in the country.

Tip: Call the toll-free number and speak with an educator. Ask him or her to send prevention information as well as stickers and magnets you can use to remind patients and staff about the poison-control hotline. You can also get drug-interaction information from counselors at a local poison-control center.

The hotline was established in 2002 as a result of the Poison Control Center Enhancement and Awareness Act of 2000. Congress intended to link all 62 U.S. poison-control centers together with one common number, allowing U.S. residents easier access to a poison control center, Falk says.

The hotline receives about three million calls each year; Falk says. Nearly 35% of the calls to U.S. poison-control centers now come in through the toll-free number, he says.

The AAPCC receives less than 15% funding for the hotline from the Centers for Disease Control and Prevention and the Health Resources and Services Administration, Falk says. The balance of the money comes from private donations, he says.
Dear reader,

Computerized physician order entry (CPOE) is a hot topic in the healthcare industry, and its effects are far-reaching. It affects not only how a prescriber orders medications, but also how you check for drug interactions and allergies. Your department needs to ensure that it can take orders entered electronically and transfer them into the pharmacy computer system. Interface your system with the hospital’s CPOE system, or use staff time and resources to type the orders into the pharmacy system as prescribers enter them. If your organization is considering launching a CPOE system, make sure your department is involved in the planning process to guarantee its needs are met.

El Camino Hospital in Mountain View, CA, became the first hospital in the world to use CPOE in 1969 when it built its own system. The hospital had to modify television screens—in the days before the modern computer—so prescribers could see the medications in the CPOE database, says Philip Strong, MD, a hospitalist with Camino Medical Group. Since then, other hospitals have tried to establish CPOE. Some were successful, while others were not.

Your hospital needs to have strong backing to begin using CPOE. Your administration must support it, but more important, staff must accept it. They must believe that CPOE will help improve patient safety and that the hospital is not doing this just to boost revenue. When your hospital is planning its CPOE system, solicit staff input into what the system will look like. After all, they are the ones who will use it daily.

This insert will show you some sample screens from the CPOE system at Beth Israel Deaconess Medical Center in Boston courtesy of John Halamka, MD, the hospital’s chief information officer. Beth Israel Deaconess built its own CPOE system in 1999 and began using it in 2001. Since that time, the hospital has not used a paper order and has reduced transcription and verbal-order errors (see the case study on p. 8 of the newsletter).

Editor’s note: To comply with the Health Insurance Portability and Accountability Act of 1996 privacy rule, all patient names shown in this insert are fictitious.

Matthew E. Bashalany
Editor
Hospital Pharmacy Regulation Report

<table>
<thead>
<tr>
<th>Table of contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPOE main menu screen</td>
</tr>
<tr>
<td>CPOE inpatient dashboard screen</td>
</tr>
<tr>
<td>CPOE medication ordering screen</td>
</tr>
</tbody>
</table>
When a prescriber clicks on a patient's name, it opens up the above screen, the main menu for the Beth Israel Deaconess Medical Center CPOE system.

The patient profile is placed prominently on the screen, with all relevant information shown to the prescriber. The profile includes the patient's age, medical record number, and physician name.

Allergy alerts, a main component of the CPOE system, are placed next to the admitting diagnosis. Prescribers will be able to view any pertinent allergy information before ordering a medication.

The prescriber has access to every patient report through Beth Israel's system. Prescribers may view the patient's admission orders, current orders, tests, and lab values. Prescribers can access those categories through the main menu column on the left side of the screen.
Patient-safety advocates have often mentioned that prescribers could accidentally select the wrong name when entering an order because two patients have similar names. Beth Israel seeks to eliminate that problem, Halamka says.

Beth Israel created dashboards, physical locations on each unit. Each dashboard shows the patients currently on that unit. For example, a physician in the intensive care unit (ICU) may bring up patients only in the ICU, not patients throughout the hospital.

These dashboards reduce the number of patients from which a prescriber must choose, reducing the potential for selecting the wrong patient.
The medication ordering screen provides prescribers with one-click ordering, reducing the number of steps they must perform to order a medication.

The system arranges medications into different categories. Prescribers may select a medication based on the top 50 most-ordered medications in the hospital. They may also select medications based on an alphabetical list, therapeutic class, nonformulary, or study medications.

The system requires prescribers to use generic names when searching for medications.

Renew today!

Is your HPRR subscription about to run out? Don’t let it happen. Contact customer service at 800/650-6787 to renew today and remain current on the latest pharmacy news and trends.