Marion General Hospital
OhioHealth

Jan 2023

Abbey, Christian, Jessica, Jocelyn

Med Safety

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SAT/SUN
WEEK 2	2	3 7:15 am: Meet in east lobby 1:30 pm: DERT 2 pm: Pharmacy Informatics	4 9:30 Brian Peifer 11 am DERT noon-1:30 MSL Huddle Assignment 1	5 11 DERT 2:30 pm: leaky pump brainstorming session 6 to 8 pm: P&T Meeting (virtual) Assignment 2	6 1:30 DERT Assignment 3 ISMP Newsletter due by 5 pm Feedback Fridays	7/8 Abbey weekend
notes			remote	remote	Dan: 2 pm to 10:30 pm On site	
WEEK 3	9 1:30 DERT Assignment 4	10 Assignment 5 Noon: P&T Committee 1:30 pm DERT	11 Assignment 6 11 am DERT Noon-1:30 MSL Huddle Update all staff email	12 Assignment 7 1:30 pm DERT	13 Project day 1:30 pm Hardin Northern School visit	14/15 Christian weekend
notes	On site Dan: 6 a to 2:30 p	remote	remote	remote	On site Dan: 6 a to 2:30 p	
WEEK 4	16 Assignment 8 1:30 pm DERT	17 Assignment 9 1:30 pm DERT 2 pm: Pharmacy Informatics	18 Assignment 10 9 am: MGH Med Safety 11 am DERT Noon-1:30 MSL 2-3:30 pm: OhioHealth Med Safety Update all staff email 7:30 pm: Christian: Editorial Bd meeting	19 Assignment 11 1:00 to 3:00 pm: Overdose and fatality review at Marion Public Health	20 Project Day (Christian vacation) 1:30p DERT ISMP Newsletter due by 5 pm	21/22 Abbey weekend
notes	remote	On site Dan: 12:30- 9 pm	remote	On site Dan: 12:30- 9 pm	Dan 2p-10:30 pm On site	
	23 Assignment 12 1:30 pm DERT	24 Assignment 13 1:30 pm DERT	25 Assignment 14 11 am: DERT Noon-1:30: MSL Huddle	26 Assignment 15 1 pm: MSOS Member briefing	27 Assignment 16 1:30 pm DERT	28/29 Christian weekend

On site Dan: 7a-3:30p	On site Dan: 7a-3:30p	remote	remote	On site Dan: 7a-3:30p	
30	31				
If needed	If needed				
Dan: 7a-3:30p					

Special Projects Together:

A) Calculate secondary percentages for all sites, using emails that I will forward to you.

I'll ask you to share this on OhioHealth Med Safety meeting on January 18.

B) **Christian and APPE students**: select one or two topics from the list for an article for the national nursing journal Nursing 2023. One of you will be the primary author, one the secondary author, one the third author, and I will be the fourth author. You'll also need to pick a corresponding author, which is usually the primary author.

C) Abbey and APPE students: Work with pharmacy informaticist Brian Peifer to identify patients who have a sulfur allergy listed, and correct these allergies to "sulfonamide antibiotics"

D) Compile Guardrails compliance data for each site, using Carefusion Integrated analytics.

E) Review ISMP Newsletter drafts (they come out every other week), by the end of Friday of week 1 and 3 and return to me with your suggestions.

F) We're finding that lispro insulin is a drug that is often not scanned. Use SlicerDicer in CareConnect to drill down on this and see if you can figure out why. Is it nursing unit specific? Is it nurse-specific? Does it depend on the type of order? What can we do to help?

G) Work with MGH pharmacist Rachel Otley to devise a simple paper or sticker that can be dispensed with insulin bags when we send them for patients with diabetic ketoacidosis. Our goal is to help nurses know what to do when.

Abbey and Christian

First day: Help APPE students establish email accounts, get badges (appointment at 9:30), G drive access, where to park, hospital tour, bathroom location, cafeteria, get books, etc. Ensure that we will get each student the required number of hours.

1) Precept Jessica and Jocelyn. Make a calendar to keep all projects on task and ensure that all assignments get done. Set times for and lead daily topic discussions. Give tactful feedback.

2) Make a Teams page for this rotation as a central hub for our projects.

3) Analyze and process all medication-related iCare reports this month, for Marion and Hardin.

4) Prepare for and lead the MGH Medication Safety meeting on Jan 18

5) Write a blurb for the MGH pharmacy newsletter (starting with week 2) each Wednesday about medication safety topics.

6) Give people Inspire points when warranted for good catches or for reporting.

Jocelyn and Jessica

1) Take minutes for:
a) MGH Medication Safety meeting on Jan 18 (email to us)
b) OhioHealth Med Safety Committee meeting on Jan 18 (email to Allison Whalen and to me)

Assignments:

1) Question of the day 1, 2 Watch TED Talk "https://www.youtube.com/watch?v=qmaY9DEzBzI
2) QOD 32, 33, 34, Read ISMP newsletter May 17, 2012 **Just Culture and its critical link to patient safety (part 1) and** Read ISMP newsletter July 12, 2012 **Just Culture and its critical link to patient safety (Part 2),**
3) QOD 35, 36, 37, tell me about the William Husel fentanyl case. How do you think it happened? Why wasn't he stopped earlier? What would you do if you were a pharmacist who received these orders?
4) QOD 3, 4, 5, 51 ISMP Newsletter Selected Medication Safety Risks to Manage in 2016 That Might Otherwise Fall Off the Radar Screen—Part I & II (Jan 28 and Feb 11, 2016)
5) QOD 17, 18, 19 Review 2022-23 Targeted Medication Safety Best Practices for Hospitals
6) QOD 20, 21, 22, 52, Cohen Chapter 3 and 87-105.
7) QOD 6, 7, 8, 9 Cohen, Ch 4
8) QOD 10, 11, 12, 13 Cohen, pages 81-86 ("Lessons from Denver), Internal Bleeding Chapter 1 & 2, appendix I
9) QOD 14, 15, 16, Cohen pages 111-141, and find 3 poorly labeled drugs in our pharmacy
10) QOD 23, 24, 25, Review Katlin Taylor's "Medication Safety in Vision Impairment" article Internal Bleeding p 67-72, appendix II and III
11) QOD 26, 27, 28, Discuss 5 high-alert meds & Safety Strategies with Dan; Internal Bleeding pages 83-93
12) QOD 29, 30, 31, Review ISMP newsletter article by Amy Fox about Parkinson's Disease;
13) QOD 38, 39, 40 Read "**Telling True Stories is an ISMP Hallmark. Here's Why You Should Tell Stories, Too…"** ISMP Newsletter August 24, 2017
14) QOD 41, 42, 43, 44 Review and discuss OhioHealth policies for Look alike/sound alike medications (NUMBER: RX910.005) and for High Risk/High Alert medications (RX-910.022)
15) QOD 45, 46, 47; Tell me two things that we should add to the questions of the day. Tell me which two questions were the least valuable to you. Discuss one Joint Commission Sentinel Event Alert. Tell
16) QOD 48, 49, 50, & tell me the top 5 things that you've learned on this rotation.

Question of the Day:

1) What is the most serious medication error that you've seen? How could it have been prevented?

2) You receive a prescription for a Fentanyl 25 mcg patch. What would you check before filling? What are important counselling points for the patient regarding Fentanyl patches?" (Hint: Google "Fentanyl Patch Fatalities "Bystander Apathy"). Tell me stories about fentanyl patch deaths in children

3) Explain how primary and secondary IV tubing are connected. Also discuss how tubing is connected for hazardous medications.

4) When administering a 50 mL bag of an antibiotic, what type of tubing should be used? How much fluid does a primary tubing hold? How about a secondary tubing? How much of a 50 mL antibiotic is lost when using a primary tubing

5) What is the difference between a "soft limit" and a "hard limit" on an IV pump?

6) Research the Emily Jerry case and give a brief synopsis of the events. What happened to pharmacist Eric Cropp as a result of the case? What do you think should have happened to him? What strategies would you use to prevent this error?

7) A hospitalized patient brings their medications in from home. Should the pharmacy allow the patient to use their own medications? What errors could result from this?

8) Your 58 year old patient has a phenytoin level of 9, a serum creatinine level of 0.9, and a serum albumin level of 1.2. The physician orders 1 gram of phenytoin to be given IVPB to correct this low level in this 70kg patient. Would you fill this order? Why or why not?

9) Why do we calculate osmolar gaps in patients who are on Ativan drips?

10) What dose and route of epinephrine is recommended for patients in cardiac arrest? What about anaphylaxis? What can happen to a patient if they receive the incorrect dose or the dose via an incorrect route?

11) What do you think are the three most dangerous medical abbreviations, and why?

12) What does the term "200% accountability" mean?

13) What do we mean by "the sharp end" of the medication distribution system?

14) What is the swiss cheese model? Give an example of how this works.

15) What do you think of the "We'll fill your prescription in 15 minutes" promise that some retail pharmacies make?

16) Explain what kind of errors happen with U500 insulin. How would you prevent these?

17) What are some reasons to use insulin pens in hospitals? What are some safety issues with them? How does MGH handle long-acting insulin doses?

18) You have an L&D patient who needs some help with cervical ripening. The pharmacy is out of Cervidil 10mg vaginal suppositories. The prescriber asks you for a Prostin E2 20mg vaginal suppository, which she will cut in half and insert. Is this a safe practice? Why or why not?

19) What is a transition of care? Why do transitions of care carry high risk of medication errors and what are some of those errors that can occur? What are ways to prevent errors during transitions of care?

20) Discussing hyperkalemia treatment and appropriate order of administration. For example, A patient presents to the emergency department with a potassium of 7.2. The provider calls you and asks for insulin, albuterol, furosemide, and calcium gluconate. What order would you recommend these medications be administered? What role does calcium gluconate play in the treatment of hyperkalemia?

21) Tell me about the medication error that killed Ruth Ann Collins. What strategies would you use to prevent this error?

22) Which of the following medications can be crushed and given to a patient who cannot swallow their pills? Use the ISMP "Do Not Crush" list to answer this, if possible.
    a) Aricept 23mg tablets b) Aricept 10mg tablets c) Cardizem Tablets
    d) Xarelto e) Oxycontin

23) What do you think about nurses being responsible for splitting tablets, such a 1mg tablets of warfarin, on the nursing unit? What problems might this cause? How do you think these problems could be prevented?

24) A pharmacist is verifying orders for a patient and runs across an order for a patient's levothyroxine to be given IV. The patient normally takes levothyroxine 25 mcg daily by mouth. What would be the proper IV dose? Once the patient is ready to go home, you receive a prescription for Levothyroxine 0.25 mg PO daily. What error should you be suspicious of?

25) What was the medication error that occurred with Dennis Quaid's twins? How could this have been prevented?

26) What is an independent double check and why is it an important component in medication safety?

27) How do you feel about the idea of pharmacist having limited ability to write prescriptions? What potential medication errors could arise from pharmacist having prescribing rights?

28) What is confirmation bias?

29) Tell me about the error involving Jasmine Gant and nurse Julie Thao. What strategies would you use to prevent this error?

30) What role does a patient play in preventing medication errors?

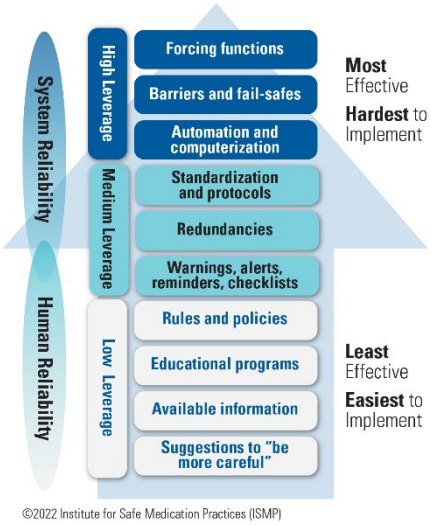
31) If a patient with Parkinson's disease were to experience acute cognitive dysfunction or an acute psychotic episode, would Haldol be an appropriate therapy option? Why or Why not? A Parkinson's disease patient is admitted to the hospital. The nurse records all the patient's medications in his profile. He tells the nurse his Sinemet is given four times a day at 10:00 AM, 2:00 PM, 4:00 PM and 8:00 PM. The nurse records this as Sinemet QID. The patient receives his doses at 8 am, 12:30, 6 pm, and 10 pm. Is this OK?

32) Do you believe a medication error that reaches a patient should be disclosed to the patient and their family, even if no harm was done to the patient?

33) Tell me about the medication error that killed Boston Globe columnist Betsy Lehman. What strategies would you use to prevent this error?

34) A patient with Alzheimer's comes into your pharmacy with her daughter. The daughter states that she can't be there with her mom all the time and the nursing aid is only there three times per week. The daughter is worried that her mother will either take too much or too little of her medications. What do you think would be the best way to help the patient with her medications?

35) The "Safety Strategies" chart (at right) shows which interventions are most effective. Make up a hypothetical error, give one example of each level of strategy, and explain why it is or is not effective.



36) You are an intern or resident, and you notice one of the pharmacists making a lot of errors lately but not reporting them. Would you do or say anything? If so how would you handle the situation? Even with measures like anonymity and nonretaliation, what do you think keeps people from reporting errors?

37) When is a saline flush utilized in the hospital? If a saline flush is not administered into a patient's port before drawing a sample to send to the lab to measure a vancomycin trough, how could this potentially alter the results?

38) Try using the Alaris smart pump. Program the pump for IV heparin administration. What potential errors do you think could occur during programing?

39) What medications become toxic after their expiration date? Would you feel comfortable telling a patient it is okay to take a medication such as ibuprofen tablets after their expiration date? What about ibuprofen liquid?

40) Discuss 3 OTC products with Dan which you find most dangerous and why.

41) Research magnesium toxicity in the Labor and Delivery setting. What are three strategies that you would put in place to reduce the chance of errors?

42) Which is safer, gravimetric or volumetric technology for IV preparation? Why?

43) What sort of fatal errors can happen with oral methotrexate therapy? What safety strategies would you use to prevent these errors?

44) Describe the medication error involving RaDonda Vaught at Vanderbilt University hospital. What medication safety practices could have prevented the error?

45) An elderly man is set up with a patient controlled analgesia pump after his surgery. When he's in pain or is arguing with the nurses, his wife pushes the button to give him a dose of

hydromorphone. Is this a problem? Why or why not?

46) What are “CDCs” in regard to Pyxis alerts? Why are they important? How is the term “alert fatigue” relevant and what strategies can be implemented to prevent alert fatigue while continuing the best safe practices?

47) A patient calls the pharmacy stating that she has a whole bunch of medications from several years ago that they are wanting to dispose of. She isn’t able to take it to the police department or the medication disposal day. What would you tell the patient on how to dispose of their medications?

48) Tell me about the medication error that killed Loretta Macpherson in Bend, Oregon. How could it have been prevented?

49) What tactics should pharmacists use to approach patients who are getting multiple new medications but do not want to be counseled/talk about their medications?

50) Think about pharmacists that you have worked with. What techniques have you seen them incorporate to help prevent errors? What unsafe practices have you seen? What will you incorporate into your practice to increase patient safety?

51) Explain the steps to reporting an error or "good catch" in iCare? What is a "good catch?" How would you recommend or motivate employees to report "good catches?"

52) A provider orders 20 mg ziprasidone IM for agitation for a patient with a history of schizophrenia. Their current medication regimen includes haloperidol 5 mg PO BID, escitalopram 20 mg PO daily, alprazolam 0.25 mg PO TID PRN, omeprazole 20 mg PO daily, losartan 25 mg PO daily, atorvastatin 40 mg PO daily, and ondansetron 4 mg PO TID PRN. Their last QTc was 505 msec. Would you feel comfortable verifying this prescription? What medications might increase this patient's risk for QT-prolongation? What is the risk associated with QT-prolongation?