

## *Florida Hospital Quality Dashboard*

Pneumonia Care	Heart Attack Care	Heart Failure Care	Infection Control	<b>Patient Safety</b>	Whole Person Care
<i>Florida Hospital monitors key patient safety indicators in six categories, each with a variety of indicators. These indicators are tied to JCAHO National Patient Safety Goals.<sup>1</sup></i>					

### **Patient Safety Indicator: Preventable Medication Errors**

Preventable medication errors occur at least 1.5 million times each year in the United States, according to a new Institute of Medicine (IOM) report.<sup>ii</sup> They occur not only in hospitals and nursing homes, but in outpatient settings and at home. These errors are sometimes fatal or near-fatal.

#### **Patient Responsibility**

In the past, hospital patients have relied on physicians and staff to prevent medication errors. But the IOM urges patients and their families to take a more active role in their care and actively monitor all medications given in the hospital.

At Florida Hospital, policy requires that clinical staff ask each patient for a medication list at admission. The staff should discuss the list with the patient and compare the patient's list to the hospital's list. When patients are transferred to other units within the hospital or to other facilities such as nursing homes, the staff must include written copies of medication documentation with the patient's chart.

#### **Preventing Medication Errors**

*A patient with a rare condition requiring daily doses of the blood thinner Coumadin undergoes major surgery.*

*Standard procedure after such surgery includes administration of a different blood thinner. When the nurse comes to give the medication, the patient refuses to take it. Her family physician has warned her that she could hemorrhage if she mixed or added blood thinners.*

*The nurse insists that the surgeon has ordered the medication. The patient insists that the nurse call the surgeon and her family physician. The nurse calls and the surgeon immediately cancels the medication order.*

Hospital patients should keep a copy of the medication list at their bedsides, and family members should know where it is. Patients should not take any medication without asking what it is for and if it will interact with the other medications on the list. Before surgery, patients should ask whether there are medications they should start or stop taking. Before discharge, patients should request a review of any medicines they will be taking home.

#### **Hospital Responsibility**

In addition to medication lists, Florida Hospital has implemented other internal processes for medication safety.

The use of mandated, standard abbreviations for patient charts and other documents helps ensure that the right medications are ordered and administered. Limiting concentrations of medications helps minimize the potential for under- or overdoses, and an

annual review of look-alike/sound-alike drugs helps prevent mix-ups. Mandatory labeling of medication and medication containers in *all* settings including operating rooms prevents staff from relying on memory.

### Florida Hospital's Quality Goals

1. Rank in the Top 10% of hospitals nationwide
2. Show ongoing cycles of improvement in all areas of patient care

#### ***Information technology reduces medication errors***

Electronic medical records (EMR) allow users to enter orders and view results, and document patient care. EMRs also "push" timely and clinically relevant information to the clinician.

In early 2007, Florida Hospital will implement the "I-Extend" electronic medical record. When used for pharmacy orders, I-Extend will allow prescribers to get detailed information on medications, electronically write prescriptions, and access a patient's medical history. The system will check for possible drug interactions and allergies, and ensure that all the necessary data is included -- and legible. "Dose-change checking" will provide alerts for any medication order that is outside the accepted dose range.

#### ***Cycles of Improvement***

"Safe, high quality patient care has far more to do with systems and processes than with individuals," said Lars Houmann, president of Florida Hospital. "We want to know what processes make patient outcomes better over time.

"This is why we continue to focus on standard safety principles and systems that are well-accepted, well-understood, well-documented and well-carried out – and patient-centered," he continued. "I-Extend and our other clinical processes will ensure that patient safety and quality care are our highest priority."

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i JCAHO is an independent, not-for-profit organization founded in 1951. It accredits over 7,800 hospitals and 7,300 other health care entities in the US, including Florida Hospital.

ii *Preventing Medication Errors*, Institute of Medicine, July 2006.

#### ***In the Next Quality Brief: Language Barriers***