the Remedi Pulse

SAFE MEDICATION & ORDER WRITING PRACTICES

A CLINICAL AND REGULATORY UPDATE FROM REMEDI SENIORCARE

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Survey Solutions

with William Vaughan, BSN, RN
VP of Education & Clinical Affairs

In Pursuit of the Perfect Medication Order

Poor communication among healthcare providers is by far one of the greatest threats to resident safety in long-term care. Communication takes many forms, but none so iconic as the physician's order (given the influx of nurse practitioners and physician assistants into the long-term care setting, perhaps prescriber's order is now a more appropriate term). From a surveyor's perspective, the prescriber's order is the yardstick by which much of the facility's performance is measured.

Medication orders form the foundation of medication management in long-term care and are, therefore, appropriately scrutinized by surveyors. In this, and the June edition of *The Remedi Pulse,* we'll offer advice on how to consistently write the perfect medication order. In doing so, facilities can improve survey results, but more importantly, promote positive outcomes for their residents.

- **Accountability:** Facilities and their pharmacy providers should set clear expectations for acceptable orders, and then insist that those expectations are followed. In the near term, there may be complaints from prescribers about the rigidity of such a system. Medical directors, administrators, directors of nursing, and other leaders in the facility should support staff, including those at the pharmacy, who refuse to accept or act upon orders that do not comport with established protocols.

- **Standardization:** There should be no variation in the manner in which medication orders are written. Everything from the use of generic versus brand names, acceptable abbreviations, unit dosing, etc., should be consistent throughout all units in a long-term care facility. The Institute for Safe Medication Practices (ISMP) has

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Drams, Minims, and Naked Zeroes

Abbreviations, Symbols, and Dose Designations that can Lead to Serious Mistakes

Diane Weakley, R.Ph., Clinical Consultant Pharmacist

The use of abbreviations, symbols, and dose designations can have serious and even potentially fatal consequences for our residents. Let's explore some of these problematic issues.

What is a "naked zero"? It's that dose that one may not be quite confident of, because the decimal point is not clearly seen.

- An order for Haldol .5 mg may be interpreted as 5 mg, a ten-fold increase from the intended dose of 0.5 mg.
  - In one actual scenario, the decimal point was too faint to be seen on a hand-written order, the resident received the higher dose, consequently fell, and broke her hip.
- A zero should **always** be used BEFORE a decimal point.
- A "trailing zero," which is a zero used AFTER a decimal point, should **never** be used. A dose of 1 mg might be seen as 10 mg if written as 1.0 mg and the decimal is not observed.

Problematic Abbreviations:

- "SC", "SQ", and "sub q", can be potentially misinterpreted.
  - When poorly written, "SC" may look like "SL" (sublingual), while "SQ" has been misconstrued as "5 every."
- Use of the letter Q has led to many misunderstandings.
  - "QD" or "q.d." has been mistaken for "QID" (4 times per day) and "q1d" (daily).
  - Poor handwriting may lead "qhs" (nightly at bedtime) to be confused with "qhr" (every hour).
  - Write out the word "every."
- "HS" has been used for both bedtime and half-strength (e.g., Dakin's Solution Half-Strength).
- "Subcutaneously," "daily" and "at bedtime" should be written out instead of using the abbreviations.
- "U" for unit should **never** be used, as it may be misread as a zero. Similarly, don't note "IU" for international unit as it may be misunderstood as IV (intravenously).
- "Eye" abbreviations can be confusing to say the least.
  - "OD" = Oculus Dexter (right eye), a Latin term with a positive connotation.
  - "OS" = Oculus Sinister (left eye), a Latin term with a negative, or evil, connotation.
  - "OU" can mean either Oculus Uterque (each eye) or Oculi Unitas (both eyes).
  - Today, it is preferable to write out the words in English to avoid confusion.
- The words "sliding scale insulin" should be written instead of SSI (which may be mistaken for strong solution of iodine), "SSRI" (mistaken as selective-serotonin reuptake inhibitor rather than sliding scale regular insulin), or "ss" (which can look like 55 when poorly written).

Potential Confusion with Morphine Oral Solution:

- Morphine is commercially prepared in two strengths as 10 mg/5 mL and 100 mg/5 mL (equal to 20 mg/mL).
- Overdoses have occurred when mg and mL were interchanged.
- An order should include the concentration and the intended dose in milligrams with the corresponding volume in milliliters.
- Use of an oral syringe is mandatory to measure accurately.
- An appropriate order might be: Morphine Sulfate Oral Solution 20 mg/mL. Dispense 30 mL. Administer 5 mg (0.25 mL) by mouth every 4 hours for pain.

Apothecary System Designations:

- Measurements - such as "dram" and "minim" - may be meaningless if one is not familiar with the apothecary system, but they still occasionally appear.
  - A "dram" is roughly equal to 5 mL or 1 teaspoonful - another term that should be eliminated.
  - A "minim" is synonymous with "drop" or 0.06 mL.
  - These measurements are rarely written today and have been replaced by units in the metric system, such as milliliter.
- "Tablespoonful" (15 mL) should be avoided due to confusion with "teaspoonful" (5 mL).
- The abbreviation "cc" (cubic centimeter) had been used interchangeably with "mL" (milliliter), but The Joint Commission has directed that "cc" no longer be utilized.

It is vital for us to eliminate the use of these inappropriate terms. Facility policy and procedure manuals should contain a list of approved, appropriate abbreviations. Additional examples of error-prone abbreviations can be found at https://portal.remedirx.com/MyRemedi/Resource.mvc/Education. For more information, visit https://www.ismp.org for tools provided by the Institute for Safe Medication Practices.

Reference:

Institute for Safe Medication Practices List of Error-Prone Abbreviations, Symbols, and Dose Designations. Available at http://www.ismp.org/Tools/errorproneabbreviations.pdf. 2013. Accessed April 24, 2015.

The Basics of Medication Reconciliation

Jennifer Hardesty, Pharm.D., FASCP, Chief Clinical Officer

Medication reconciliation is a process that helps reduce medication errors and the risk of resident harm by identifying discrepancies in drug therapy. This is accomplished by comparing the current medication regimen against prior medications taken at home, or while in another health care setting. While this sounds like a simple concept in theory, timely, accurate, and complete medication reconciliation is often a challenge. There are several key pieces of information that are ideally needed to perform comprehensive medication reconciliation for a resident recently discharged from an acute care setting:

1. Resident's home medication list, prior to hospitalization prescription and over-the-counter medications
2. Medication list from acute care setting/discharge summary
3. Current proposed medication list in your LTC facility
4. Resident/ Caregiver interview or history

Tips for Conducting a Patient Medication Interview or Discharge Summary Review

Medication Information: To obtain or verify a list of the resident's current medications, you should inquire about:

- Prescription medications
- Over-the-counter (OTC) drugs
- Vitamins
- Herbals /Nutraceuticals/Health supplements
- Respiratory therapy-related medications (e.g., inhalers)

Full dosing information should be captured, if possible, for each medication. This includes:

- Name / Strength /Dose of the medication
- Formulations (e.g., extended release, controlled delivery, etc.)
- Route
- Frequency
- Last dose taken

Note: Discharge Summaries may have key medication information documented in a variety of places, or may have last-minute therapy changes noted in the text, but not in the discharge medication list.

Medication History Prompts

Incorporating various types of "probing questions" into the resident interview may help trigger their memory on what medications they are currently taking.

- Use both open-ended questions (e.g., "What do you take for your high cholesterol?") and closed-ended questions (e.g., "Do you take medication for your high cholesterol?") during the interview.
- Ask about routes of administration other than oral medicines (e.g., "Do you put any medications on your skin?"). Residents often forget to mention creams, ointments, lotions, patches, eye drops, ear drops, nebulizers, and inhalers.
- Ask about what medications they take for their medical conditions (e.g., "What do you take for your diabetes?").
- Ask about the types of physicians that prescribe medic tions for them (e.g., "Does your 'arthritis doctor' prescribe any medications for you?").
- Ask if their doctor recently started them on any new medicines, stopped medications they were taking, or made any changes to their medications.

Once a comprehensive medication list is obtained, it should be maintained in a single place - the concept of "One Source of Truth." This "One" list should be shared and utilized by all disciplines caring for the resident, regardless of the format (electronic or paper-based). The list should be centrally located and easily visible within the patient's medical record, and becomes the reference point for ordering decisions and determining the medication regimen upon discharge.

Reference:
Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation. Gleason KM, Brake H, Agramonte V, Perfetti C. Rockville, MD: Agency for Healthcare Research and Quality; Revised August 2012. AHRQ Publication No. 11(12)-0059.

National Nurses Week!

While the team at Remedi SeniorCare values the integral role of nurses day in and day out, we would like to take this opportunity of National Nurses Week to formally recognize their dedication and commitment to their residents and colleagues. This tribute week of May 6-12 is well deserved.

Thank you for all that you do!

Nurse of the Month

SUZANNE STOCKING, LPN
St. Mary's Nursing Center, Leonardtown, MD

CONGRATULATIONS to Suzanne Stocking, LPN, Unit Manager, Rehab Unit, at St. Mary's Nursing Center, Leonardtown, Maryland for being chosen as the Remedi "Nurse of the Month." Suzanne was nominated by her DON, Kimberly Wood, RN, BSN, CDONA/LTC, RAC-CT. Per Kimberly, "Suzanne has 19 years of experience as an LPN and has worked at St. Mary's for the past 15 years. In addition to her other many duties, Suzanne has taken on the role as 'expert user' for the Remedi electronic order entry (EOE) system at our facility. She has become vested in being well versed in the Remedi EOE process along with the Paxit system and processes. Suzanne troubleshoots problems on site and when she cannot correct them, she works closely with Amanda at Remedi to correct issues, improve processes, educate staff, and/or make suggestions. She has made 'cheat sheets' with important key information to assist all users of EOE at our facility. Suzanne is invaluable in maintaining Remedi EOE's smooth functioning at our facility. She always follows through completely on issues and openly communicates with all involved. Suzanne is consistently thorough and professional at all times, and she is an integral member of St. Mary's community.

Remedi acknowledges a "Nurse of the Month" in each of our newsletters. DONs/ADONs/LNHAs, now is the time for you to reward the nurse(s) at your facility, who exemplify excellence in nursing practice. The "Nurse of the Month" will receive an award and a certificate of commendation from Remedi. Please submit the following information: nominated nurse's name/title, facility name, state, years at facility, years of experience and why this nurse should be chosen, such as leadership abilities, clinical expertise, teamwork, professional and personal strengths.

Email your Nurse of the Month nomination(s) by the 30th of the month to Rebecca.Ogden@RemediRx.com. Nurses Rock!!

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has published "Guidelines for Standard Order Sets" which can be found at:
http://www.ismp.org/tools/guidelines/standardordersets.pdf
Keep in mind that in nursing homes, there is a federal regulation (F281), that requires facilities to provide services that "meet professional standards of quality." Surveyors rely on standards published by organizations such as ISMP when citing this regulation, so a careful review of the above guidelines is certainly warranted.

• **Write to Reduce Risk:** How an order is written can increase or decrease the likelihood that a medication error will be cited during a survey. The guidance to surveyors at F332 defines a medication error as the failure to prepare/administer a medication in accordance with: *1) the prescriber's order, 2) the manufacturer's specifications, or 3) acceptable professional standards.*

Imagine then the effect of putting a specific time of administration in an order. The failure to administer the medication at the designated time could be considered a medication error as the drug was not given "in accordance with the prescriber's order." It is clinically appropriate for some medications to be administered on a rigid schedule, but for most, this is not the case.

• **Allergies:** Every medication order should be considered in the context of a resident's allergy profile. Prescribing, dispensing, or administering a medication to which the resident has a documented allergy is deficient under almost all circumstances, even if there is no adverse clinical outcome. At best, it represents a process failure, and at worst, varying degrees of resident harm result. Facilities should periodically review allergy documentation for accuracy and attempt to differentiate true allergies from adverse drug reactions (e.g., stomach discomfort from ferrous sulfate). Ultimately, documented allergies should be zconsidered valid until proven otherwise.

Coming in June… Verbal orders and their regulatory implications.

Note: Bill was a surveyor with the Maryland State Survey Agency from 1988 until 2001. He became Chief Nurse of the agency in 2001 and remained in that position until joining Remedi SeniorCare in 2013.