

2010 National Patient Safety Goals

For Ambulatory Care

The Joint Commission

Standards for Medication Safety

◀ Goal 1: Improve the accuracy of patient identification.

Use at least two identifiers when providing care, treatment or services.

Our policy: Prior to administering medication, nursing staff will identify patient verbally and by ID band. If the patient is unable to respond verbally, the patient's DOB will be used as alternative identifier.

◀ Goal 3: Improve the safety of using medications.

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

Our policy: All medication and solution containers (syringes, medicine cups, basins, etc.) on or off the sterile field in the OR or in any other procedure setting will be labeled, even if there is only one medication being used.

Labeling will occur when any medication or solution is transferred from the original packaging to another container.

Labels will include: drug name
drug strength
amount
expiration date

Medications which need to be diluted will have sticker affixed stating so.

No more than one medication or solution will be labeled at one time.

Medications not labeled will be discarded!

OR staff will review all labeled medications on and off sterile field and the amount of medication administered when change of staff occurs.

All labeled containers on sterile field will be discarded at end of case.

◀ **Goal 3: Improve the safety of using medications. (Continued)**

Prior to administering medication to patient, the nurse will:

Verify order, confirm/consult MD if order is incomplete, illegible or unclear.

Identify patient verbally, check ID band, and DOB.

Verify with patient, they have no drug allergies.

Check stability and expiration date of medication

Verify: Right patient
 Right drug
 Right route
 Right dose
 Right time
 Right use

Advise patient/family about any potential significant adverse reactions about administering a new medication.

◀ **Goal 4: Accurately and completely reconcile medications across the continuum of care.**

A process exists for comparing the patient's current medications with those ordered for the patient while under the care of the organization.

When a patient leaves the organization's care, a complete and reconciled list of the patient's medications is provided directly to the patient, and as needed, the family, and the list is explained to the patient and or family.

Note: These standards are not in effect at this time.

Our policy: Medication reconciliation will be done at every change in the facility involving a transition of care in which new medications are ordered or existing order are rewritten: on admission, at discharge and upon transfer to another facility. The Medication reconciliation form will be filed in the patient's medical record.

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Preventing Medication Errors

- ◀ 98,000 Lives + die from medical mistakes yearly (Institute of Medicine).
- ◀ 7,000 + lives die from medication errors alone.
- ◀ Preventable adverse drug events cost \$ 2 billion ANNUALLY (Inpatient).
- ◀ Medical mishaps, medication errors run rampant in US health care system.
- ◀ Long standing belief that every health care professional should be perfect.
- ◀ Rampant errors do not reflect incompetence.
- ◀ Root problem is the lack of system-wide strategies to prevent common human errors, as well as the fragmented delivery of health care. MD's, hospitals, and other health care providers operate independently.
- ◀ Children run especially high risk of suffering a medication error. (100,000 prescriptions examined/500 drug orders with errors found/27 potentially lethal errors were found.

Some Possible Solutions

- **Technology** Supermarket-style bar coding on patient wrist bands and Drug dispensers
Computer systems into which physicians must enter and transmit drug prescriptions (Software to include monitoring for improper drug doses, potentially harmful drug-drug interactions, or high risk of allergic reaction.

Switching to computerized entry of drug prescriptions has decreased serious medication errors by 50%

- **Dedicated Medication Personnel-** people who work in teams makes less errors!
- **Packaging** Color coded bottles for different doses
- **Standardizing equipment** IV pumps, 25% of pumps are free flow!
- **Increasing reporting medication errors**
- **Standardize the entire prescription writing and prescribing rules**

2/2010

Medication Safety -2010



What is the expiration date for Multi-Dose Vials?

What information needs to be documented on a multi-dose vial the 1st time it is opened?

1. The expiration date has been revised from 30 days to 28 days if the multi-dose bottle has been opened. If unopened, then the manufacturers' expiration date is when the bottle is expired.
2. If it is the 1st time the vial is used, label the vial with the date opened, time and your initials.

Why????

To comply with the USP Standards for the Preparation of Sterile Products which were revised to 28 days in the 3rd Quarter 2007 with some insulin vials also expiring in 28 days per the manufacturer.



What are the Five Elements of a Complete Medication Order

1. Medication Name
2. Dose of Medication
3. Route of administration
4. Frequency
5. Any special instructions



What are some of the Look Alike/Sound Alike drug combinations staff need to be more aware of?

Oxycontin vs Oxycodone
Ephedrine vs Epinephrine
Hydroxyzine vs Hydralazine
Novolin vs Novolog
Fentanyl vs Remifentanyl
Methylprednisolone vs Metoclopramide
Cardene vs Cardizem
Celexa vs Celebrex
Hydrocodone vs Oxycodone
Folic Acid vs Folinic Acid

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Name: _____ Date: _____

Preventing Medication Errors Post Test

1. Each year, 98,000 lives are lost due to medical mistakes.
True False
2. Experts attribute most medication errors to incompetence by nurses, Doctors, and pharmacists.
True False
3. 1000 lives are lost annually from medication errors.
True False
4. Unlabeled medication syringes/containers can lead to perioperative adverse medication errors.
True False
5. Use of computerized entry of drug prescriptions has been shown to decrease serious medication errors by more than 50%.
True False
6. Verbal and telephone orders will be taken in extenuating circumstances.
True False
7. One way to reduce medication errors is to train staff to work in teams; people who work in teams make fewer mistakes when they work in teams.
True False
8. Experts agree that the best way to reduce medical mistakes is to add safety systems to hospitals, and all medical facilities.
True False
9. Children run less of a risk of suffering medication errors than adults.
True False

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