

Use of High-risk Medications

- Implement a reliable system that ensures opened multi-dose injectable vials are labeled with the expiration date (not the opened date).
- Do NOT use single-dose injectable vials as multi-dose containers.



Use of High-risk Medications

- Remove promethazine 50 mg/mL injectable vials from the Pharmacy and delete from the Formulary.
- Created comment that appears on pre-printed medication orders, labels and MAR..”dilute in 10 mL and infuse over 10 minutes”



Phenergan extravasation caused gangrene in a young woman's fingers.

- Prohibit IV route of administration.

Use of High-risk Medications

- 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.



Use of High-risk Medications

- 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.



Neuromuscular
blocker storage
and labeling

Use of High-risk Medications

- Insulin vials / pens are diverse to prevent look-alike/sound-alike errors.



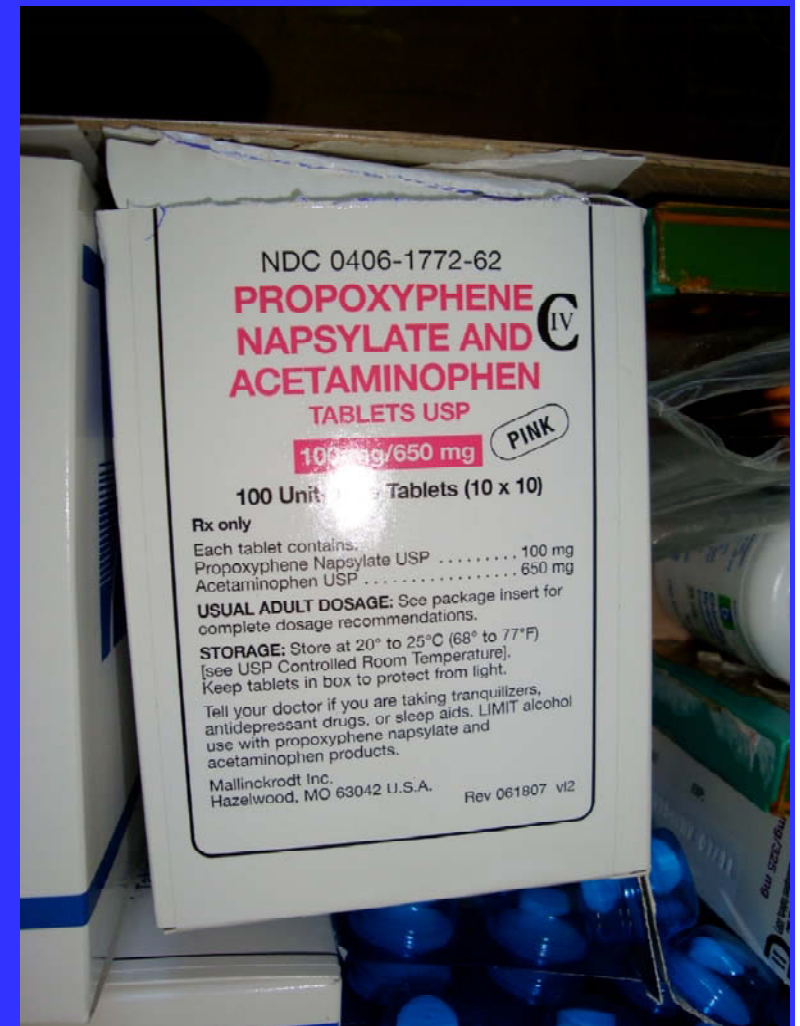
Use of High-risk Medications

- Insulin vials are NOT placed back in original boxes for storage after opening.



Prescribing Best Practices

- Remove Darvocet[®] from the hospital formulary and prohibit use of the patient's own supply during the inpatient admission.



Prescribing Best Practices

- Restrict use or delete meperidine (Demerol) from the Formulary.



Prescribing Best Practices

- 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”. Patient weight must also be included on each order page.
- Remove the option to order a vancomycin peak serum concentration from the vancomycin pre-printed physician order form.

Prescribing Best Practices

- Develop and implement a policy to prohibit the use of fentanyltransdermal 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 fentanyltransdermal patches. Use of this form must be required.

Prescribing Best Practices

- 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.

Prescribing Best Practices

- 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.
- 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).

Process Improvements

- Medication administration
 - ◆ Evaluate current medication administration policy and procedure to ensure it contains a reliable system for (1) nursing personnel to take the MAR to the bedside during the administration process, (2) enforce two patient identifiers, (3) require medications to remain in the unit-dose packaging until the point of administration, and (4) verify expiration dating.

Process Improvements

- 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.

Process Improvements

- 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.
- Require onsite pharmacist to work directly with prescriber (instead of through nursing staff) to correct detected prescribing errors. Monitor to determine compliance.

Process Improvements

- Remove outdated medication references from the hospital. Replace with online or hardcopy medication references.
- Develop, implement, and monitor a reliable system to obtain and document patient allergy symptoms at admission. In addition, improve processes to ensure allergy documentation is consistently applied to required locations (e.g. front of chart).

“Other” Recommendations

- Cardboard shipping boxes are NOT present in the hospital pharmacy.
- Apply external labels to all drawers and containers within the ADC.



Quality Strategic Plan

- Identify quality indicators important to the organization (external and internal)
- Develop scorecard for measuring performance
- Acquire BOD approval
- Establish Quality agenda item at each BOD meeting
- Develop PI Teams to address each quality indicator (leadership, MD and administrator participation)