CAH Site Visit Summary 2010-2011 (Part 1)

Tom Johns, PharmD, BCPS
University of Florida
Shands Hospital

Almut Winterstein, PhD
University of Florida
College of Pharmacy

“Top 10” Recommendations

- Remove promethazine 50 mg/mL injectable vials from the Pharmacy and delete from the Formulary.
- Develop, implement, and monitor use of standardized pre-printed physician order forms for unfractionated heparin, warfarin reversal, venous thromboembolism (VTE) prophylaxis, and subcutaneous insulin therapy with sliding scale component.
- Develop, implement, and monitor a reliable system to obtain and document patient allergy symptoms at admission.
- Review policy that requires an indication to be written with each PRN medication order. Implement necessary policy changes. Audit prescribers and deliver individual feedback as a method to increase compliance

“Top 10” Recommendations

- Develop and implement a policy to prohibit the use of fentanyl transdermal patches for the treatment of acute pain or in those patients who are not opioid tolerant. We recommend development of a drug-specific pre-printed physician order form for prescribing fentanyl transdermal patches. Use of this form must be required.

- Utilized oral unit dose syringes for all oral liquid medications drawn up in nursing unit. Oral unit dose syringes should be stocked and readily available in the nursing unit. Nurses should not utilize injectable (luer lock) syringes for oral liquid preparation.

- Replace current crash carts with a commercially manufactured emergency cart. As a component of the new emergency cart, purchase and implement a standardized medication tray that effectively separates drugs and allows for effective labeling to prevent errors.

“Top 10” Recommendations

- Obtain current pediatric emergency medication dosing guide.
- Implement a reliable system that ensures opened multi-dose injectable vials are labeled with the expiration date.
- Develop and implement a high-risk medication policy. Essential elements include consistency of labeling practices in all medication storage areas, inclusion of warning information at order entry into MDG, nursing personnel double-checks during order entry, removal of medications from MDG and administration procedures (including IV pump programming).
- Remove outdated medication references from the hospital. Replace with online or hardcopy medication references.

“Top 10” Recommendations

- Reduce the number of medications in the Formulary by implementing an effective therapeutic interchange program for the following medication classes: H2-receptor antagonists, proton pump inhibitors, and ACE inhibitors

- Audit the frequency of incomplete and illegible medication errors written by prescribers. As an intervention strategy, provide direct feedback to those prescribers in non-compliance. Implement monthly monitoring plan to evaluate effectiveness of the intervention strategy.

“Top 10” Recommendations

- Require onsite pharmacist to work directly with prescriber (instead of through nursing staff) to correct detected prescribing errors. Monitor to determine compliance.
- Develop a process to require all medications in oral solid dosage forms to be dispensed from pharmacy in unit dose packaging.
- Review policy and implement procedure for properly labeling medications draw into syringes for administration.
- Formally evaluate the ability of the organization to provide 24/7 pharmacist review of all medication orders prior to medication administration. This evaluation should include a review of current resources as well as services provided by commercial vendors.

“Top 10” Recommendations

- Form a multidisciplinary quality improvement team (including medical staff) to formally evaluate blood glucose control and/or pain management in the inpatient setting. Goal is to establish a standard organizational care process, implement necessary policies and procedures, develop and implement process tools (e.g. pre-printed physician order forms), and monitor outcomes of the program.

- Evaluate policies and procedures for neuromuscular blockers storage and labeling. Specifically, neuromuscular blockers should be stored in a manner that segregates these drugs from all others. We recommend a small, red box be used to store these medications in refrigerators. This red box should have a lid and contain a warning sticker that states “Warning: Paralyzing Agent – Causes Respiratory Arrest”. We also recommend each vial be placed in a shrink wrap sleeve that also contains the above warning language.

“Top 10” Recommendations

- Develop, implement, and monitor compliance with a policy that requires weight-based dosing for all inpatient pediatric medication orders. For example, pediatric medication orders must be written as “ampicillin 100 mg (25 mg/kg/dose) IV q6hr”.

FL Hospital Wauchula

- Purchasing and installing Hospira Smart Pumps
- State-of-the-art EMR with CPOE
- EMR allows plotting of pain scores and capability to match pain medications to the score
- Standardized SSI order set
- Focused effort to prevent harm from hydromorphone (Dialudid)
  - Educational materials
  - Flow sheet that incorporates dose, route , frequency, and pain scores
- Deleted meperidine (Demerol) from the Formulary [only CAH to accomplish]
- Executive rounds to improve communication and enhance safety culture

“Top 10” Recommendations - Incomplete

- Review policy and procedures for ensuring temperatures for medication refrigerators are maintained within required range.

- Ensure PRN medications with duplicate indications are clarified with the prescriber prior to patient administration. For example, if morphine and oxycodone are both order “PRN pain”, the prescriber should clarify the sequence of administration or further define the pain condition for each medication (eg. morphine for “severe” pain and oxycodone for “moderate” pain)

"Top 10" Recommendations - Incomplete

- Develop an effective policy and procedure to annually review all pre-printed physician order forms. All forms should be reviewed and approved by a pharmacist prior to implementation.

- Remove unsafe abbreviations from all pre-printed medication-related documents.

- Require nursing staff to retrieve medications for patient administration directly from automated dispensing cabinet. Eliminate the use medication carts as a component of the medication distribution system.

New “Top 10” Recommendations

- Complete of comprehensive review of warfarin prescribing practices and monitoring. If appropriate, utilize findings to support process changes to improve anticoagulation practices.
- Complete of comprehensive review of antibiotic prescribing practices in the ED. If appropriate, utilize findings to support process changes to improve prescribing practices that will not only benefit the hospital but the community as well.
- Evaluate Pyxis override policy to determine existing requirement for documentation of reason for each medication removed via this mechanism. Develop and monitor a process for leadership evaluation of reasons for medication removal via override.
- Evaluate use ISMP Assess-ERR worksheet for each medication error that does not result in an RCA. Use findings to make system changes in an effort to prevent future medication errors.

New “Top 10” Recommendations

- Ensure prospective review of medication orders by a Pharmacist prior to patient medication administration by Nursing staff.
- Evaluate policy and procedure for screening and administration of pneumococcal and influenza vaccines. Consider inclusion in the admission process to improve compliance rates.
- Delete phenytoin from the hospital formulary. Replace all phenytoin use with fosphenytoin.
- Implement a policy and procedure to apply expiration dates to IV fluids kept in the OR warmer.
- Remove all alcohol products from the Pharmacy. The Pharmacy does possess a liquor license to sell alcohol. The standard of care in hospital pharmacies is to no longer stock and dispense alcohol. We recommend development of a standardized, medical-staff approved, DT prevention/alcohol withdrawal order set.

New "Top 10" Recommendations

- Evaluate the feasibility of purchasing commercial medication refrigerators to optimize storage conditions and reduce false-alarms of new central temperature monitoring system.
- Develop and implement a reliable process for obtaining a patient's home medication list and comparing to hospital medications for discrepancies. At discharge, reconcile hospital medications with prior home medications, and provide patient with a comprehensive list of medications to be taken at home.
- Prohibit the use of Demerol for the treatment of acute or chronic pain.
- Continue remote medication order review during hours the pharmacy is closed.
- Standardize patient weight documentation across all hospital departments. Recommend only documenting patient weight in kilograms.

Survey Scores

- Survey instrument was updated to
  - Remove items that
    - score consistently high across institutions (eg, critical labs alerts)
    - have become irrelevant (eg, Darvocet)
    - are not directly relevant to medication safety (eg, cardboard boxes)
  - Add items to expand clinical scope
    - More infectious control
    - Patient information / interview module
    - Total number of items dropped from 154 to 134

Final Item Categories

- HIT (10)
- Orders (6)
- Clin Pharm Serv (10)
- Core Pharm Serv (6)
- High-alert/alikes (7)
- Administration (14
- Anticoag (8
- Antihyperglyc (6)
- ID (7)
- Pain (5)
- Order forms (6)
- Crash carts (6
- Pharmacy storage (7
- Floor storage (13)
- Med Saf Org (11)
- Med Rec (3)
- Allergies (8)

2009/2010 Scores (11 Hospitals)

1.2
1
0.8
0.6
0.4
0.2
0

HIT (10)
Orders (7)
Clin Pharm Serv (10)
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ID (7)
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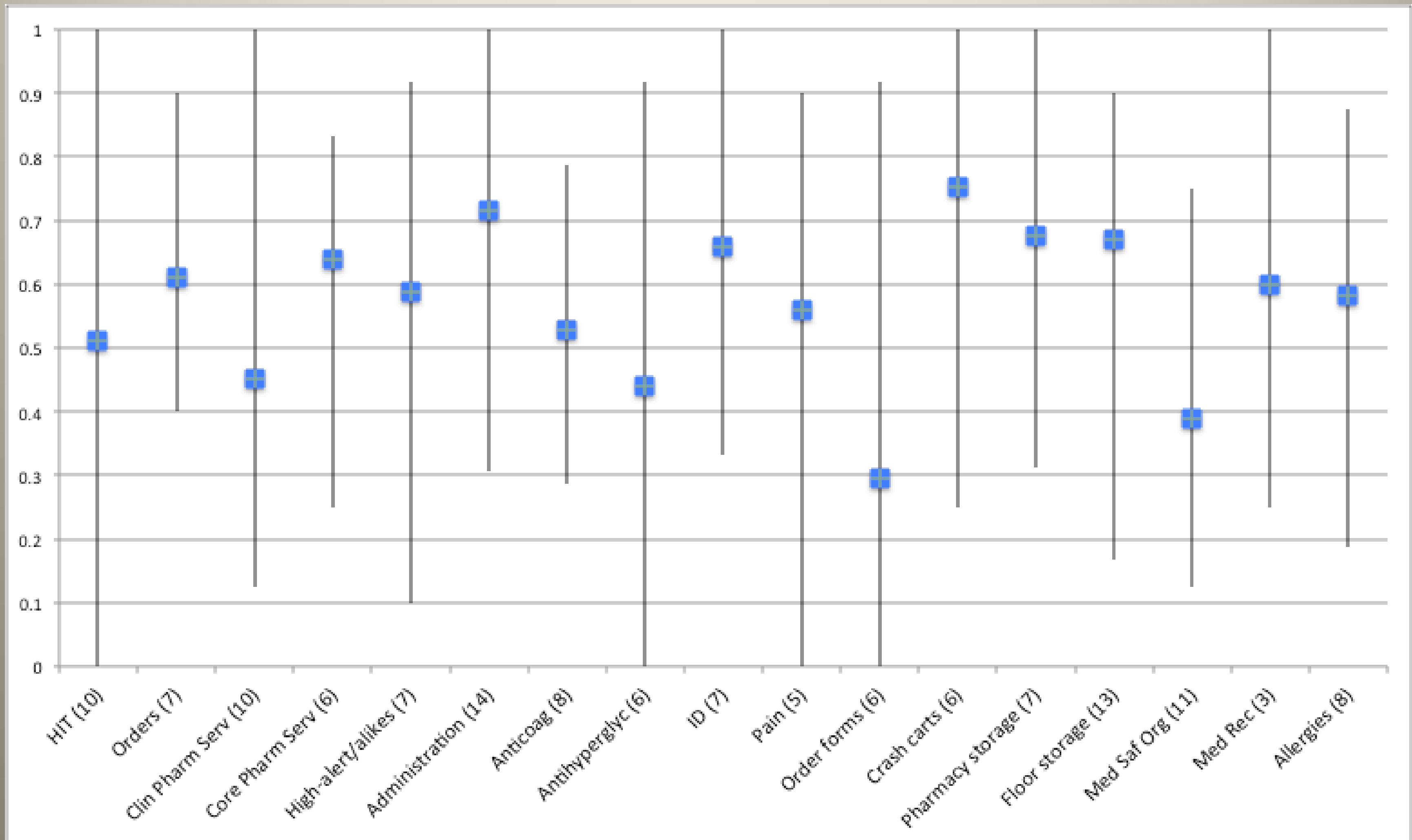
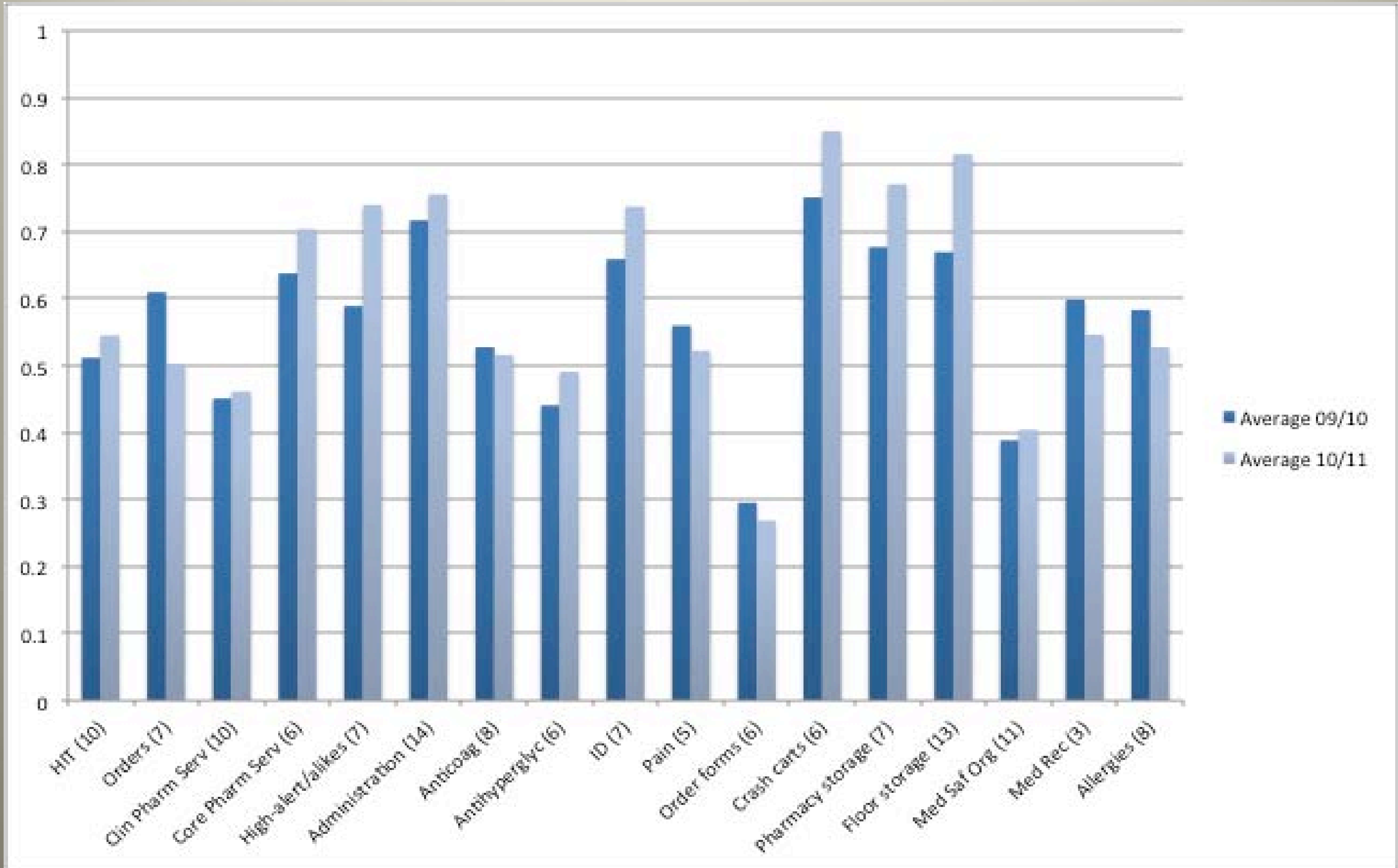
Pharmacy storage (7)
Floor storage (13)
Med Saf Org (11)
Med Rec (3)
Allergies (8)

1
2
3
4
5
6
7
8
9
10
11

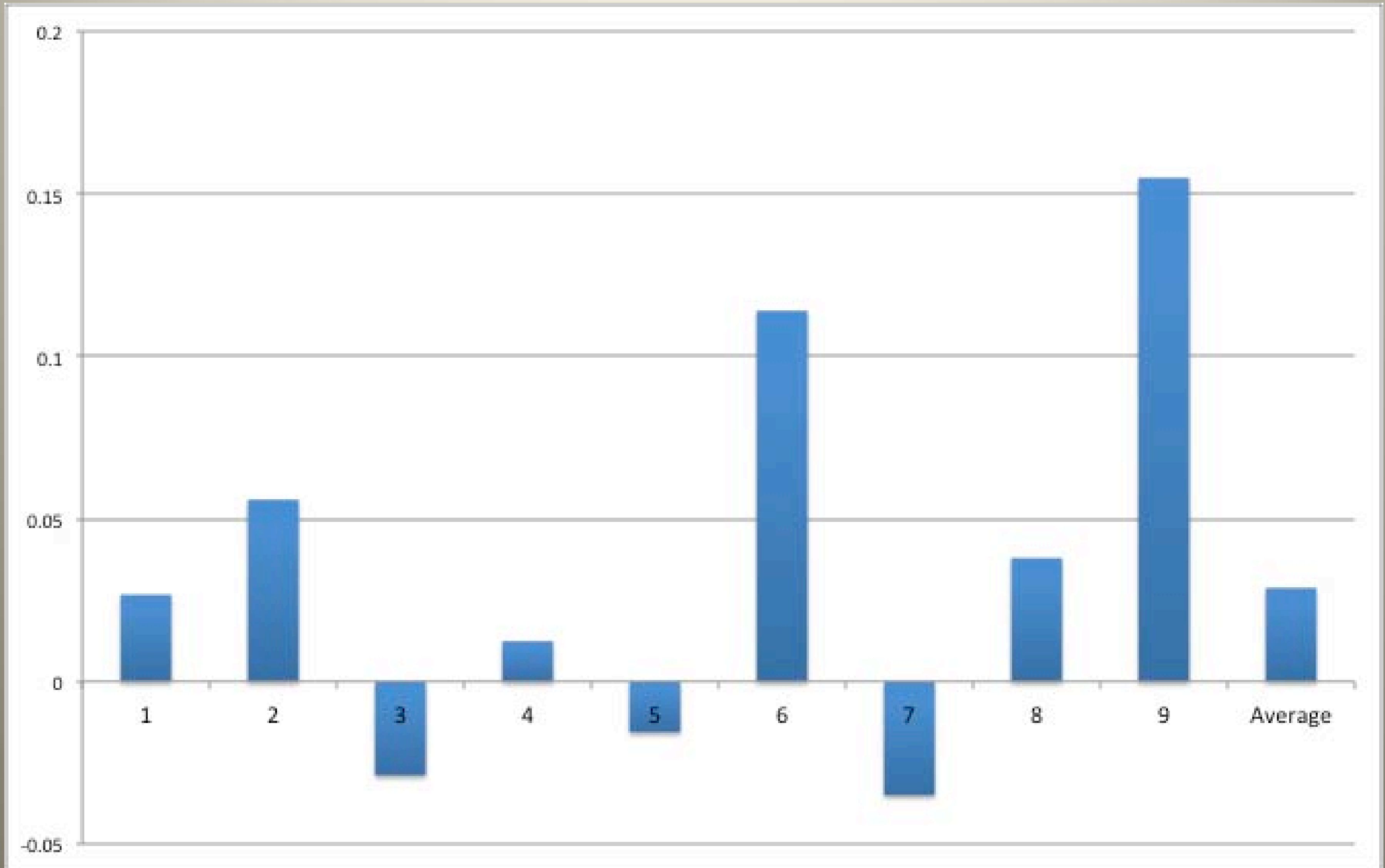
2009/2010 Score Average & Range



Changes in Average Scores: 09/10 versus 10/11 (9 Hospitals)



Average Change per Hospital



Issues

1. Does the survey meet its purpose to provide valuable information to institutions?
   - Benchmarking
   - Highlight high-priority areas for improvement
   - Facilitate assessment of progress
2. Does the survey hinder our ability to interact with staff during site visits?
3. Are survey results counter-productive in producing sense of assessment and judgment?

Questions?

- Would you like continuation of survey?
- Addition/removal of certain items?
- More time with us during site visits?
- Different/same emphasis in our distribution of time?
- Display of individual scores along with comparison to other institutions in report?

Questions?