



Medication Error Reduction

Dr. Katy Marconi, Pharm D
Director of Pharmacy
Director of Clinical Quality





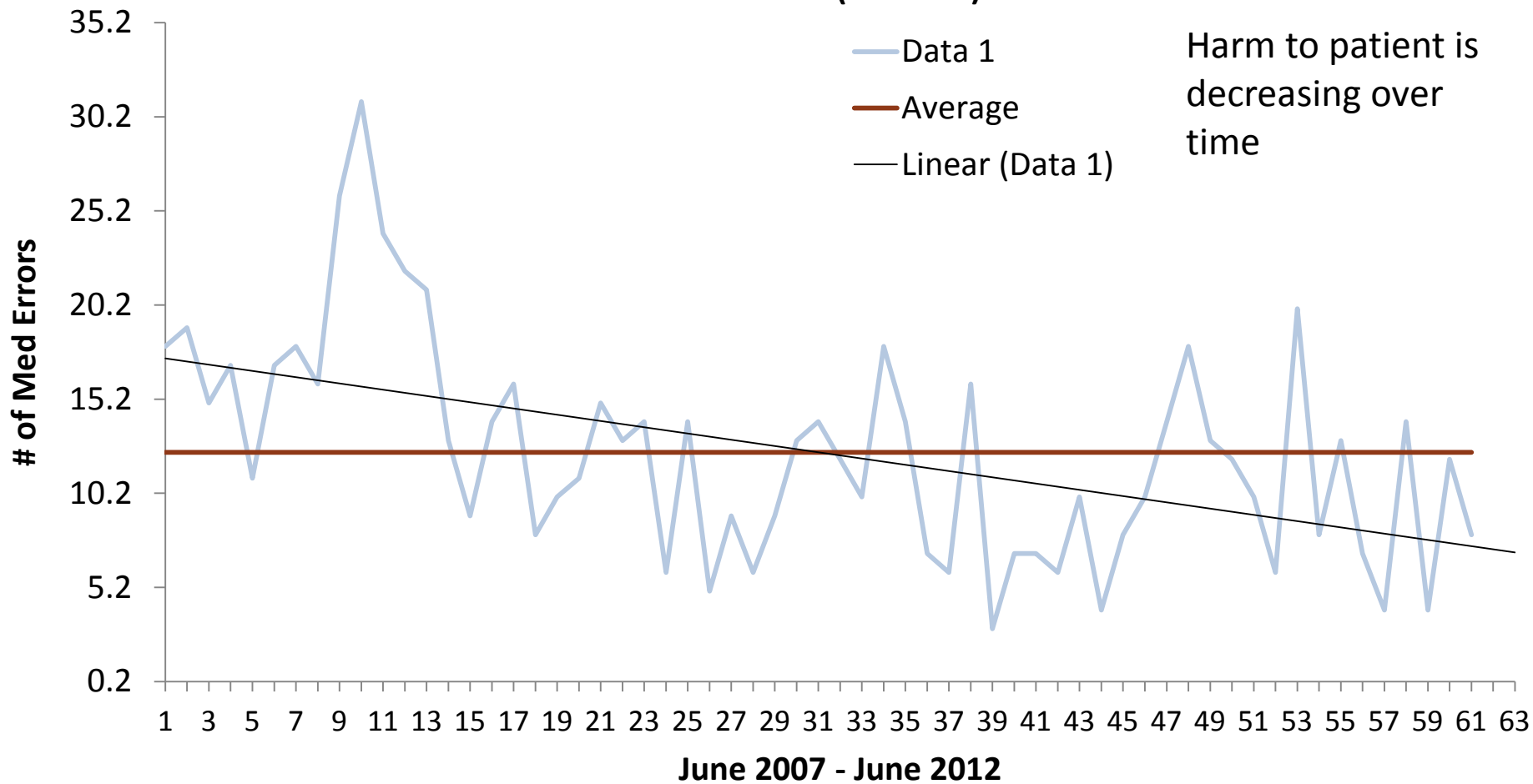
Objectives

- Address medication safety challenges with high alert medications
- Provide safety practices to reduce ADEs associated with high alert medications
- Measurement strategies to evaluate effectiveness of improvement processes.





Medication Errors - C&D (no harm) - DHM





The Issues and the Challenges

- Issue: High alert medications are often the most utilized medications but high alert medications can potentially cause the greatest harm.
- Challenge: how to ensure safe use at all times
- Issue: To ensure potential harm is limited/eliminated, checks are put into place, but can often be cumbersome or time consuming
- Challenge: How to keep on task and on track to ensure safe administration.





The Answers

- **policy and procedure (P&P)** to guide
 - Ensure P&P is reviewed by those that actually must follow
 - Ensure that when P&P is not followed, a just culture is followed to remedy
- **Order sets and standardized procedures**
 - Eliminate potential for error
 - Eliminate potential for variation/deviation from safe practices





The Answers

- P&P defines
 - Intent
 - Purpose
 - Benefits
 - What the organization considers as high alert
 - The requirements of risk-avert strategies
 - Safety features to be used
 - Literature and reference of best practices
 - Recommend ISMP (Institute for Safe Medication Practices)
- PPOS and Standardized procedures
 - Guide and simplify the process
 - By having things clearly written and defined, you reduce variability in ordering practices that could keep you from your P&P
 - Approved by the medical staff, so they know the rules and expectations as well as staff



An Example - Opioids

Policy

- We defined PCA opioids and opioid drips as high alert requiring, thus requiring an independent double check prior to administration
- We defined all other opioid narcotics as high alert, thus requiring safety features to be employed

Requirement

- Anytime a PCA opioid or opioid drip is being set up or a change is made to the settings, a second nurse must **double check** the chart order or MAR with: Correct Drug, Correct concentration, and Correct pump settings. The double check is documented with the initials of both RNs on the Medication Administration Record.
- Verify frequency and dose, noting that morphine and hydromorphone are not equipotent – see chart for dosing equivalencies – 10mg of Morphine = 1.5mg Dilaudid, so 2mg of Morphine = 0.3mg Dilaudid.

Dosage Conversion Guidelines

Current Analgesic	Total Daily Dosage (mg/day)			
Oral morphine	60-134	135-224	225-314	315-404
IM/IV morphine	10-22	23-37	38-52	53-67
Oral oxycodone (Percocet, Oxycontin)	30-67	67.5-112	112.5-157	157.5-202
Oral codeine	150-447	448-747	748-1047	1048-1347
Oral hydrocodone (Vicodin, Lortab, Norco)	27-54	-	-	-
IV hydromorphone (Dilaudid)	1.5-3.4	3.5-5.6	5.7-7.9	8-10
Oral hydromorphone (Dilaudid)	8-17	17.1-1-28	28.1-39	39.1-51
IM/IV meperidine (Demerol)	75-165	166-278	279-390	391-503
Oral methadone	20-44	45-74	75-104	105-134
Fentanyl patch	12 or 25 mcg/hr	50 mcg/hr	75 mcg/hr	100 mcg/hr

A. Analgesia via Abbott PCA II Infuser

_____ Morphine 1mg/ml
 _____ Dilaudid 0.2mg/ml

_____ Demerol 10mg/ml*
 _____ Other: _____

* Should be used for brief courses in patients who are allergic to other opioids listed above.

B. PCA & Continuous (Patient Control with Background Continuous Infusion)

(1) PCA DOSE	Suggested:	Morphine:	
		0.6mg-2mg	
		Dilaudid:	0.1 mg-0.3mg
		Demerol:	5mg – 20mg
(2) _____ DELAY (LOCKOUT)	Suggested:	Morphine:	5 -
	100min		
		Dilaudid:	5 – 10min
		Demerol:	5 – 10min
(3) _____ CONTINUOUS INFUSION (Basal Rate)	Suggested:	Morphine:	0-1.25mg/hr
		Dilaudid:	0 – 0.1 mg/hr
		Demerol:	0 – 10mg/hr
(4) _____ 4 HOUR LIMIT	Suggested:	Morphine:	30
	mg		
		Dilaudid:	4.8-8mg
		Demerol:	50-300mg
(5) _____ LOADING/BOLUS DOSE	Suggested:	Morphine:	
	2.5mg		
		Dilaudid:	0.4mg
		Demerol:	20mg



Our order set for Fentanyl Patches – Addresses Black Box Warning

Choose One:

1. Continuation of fentanyl patch regimen from prior to admission.
 - Verified the patient on patch within 24 hours:
2. If off the patch, was equivalent opiate analgesia reviewed to provide continuous coverage?
3. Adjustment of fentanyl patch dose. If patch strength is increase, the patient must have tolerated the previous strength for a minimum of 3 days from initial dose. Changes in dose can be no more frequently than every 6 days thereafter

Initiation of fentanyl patch therapy: Verify 7 days opiate analgesic history to confirm a patient is not opiate naïve prior to initiation of a fentanyl patch and confirm patch strength.

Doctors Hospital Of Manteca <small>Tulare California</small>		*139*	
		<small>139 OHM R07/2011</small>	
DATE:	TIME:	HT:	WT:
STATUS: <input type="checkbox"/> OUTPATIENT: <input type="checkbox"/> Observation <input type="checkbox"/> ICU <input type="checkbox"/> MedSurg <input type="checkbox"/> MedSurg Tele <input type="checkbox"/> OB			
<input type="checkbox"/> INPATIENT ADMIT: <input type="checkbox"/> ICU <input type="checkbox"/> MedSurg <input type="checkbox"/> MedSurg Tele <input type="checkbox"/> OB			
DIAGNOSIS:			
ALLERGIES:			
<u>Choose One:</u>			
<input type="checkbox"/> Continuation of fentanyl patch regimen from prior to admission. <ul style="list-style-type: none"> <input type="checkbox"/> Verified the patient on patch within 24 hours: Source: <u>Nurse</u> <u>Patient</u> <u>Family</u> <u>Other</u> <input type="checkbox"/> If off the patch, was equivalent opiate analgesia reviewed to provide continuous coverage? 			
<input type="checkbox"/> Adjustment of fentanyl patch dose. If patch strength is increase, the patient <u>must</u> have tolerated the previous strength for a minimum of 3 days from initial dose. Changes in dose can be no more frequently than every 6 days thereafter			
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Fentanyl patch	12 or 25 mcg/hr	50 mcg/hr	75 mcg/hr
			100 mcg/hr
<input type="checkbox"/> Pharmacy to Dose			
1. Apply Transdermal Fentanyl patch _____ mcg/hr every 72 hours.			
2. Inspect skin and remove any existing fentanyl patches prior to applying new fentanyl patch(es). Avoid exposing patch or surrounding area to direct external heat sources such as heating pads or heated blankets.			
3. Assess pain, vital signs, and level of consciousness every 2 hours for 24 hours as per protocol when patient receiving the initial patch or if applying a patch of an increased dosage. If respiratory rate remains above 20 and the patient sedation level is less than 3 after 24 hours, vital signs every 4 hours.			
4. Administer oxygen at 2 liters per nasal cannula to keep oxygen saturation greater than 90%.			
5. For sedation greater than 3 on sedation scale, remove existing fentanyl patch(es), and notify physician. <ul style="list-style-type: none"> a. If IV accessible, give naloxone (Narcan) 0.1mg IV once. May repeat once in 5 minutes. b. If no IV access, give naloxone (Narcan) 0.4mg IM or subcutaneously once. May repeat once in 5 minutes. 			
6. ABG if respirations less than 10 or sedation 3 or greater after second dose of naloxone.			
Physician's Signature:		Date:	Time
FENTANYL (DURAGESIC) PATCH ORDER		*«PatientNumbe	
		<small>«PatientName» «BirthDate» ACCT# «PatientNumber» «AdmitDate» «AdmitTime» «AdmittingDoctorName» MTC-«MedicalRecordNumber» «Gender» «Age» DNM HSV «HospitalService» FC «InClass» PT «PatientPos»</small>	



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Doctors Hospital Of Manteca <small>San Joaquin County, California</small>		*139*	
		<small>139 DHM R07/2018</small>	
DATE:	TIME:	HT:	WT:
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PDCA – for process

DOCTORS HOSPITAL OF MANTEGA
 PERFORMANCE IMPROVEMENT
 PDCA report

Performance Improvement Activity:
 USE OF DURAGESIC PATCHES (FENTANYL)
 Reporting Period (month or quarter, year):
 01/01/12 TO 03/31/12 (1ST QUARTER, 2012)

PLAN - Goals (Measurable)
 DETERMINE IF APPROPRIATE BLACK BOX WARNING PRECAUTIONS ARE BEING
 UTILIZED WHEN DURAGESIC PATCHES ARE ORDERED

DO - Description of Current Activity:

- Duragesic (fentanyl) patches have a black box stating: “Should ONLY be used inpatients who are already receiving opioid therapy, who have demonstrated opioid tolerance, and who require a total daily dose at least equivalent to fentanyl (Duragesic) 25 mcg/hr.
- Patients who are considered opioid tolerant are those who have been taking, for a week or longer, at least 60 mg of morphine daily, or at least 30 mg of oral oxycodone daily, or at least 8 mg of oral hydromorphone daily or an equianalgesic dose of another opioid.
- Transdermal fentanyl is only for use in patients who are already tolerant to opioid therapy of comparable potency. Use in non-opioid tolerant patients may lead to fatal respiratory depression.

The black box warning requires that patients be monitored for hypoventilation for a minimum of 24 hours and previous/current opioid dosing to verify tolerance.

CHECK - Data Analysis/Interpretation of Results (attach all charts used for data analysis):
 A utilization review was done for the months of January through March, 2012. A total of 36 patients were ordered patches for this time period. All 36 patients were assessed to see if appropriate black box monitoring was being initiated and if dosing guidelines were appropriate for the patient population. Of these 36 patients assessed, 35/36 (97%) were dosed appropriately and 1/36 (3%) was not. 36/36 (100%) of the patients had a black box sticker placed in the patient chart. The results of the analysis done on the patient fallouts are as follows:

Acct/RPH	Dose Ordered/MD	Dose Appropriate	BBW stickers placed in chart by pharmacy
3551270/TL	25mcg/0216	No. no documentation of opioid tolerance; RPH contacted MD; MD insists on starting patch	Yes

Note:
 For 3551270, patient possibly has pancreatic cancer with severe pain. MD ordered dilaudid 1mg q2h prn pain and 25mcg fentanyl patch. RPH spoke to MD and per MD he cannot calculate how much narcotics the patient is getting each day. No pain meds on patient’s med reconciliation.

PLAN - Goals (Measurable)

- Determine if appropriate black box warning precautions are being utilized when Duragesic patches are ordered

DO - Description of Current Activity:

- Duragesic (fentanyl) patches have a black box stating: “Should ONLY be used in patients who are already receiving opioid therapy, who have demonstrated opioid tolerance, and who require a total daily dose at least equivalent to fentanyl (Duragesic) 25 mcg/hr.
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PDCA – for process

DOCTORS HOSPITAL OF MANTECA
PERFORMANCE IMPROVEMENT
PDCA report

Performance Improvement Activity:
USE OF DURAGESIC PATCHES (FENTANYL)
Reporting Period (month or quarter, year):
01/01/12 TO 03/31/12 (1ST QUARTER, 2012)

PLAN - Goals (Measurable)
DETERMINE IF APPROPRIATE BLACK BOX WARNING PRECAUTIONS ARE BEING UTILIZED WHEN DURAGESIC PATCHES ARE ORDERED

DO - Description of Current Activity:

- Duragesic (fentanyl) patches have a black box stating: "Should ONLY be used inpatients who are already receiving opioid therapy, who have demonstrated opioid tolerance, and who require a total daily dose at least equivalent to fentanyl (Duragesic) 25 mcg/hr.
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CHECK - Data Analysis/Interpretation of Results :

- A utilization review was done for the months of January through March, 2012.
- A total of 36 patients were ordered patches for this time period.
- All 36 patients were assessed to see if appropriate black box monitoring was being initiated and if dosing guidelines were appropriate for the patient population.
- Of these 36 patients assessed, 35/36 (97%) were dosed appropriately and 1/36 (3%) was not. 36/36 (100%) of the patients had a black box sticker placed in the patient chart.



PDCA – for appropriate use

**DOCTORS HOSPITAL OF MANTECA
PERFORMANCE IMPROVEMENT
PDCA REPORT**

Performance Improvement Activity:
USE OF NARCAN IN THE OR DEPARTMENT

Reporting Period (month or quarter, year):
JANUARY THROUGH MARCH 2012

PLAN - Goals (Measurable)
DETERMINE IF NARCAN IS BEING UTILIZED APPROPRIATELY IN THE OR AREA

DO - Description of Current Activity:
Assess if narcan usage in the OR is being used to assist in waking up patients post-op (low dose) or used as a reversal agent.

CHECK - Data Analysis/Interpretation of Results (attach all charts used for data analysis):
A utilization review occurred for the months of January through March 2012. Narcan was pulled for 3 patients and all 3 patients received narcan in the OR area. All of the patients received low dose narcan for assisting in waking up. There were no fallouts.

Acct/MD	Amount of Narcan	Appropriate?
3309720/1280	0.1mg	Yes—low dose for assisting in wakeup
3378330/1349	0.1mg	Yes—low dose for assisting in wakeup
3391493/1280	0.1mg	Yes—low dose for assisting in wakeup

ACT - Action Taken:
Share findings with OR Department and medical staff. Any narcan given for the purpose of waking patients up should be low dose (0.1mg or less). Doses higher than 0.1mg, if used inappropriately, will be submitted for peer review as higher doses inhibit future pain control endeavors. Higher doses are reserved for use as a reversal agent.

Follow-up Plan/Responsible Parties:
None at this time – pending input from Dept. of Surgery Committee

Report Submitted by:
Veneeta Maharaj, MS, Pharm.D.
Manager of Pharmacy Services

Date:
05/02/12

PLAN - Goals (Measurable)

- DETERMINE IF NARCAN IS BEING UTILIZED APPROPRIATELY IN THE OR AREA

DO - Description of Current Activity:

- Assess if narcan usage in the OR is being used to assist in waking up patients post-op (low dose) or used as a reversal agent.
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- **CHECK - Data Analysis/Interpretation of Results (attach all charts used for data analysis):**
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PDCA

- Act (MD)
 - With the data analysis and facts, present to medical staff
 - Informational letters when process is new
 - Peer review when process is established and education via letter does not seem effective





PDCA

- Act (RN/RPh)
 - With the data analysis and facts, present to patient care staff
 - Informational letters when process is new
 - The Just Culture



The Just Culture

The Three Behaviors



Human Error

Inadvertent action: slip, lapse, mistake (special cause)

Manage through changes in:

- Processes
- Procedures
- Training
- Learning to correct behavior

Console/Manage

At-Risk Behavior

*A choice: risk not recognized or believed justified (common cause)
Usually find that one than one person is doing-unreliable process*

Manage through:

- Removing incentives for At-Risk Behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness
- Design/Redesign using intermediate and high level interventions- improve reliability

Coach/Redesign

Reckless Behavior

Conscious disregard of unreasonable risk- (special cause) Do something which is a clear violation of their training/licensure

Manage through:

- Remedial action
- Punitive action
- LIP- immediate corrective action

Punish

Storage



- Utilize functions in ADC to assist
 - Scanning upon entry into ADC
 - Scanning upon removal
 - Use of clinical messaging
 - Use of labeling





Additional Things to Improve Outcomes

- FMEA
- Complete the ISMP survey (on line)
- Take a look at the California requirements of SB1875 – also known as the MERP (medication error reduction plan)
- The MERP and its 11 elements are built into the 2011 ISMP survey process
- <http://www.ismp.org/>
- <http://www.ismp.org/selfassessments/Hospital/2011/Default.asp>



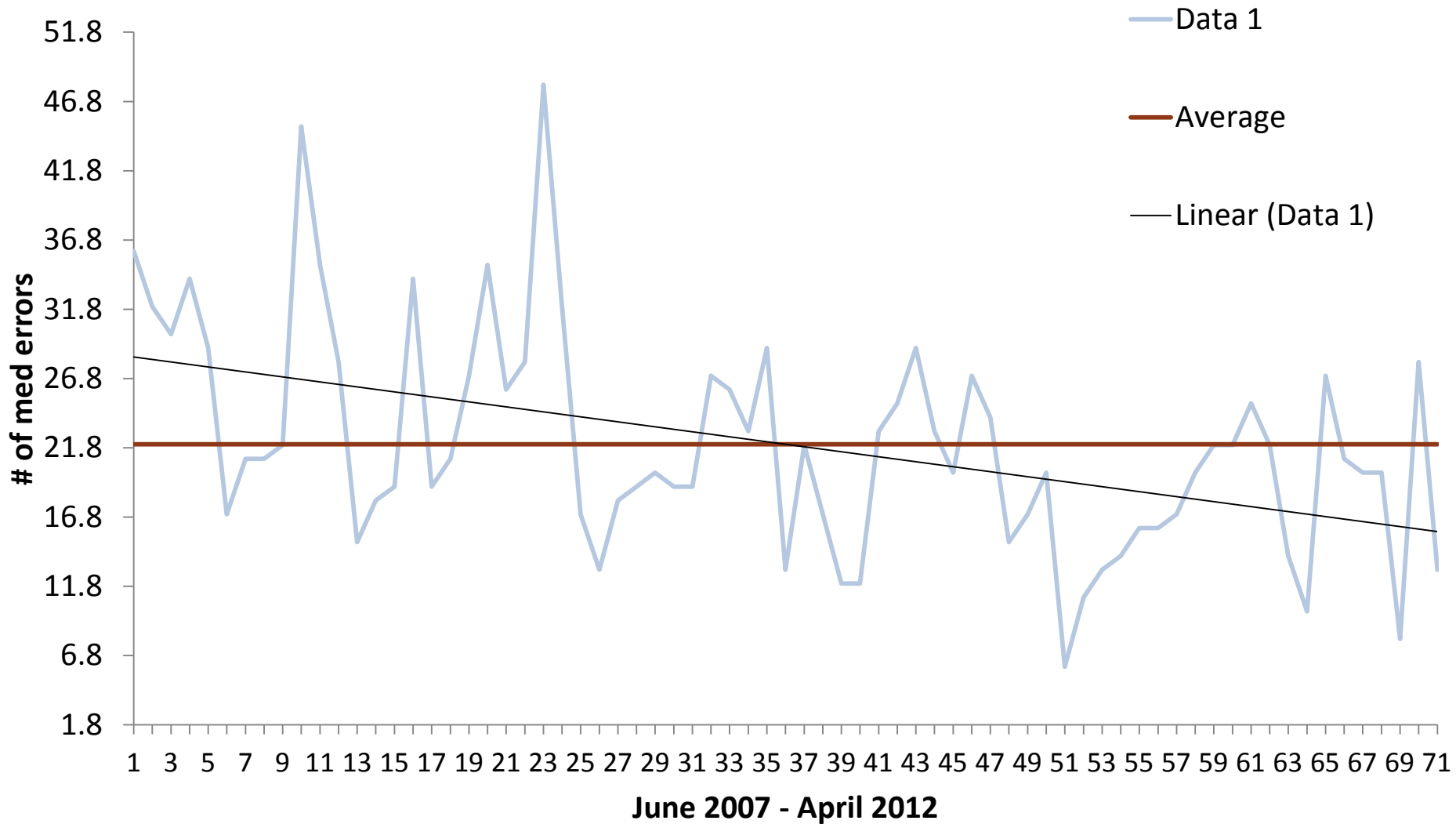


The Data

- Not only do you get data from your specific PDCA department projects, but you can get data from your risk management system as well
- Ensure reporting is adequate
- The goal
 - consistent reporting
 - Incidents reported are of less or decreasing harm



Med Errors - all categories - DHM





Medication Error data interpretation (for previous slide)

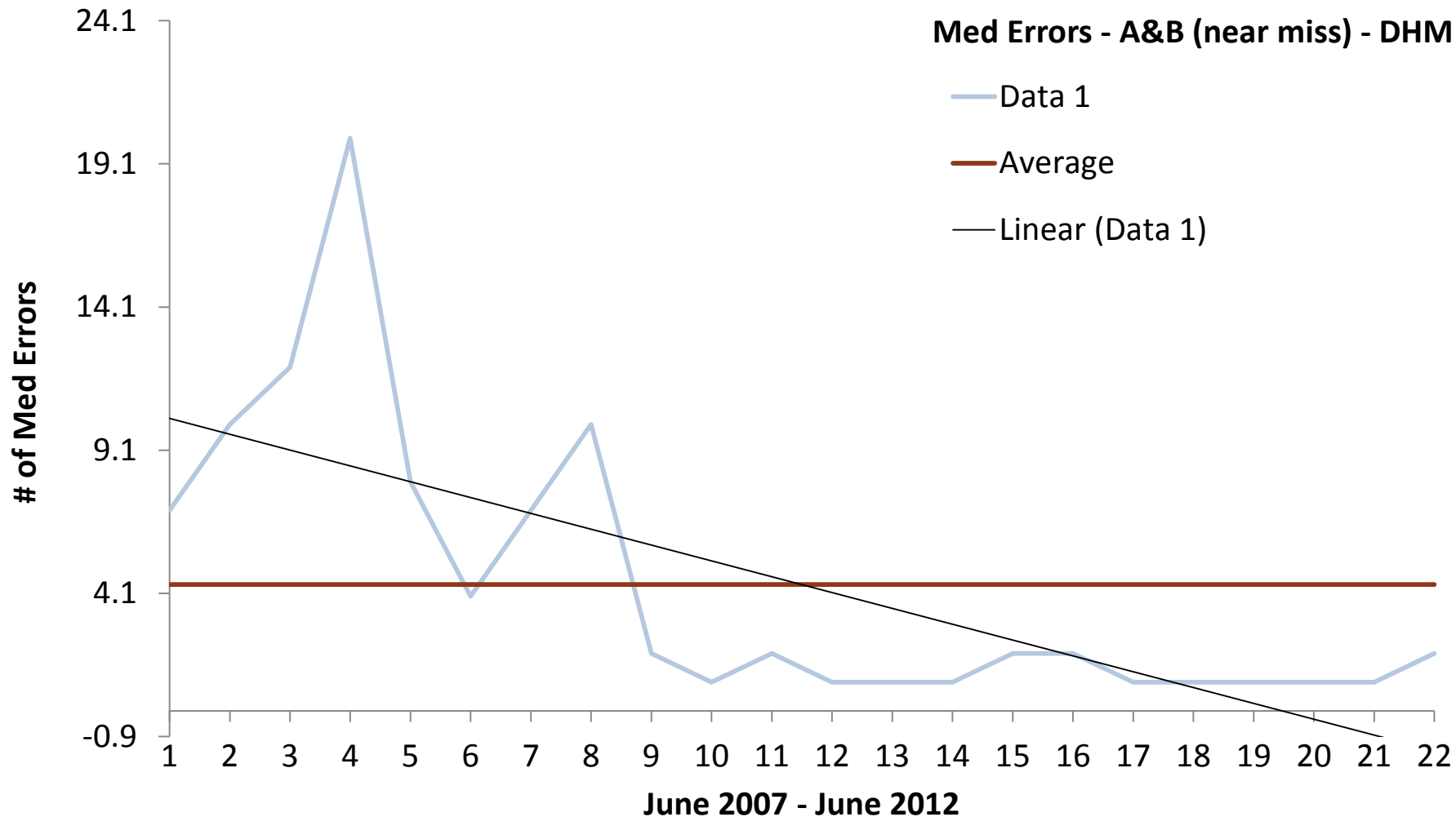
- Data represented is from June 2007 to 2012
- Slide 1 represents all errors, all categories
- Although trend line is decreasing (decrease in census from 2007 to 2012), please note that ADE reporting is within expected limits.
- Current average is 21/month
- Average monthly census is 350
- 6% reporting

Reference: JAMA 1997;277:312-7



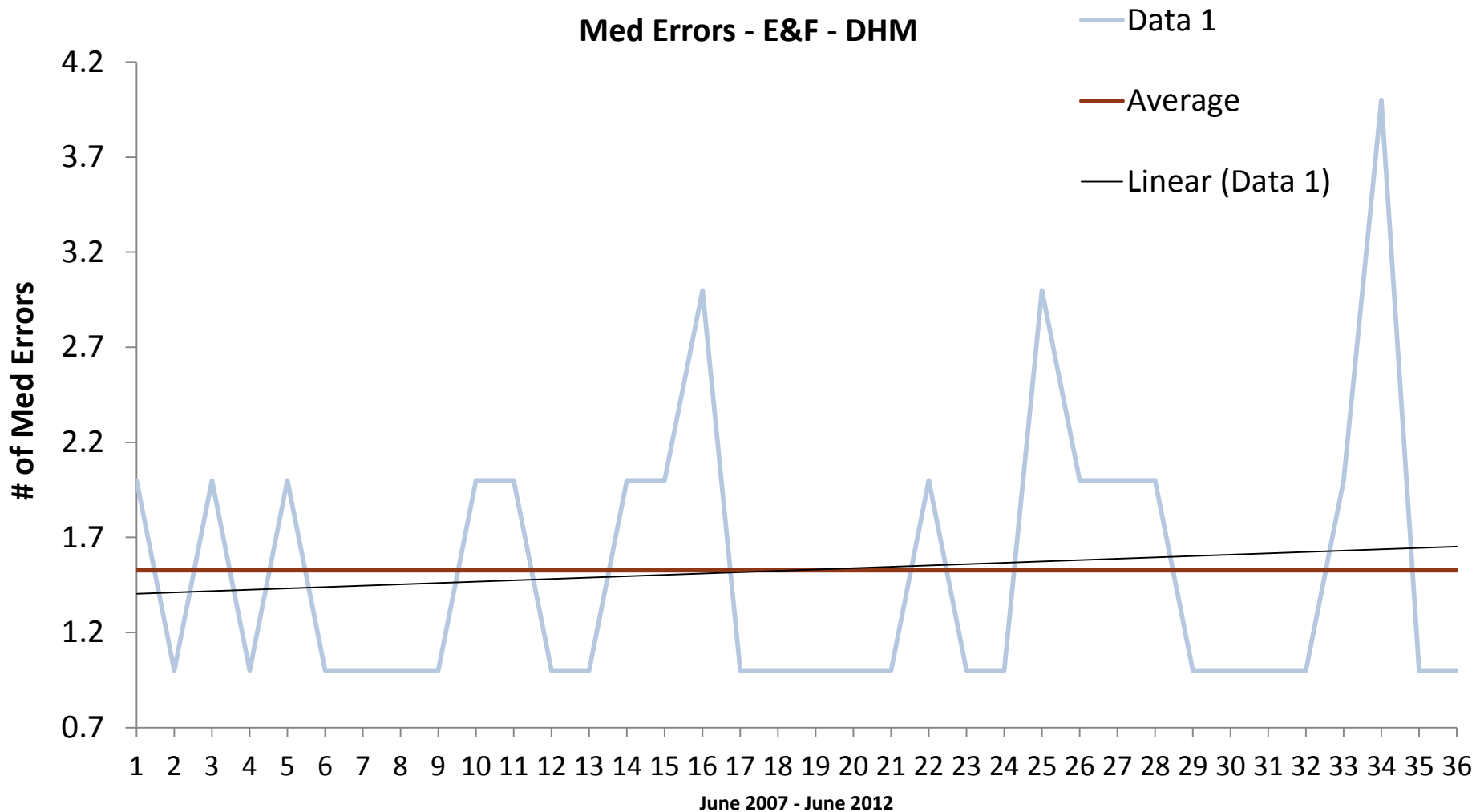


Near miss reporting is down

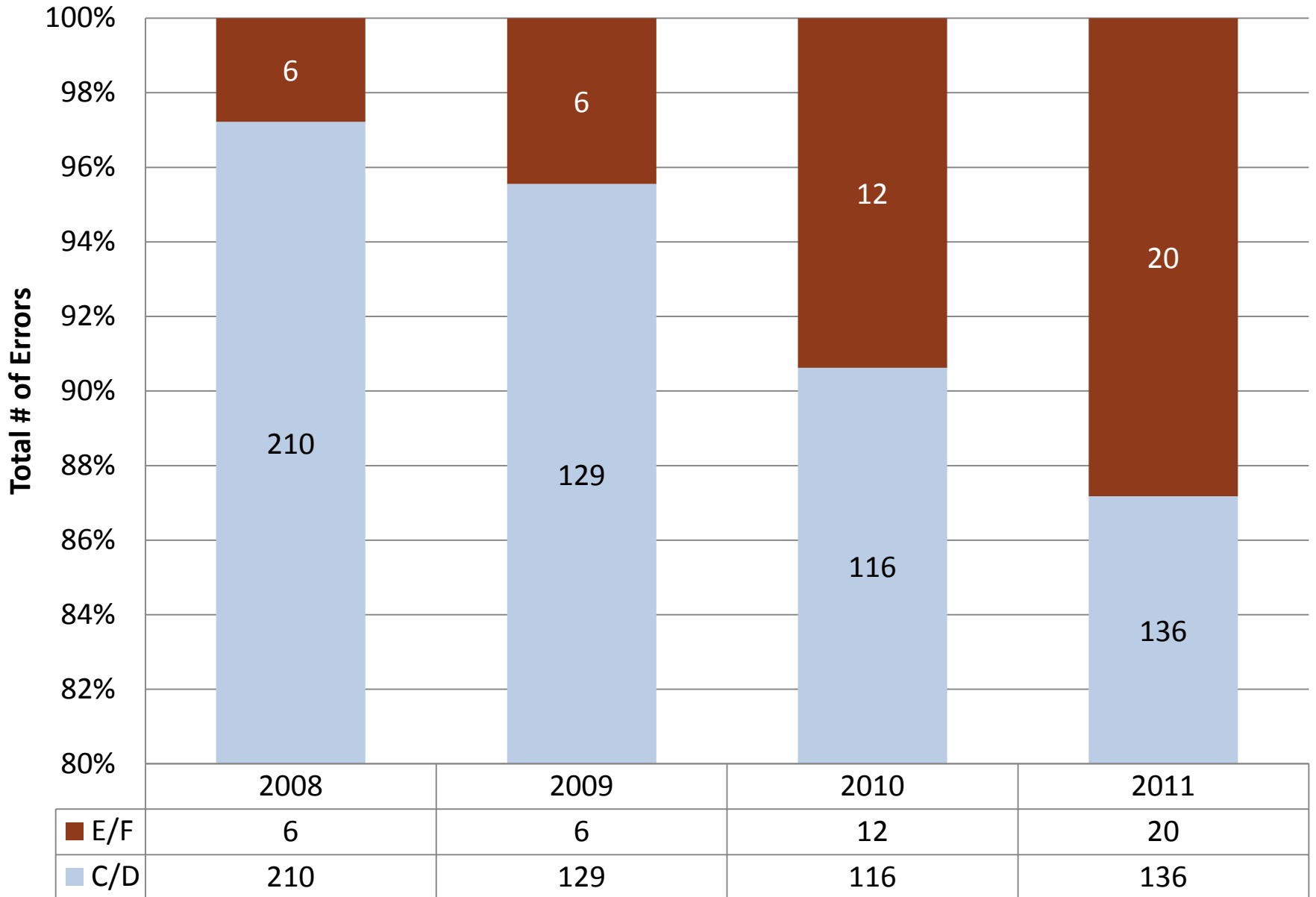




Trend line is on the slight increase, so over time, more harm is being seen
It is important to note however that only E and F harm has been reported.
There have been no G, H or I med errors

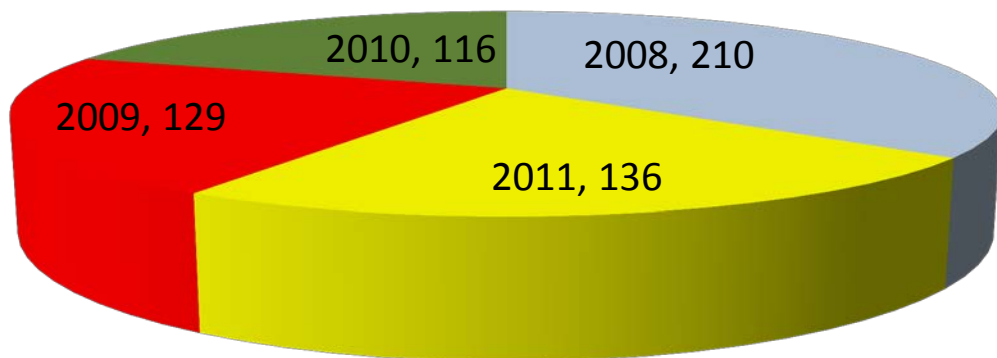


Medication Errors C-F DHM

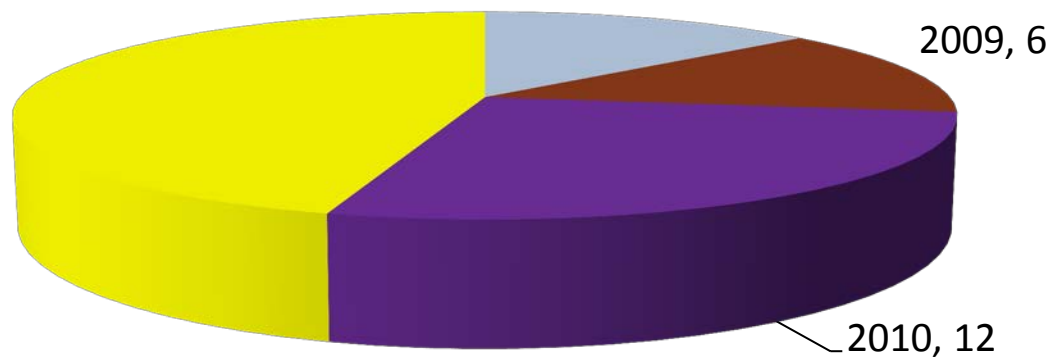




C/D Errors - DHM



E/F Errors - DHM



Blue = 2008
Red = 2009
Purple = 2010
Yellow = 2011



"If we want to succeed as a team, we need to put aside our own selfish, individual interests and start doing things my way."

It really is all about TEAM WORK

Any Questions??

Katy.marconi@tenethealth.com

(209) 824-4926