

## Rx FOR DRUG SAFETY: An Ounce of Prevention

Each year, more than 7,000 people die due to medication errors, according to the Institute of Medicine. "No one intends to make a mistake, but they do occur. That's why we need systems in place to prevent errors," says Hedy Cohen, RN, BSN, MS, and a Vice President of the Institute for Safe Medication Practices (ISMP).

Below are some preventative measures that Cohen recommends to ensure patient safety in the operating room.

### Involve Your Pharmacists

Before you bring a new medication into the OR, have your pharmacists do a Failure/Risks Analysis to identify what can go wrong with a drug. "Then make sure everyone in the OR is familiar with the new drug and its side effects," Cohen advises.

### Sound-Alike/Look-Alike Names

When storing drugs, use **tall-man lettering** on shelf labels for drugs that have sound-alike/look-alike names. "It is easy to confuse drugs such as 'ephedrine' and 'epinephrine,'" notes Cohen. But less easy to mix up ePHEDrine with EPInephrine. "It's also easy to reach into a bin and pull out the wrong one since they both begin with the letter 'E.'" Be sure you separate drugs such as these.

### Label Everything

Everything that is brought into the sterile field - from drugs to sterile saline - should be labeled. "Sometimes people pour sterile saline into the basins. But maybe in the next OR it is chlorhexidine, not saline," Cohen points out. "Since they are both clear, only labeling will ensure that you can differentiate between the two."

### Worth Repeating

To avoid mistakes, nurses should repeat back what they have heard when a physician gives a verbal order. Scrub



nurses who are leaving the OR should state what medication they are handing over and what medications are hanging, on the operating table, on the Mayo stand, and in the sterile field.

### Don't Rely on Color-Coding

Reliance on the color-coding of drugs can be dangerous for many reasons. A nurse may be color blind or a physician may be unfamiliar with a medication. These are just two reasons why you should always read the label. "At the end of the day, the question is: 'What can we do better?' The best response is effective communication and that translates into improved patient care," Cohen says.

## Data Bytes

*Serving you the latest quality and safety data*

### 2004 SCIP Performance Measures

Findings from QSS physician data and suggested actions to reduce the risk of cardiopulmonary complications from surgery and prevent post-operative infections.

#### Cardiopulmonary:

- Elevate head of bed to lessen aspiration
- Continue beta blockers – 30% non-compliance promotes post-op AMI
- Initiate new beta blockers – 50% non-compliance in cardiovascular cases increases risk of post-operative complications
- Venous thromboembolism—focus upon major lower extremity orthopedic procedures, which pose the greatest risk for pulmonary embolism and deep vein thrombosis

#### Infection:

- Monitor surgical cases lasting greater than 2 hours for:
- Blood sugar greater than 150, including non-diabetic patients
  - Core body temperature less than 96°F

## THE GUIDE WIRE

Check out the latest resources listed below for you and your patients.

### Eliminating Error-Prone Medical Abbreviations

The Institute for Safe Medication Practices (ISMP) and the FDA announced that they will launch an educational campaign this spring to eliminate the use of medical abbreviations that can lead to harmful medication errors.

Key to the campaign is a list of error-prone abbreviations, symbols and dose designations compiled by ISMP. All healthcare professionals will be advised not to use these abbreviations when communicating medical information. The list includes abbreviations in JCAHO's National Patient Safety Goal 2B do-not-use list, as well as those reported to the USP-ISMP Medication Errors Reporting Program.

Download the list at [www.ismp.org/PDF/ErrorProne.pdf](http://www.ismp.org/PDF/ErrorProne.pdf).

### New Surgery Brochure for Patients

HHS's Agency for Healthcare Research and Quality (AHRQ) released a new publication, *Having Surgery? What You Need to Know*, to help patients make informed decisions when planning for surgery. The brochure and a Spanish-language version are available online, respectively at <http://www.ahrq.gov/consumer/surgery/surgery.htm>, and <http://www.ahrq.gov/consumer/spsurgery/spsurgery.htm>.

To order a free copy, call (800) 358-9295 or email [ahrqpubs@ahrq.gov](mailto:ahrqpubs@ahrq.gov).

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