MSOS Member Briefing
May 2020

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Moderated by: E. Robert Feroli, PharmD, FASHP

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MEDICATION SAFETY OFFICERS SOCIETY

1

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Medication Safety in the Perioperative Area

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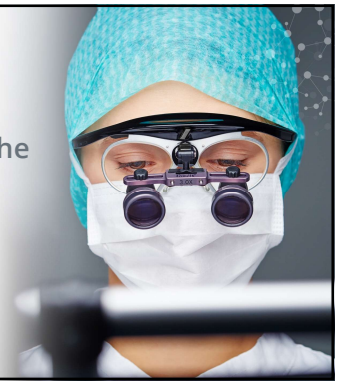

2

Hazards in the Perioperative Space

- Medication storage and organization
- Poor communication
- Tricky technology and transitions of care
- Unique situations

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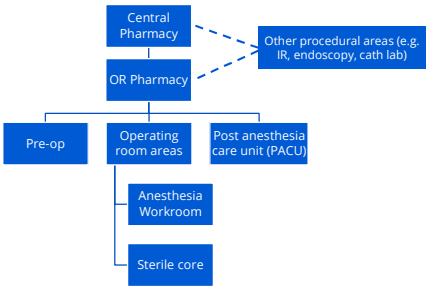
Where are the medications stored?



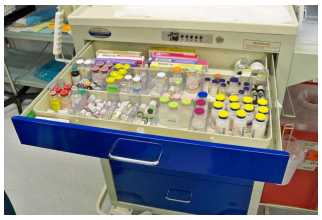
4

Safe Practice Recommendations

- Have a conversation with perioperative practitioners to discuss their medication needs
- Make sure it is clear which medications are available and where
- Confirm supply is limited to the amount of medication needed to meet essential patient needs between replenishment
- Confirm the variety of different medication concentrations and formulations is restricted

5

How are the medications organized?



6

Safe Practice Recommendations

- Storage is configured to allow practitioners to immediately view the label while selecting medications (i.e., label is facing up), instead of a "cap up" storage configuration which has only the top of the vial (e.g., cap) facing up
- Medications that have similar or confusing labels, packaging, and/or drug names, are stored separately in individual compartments in anesthesia trays/kits/carts and/or ADCs (e.g., locked-lidded compartments)
- Auxiliary warnings and/or other label enhancements (e.g., tall man lettering to accentuate differences in look-alike drug name pairs) are used on packages and/or storage compartments of perioperative medications with look-alike names, packages, and/or labels
- Refrigerated and nonrefrigerated neuromuscular blocking agents are segregated from other medications or sequestered in a rapid sequence intubation kit or lidded box/drawer wherever they are stored in the facility (including ADCs, pharmacy, anesthesia supplies)

7

How are anesthesia prepared medications labeled?

8

Safe Practice Recommendations

- The facility has established standard concentrations for perioperative IV infusions of high-alert medications such as morphine, heparin, insulin, vasopressors, and neuromuscular blocking agents
- Preprinted labels, or blank labels and smudge-proof markers, are used for labeling medications/solutions
- Syringes of medications prepared by anesthesia providers are labeled with the complete name and concentration/dose of the drug, and the expiration date and time, and are free of error-prone abbreviations.
  - Exception: Labeling is not required if the syringe is prepared immediately before drug administration, never leaves the hand of the preparer before administration, and the entire dose in the syringe is administered or the remaining volume is immediately wasted or discarded before the syringe leaves the preparer's hand

9

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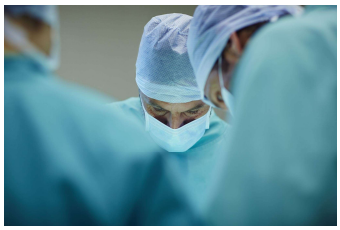
Poor Communication

- Pharmacist to Physician
  - Anesthesia
  - Surgery



10

Safe Practice Recommendations

- Face-to-face verbal orders from prescribers who are onsite in the facility are never accepted, except in emergencies or during sterile procedures where ungloving would be impractical
- During a medical and/or surgical procedure, a medication order communicated verbally by the prescriber is read back (or repeated back under sterile conditions) to the prescriber and the verbal order is documented in the EHR or medical record

11

Tricky Technology and Transitions of Care

- Are there multiple electronic medical record systems involved?
- Are they fully integrated?
- Are medications accessible outside of the pharmacy actually being ordered and charted?
- How does this affect transitions of care?

12

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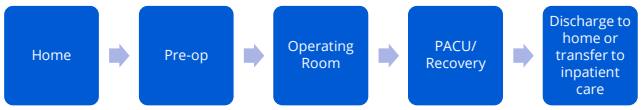
Safe Practice Recommendations

- Medications that the patient was taking at home before the medical and/or surgical procedure are reconciled with the list of medications prescribed at the time of admission/encounter, upon transfer within the facility, and upon discharge as appropriate; and any identified discrepancies (e.g., omissions, duplications, contraindications, unclear information) are resolved



13

Unique Situations

- Where are the antidotes?!
  - In perioperative settings, all appropriate antidotes, reversal agents, and rescue agents, with directions for preparation and use, are readily available and easily accessible; and protocols or coupled order sets permit their emergency administration to prevent patient harm
- And now….COVID-19

14

Coming soon in September!

ISMP Medication Safety Self Assessment® for Perioperative Settings

To volunteer as a potential pilot site please email: ismpinfo@ismp.org

15

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16

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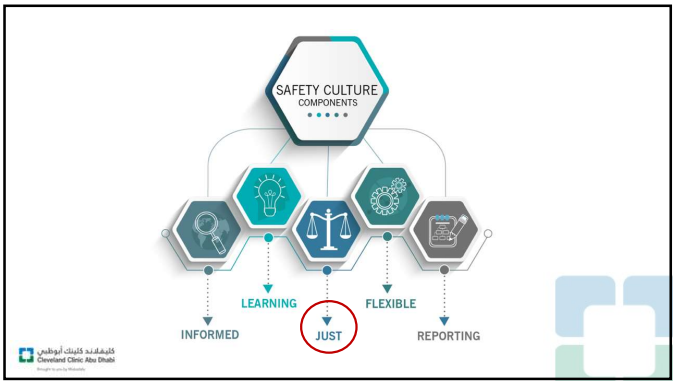
18

Learning Objectives

1. Recognize the importance of Just Culture as part of establishing a Safety Culture
2. Describe strategies implemented at Cleveland Clinic Abu Dhabi for developing a Just Culture within an organization

19



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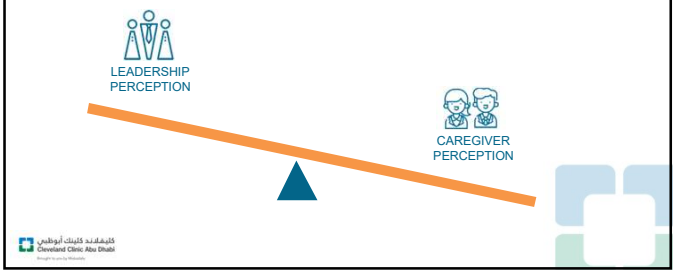
Why the focus on Just Culture?



21

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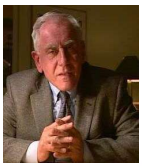
What is Just Culture?

*"An atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety-related information, but in which they are also clear about **where the line must be drawn between acceptable and unacceptable behavior".***

-James Reason



22

Leadership Expected Behaviors

- Shared Accountability
- Encourage Open Reporting
- Recognize Safety Champions
- No Tolerance for Disruptive Behavior
- Value Diversity & Fairness
- Learning from Events

23

24

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Developing the Guide

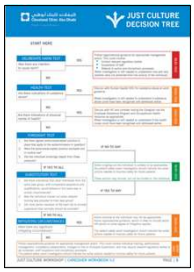
Participant Guide

Clinical & Non-Clinical Scenarios

25

Developing the Guide

Decision Tree Introduction

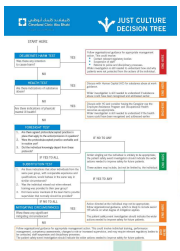


Decision Tree

26

Just Culture Decision Tree

- Helps leaders decide on the culpability of an unsafe act
- There are likely a number of unsafe acts that contributed to the incident
- The decision tree should be applied separately to each decision



27

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Q.1 Deliberate Harm Test

- Helps the manager identify at the earliest possible stage those rare cases where harm was intended.
- Asks the manager to consider whether the individual's actions were as intended and whether the outcome was as intended

28

The New York Times

DEATH ON THE NIGHT SHIFT: 16 Years, Dozens of Bodies; Through Gaps in System, Nurse Left Trail of Grief

This article is by Richard Pérez-Peña, David Kocieniewski and Jason George.

Feb. 29, 2004

He tried suicide at least three times, did four stints at mental hospitals, broke into a colleague's house and wanted a doctor prosecuted just for drawing his blood.

He was once found wearing surgical scrubs at the missile controls of a nuclear submarine, and he was known in his neighborhood for his nighttime chasing of cats.

And even before the deaths that led to his arrest in December, at least four times in his career as a nurse, people claimed Charles Cullen might have killed patients in New Jersey and Pennsylvania.

Mr. Cullen, who has told prosecutors he killed perhaps 40 people with intentional drug overdoses, defies the cliché about serial killers: that nobody suspected anything, nobody noticed anything strange. Wherever he went, people found his behavior erratic, suspicious, even criminal.

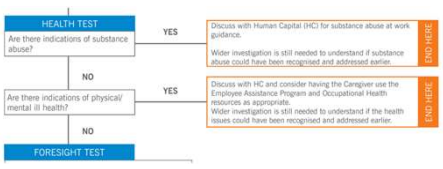
In hindsight, his life looks like a trail of signal flares, warning of instability and a capacity to harm himself or others. Yet Mr. Cullen was able to go from job to job for a decade after the first homicide accusation, confounding co-workers, government investigators and relatives of patients who died. If his story is true, he is among the most prolific serial killers in American history.

Image Source: https://www.mycentraljersey.com/picture-gallery/news/crime/jersey-mayhem/2020/02/25/charles-cullen-killer-nurse-over-years/4870123002/

29

Q.2 Health Test

- Helps to identify whether ill health or substance abuse caused or contributed to the patient safety incident.



30

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Q.3 Foresight Test

- Examines whether protocols and safe working practices were adhered to.

31

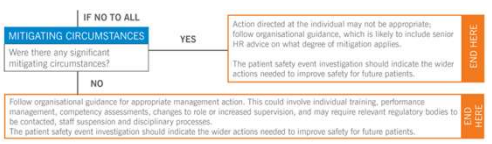
Q.4 Substitution Test

- Helps to assess how a peer would have been likely to deal with the situation

32

Q.5 Mitigating Circumstances

- Considers exceptional, unforeseen and unpreventable events.



33

Questions?

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34

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Cleveland Clinic Abu Dhabi
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35

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ISMP Update
MSOS Briefing May 21, 2020

Michael R. Cohen, RPh, MS, ScD (hon.), DPS (hon.), FASHP
President, Institute for Safe Medication Practices

36

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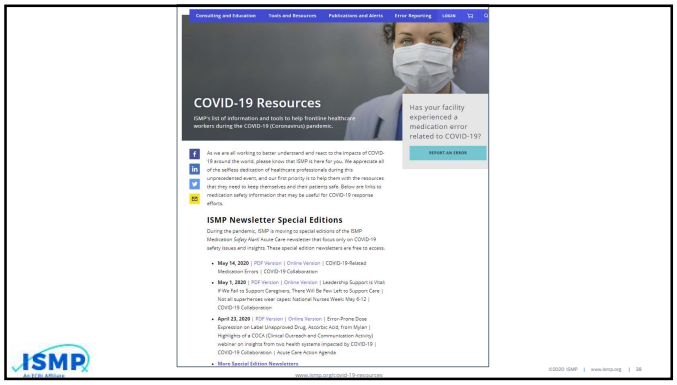
37



38

39

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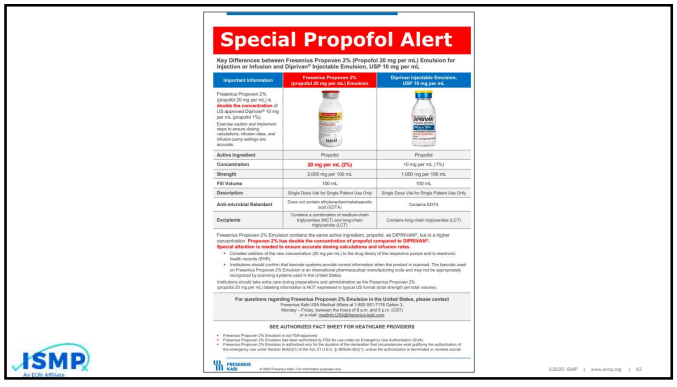
41



42

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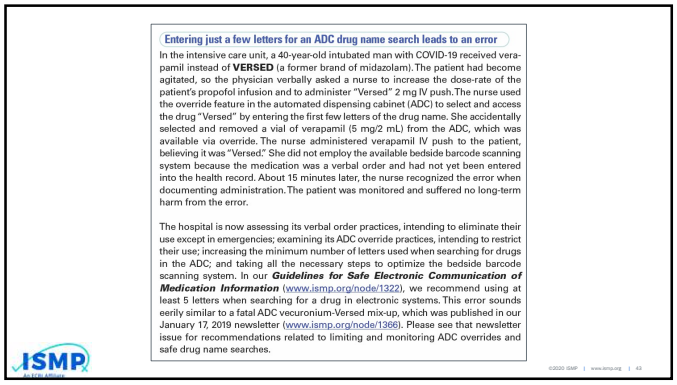

Entering just a few letters for an ADC drug name search leads to an error

In the intensive care unit, a 40-year-old intubated man with COVID-19 received verapamil instead of **VERSED** (a former brand of midazolam). The patient had become agitated, so the physician verbally asked a nurse to increase the dose-rate of the patient's propofol infusion and to administer "Versed" 2 mg IV push. The nurse used the override feature in the automated dispensing cabinet (ADC) to select and access the drug "Versed" by entering the first few letters of the drug name. She accidentally selected and removed a vial of verapamil (5 mg/2 mL) from the ADC, which was available via override. The nurse administered verapamil IV push to the patient, believing it was "Versed." She did not employ the available bedside barcode scanning system because the medication was a verbal order and had not yet been entered into the health record. About 15 minutes later, the nurse recognized the error when documenting administration. The patient was monitored and suffered no long-term harm from the error.

The hospital is now assessing its verbal order practices, intending to eliminate their use except in emergencies; examining its ADC override practices, intending to restrict their use; increasing the minimum number of letters used when searching for drugs in the ADC; and taking all the necessary steps to optimize the bedside barcode scanning system. In our ***Guidelines for Safe Electronic Communication of Medication Information*** (www.ismp.org/node/1322), we recommend using at least 5 letters when searching for a drug in electronic systems. This error sounds eerily similar to a fatal ADC vecuronium-Versed mix-up, which was published in our January 17, 2019 newsletter (www.ismp.org/node/1366). Please see that newsletter issue for recommendations related to limiting and monitoring ADC overrides and safe drug name searches.

43

Acute Care
ISMP Medication Safety Alert!

Incorrect use of smart infusion pump in the OR leads to milrinone overdose

Special Alert!
Short period of Surescripts medication history inaccuracies

Special Alert!
Short period of Surescripts medication history inaccuracies

44

Acute Care
ISMP Medication Safety Alert!

Subtherapeutic heparin infusions: Is your organization at risk of bypassing soft low-dose alerts?

SAFETY briefs

45

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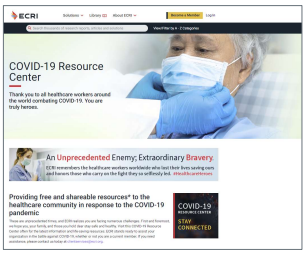

Webinar Recording (May 15, 2020) | Medication Safety During COVID-19: What Have We Learned?:

Webinar Recording (April 8, 2020) Infusion Therapy - Conserving Supplies in the Age of COVID-19

46

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Questions?

47

Questions?

- A copy of today's slides will be posted on our website
- Next MSOS Briefing date – July 23, 2020.

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48