



Patient Safety  
Reporting System

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# FEEDBACK

Issue 19



## PSRS REPORTER “CAUTIONS!”:

Medication Precautions and Hazards Ahead

The following PSRS reports present specific warnings from reporters regarding point-of-care equipment, staff training, procedures, and software issues, which have had an impact on medication safety.

### CAUTION: “New Glucometer and Blood Sugar Concerns”

False high finger-stick glucose values were noted with inpatients after introducing a new glucometer to a VA facility.

A nurse reported to PSRS:

■ *Since first receiving the [digital blood glucose monitoring device,] staff on my unit noticed the blood sugars were higher than with the machines we previously used. We have also had numerous critical high values, which we check with venous lab draws. In many cases, the venous blood sugars were significantly lower than the finger-sticks recorded with the [new monitors]...Patients receive insulin and have their insulin dosages altered based on these finger sticks. My fear is that a patient will suffer significant injury because they are receiving insulin based on the blood sugar reading from faulty equipment.*

The reporter added that local nursing and laboratory finger-stick and blood-draw procedures were checked, and additional “in-services” were held to increase the accuracy of the new equipment. Despite careful monitoring of all blood sugar procedures, new glucometer equipment readings did not equate to other facility blood-draw readings. A further study of equipment and data could not explain these blood sugar reading inconsistencies. Company staff and other clinical personnel are reviewing this situation.

#### Additional Resources:

- 1) Institute for Safe Medication Practices. ISMP Medication Safety Alert: Nurse Advise-ERR (November 2008, Volume 6, Issue 11) “Falsely Elevated Glucose Readings from Maltose-Containing Drugs.” [www.ismp.org/Newsletters/nursing/backissues.asp](http://www.ismp.org/Newsletters/nursing/backissues.asp)

- 2) Eastham J, Mason D, Barnes D, et al. Prevalence of interfering substances with point-of-care glucose testing in a community hospital. *American Journal of Health - System Pharmacy*. 2009; 66:167-170.
- 3) Institute for Safe Medication Practices. ISMP Medication Safety Alert (September 8, 2005 Issue). “Be Aware of False Glucose Results with Point-of-Care Testing.” [www.ismp.org/newsletters/acutecare/articles/20050908.asp](http://www.ismp.org/newsletters/acutecare/articles/20050908.asp)

### CAUTION: “Dangerous Duties Ahead”

Two CBOC pharmacists report that inpatient safety is potentially being jeopardized by assigning specialized inpatient pharmacy duties to outpatient (CBOC) pharmacists.

According to these reporters, many of these CBOC staff have had no hospital experience in their careers, have received only one day of inpatient orientation in the past 4-7 years, and yet are asked to perform as expert hospital pharmacists. These reporters’ concern is that outpatient and inpatient pharmacy duties differ greatly in scope, responsibility, and knowledge requirements.

One reporter writes:

■ *This situation jeopardizes patient care. Outpatient CBOC pharmacists are not qualified to work as inpatient pharmacists. This situation is an accident waiting to happen. Even if these CBOC pharmacists were trained, working every few months for one weekend is not enough experience to assure proper patient care.*

During a PSRS Analyst’s callback conversation, the reporter stated:

■ *... Ongoing limited exposure to inpatient duties has curtailed my inpatient knowledge base and ability to safely perform all inpatient pharmacy duties.*

One reporter feels safety requires more training for CBOC pharmacists, increased staffing of trained inpatient pharmacists, and department budget increases.

### CAUTION: “Mind Your P’s and Q’s”

A physician order through a drop down menu resulted in the wrong order. A pharmacist questioned a medication labeled to be taken 4 times a day (QID), but after checking with the physician, it was learned that the

FEEDBACK shares excerpts of reports sent to PSRS. Actual quotes appear in italics. In May 2000, NASA and the VA initiated the PSRS, a voluntary, confidential, and non-punitive reporting system. PSRS encourages personnel to describe safety issues from their firsthand experience and to contribute their information to PSRS.

directions were supposed to read: “take every evening at bedtime (QHS)”.

■ *Twice in the past 3 months I am aware of prescription orders being for QID that were intended to be QHS. In this case, I caught and contacted the MD and changed it before it was filled. Since this is a 4-fold increase in dose, given this occurring with some meds, could be serious toxicity or even lethality. I believe it is related to a lack of attention and selecting the wrong instructions from the drop-down menu.*

### WARNING: “Medication Mix-Up”

A pharmacist reports a long-term care consulting pharmacist recommended that an antipsychotic medication, aripiprazole (“Abilify®”), be discontinued for a schizophrenia inpatient and changed to citalopram (“Celexa®”), an antidepressant. The intention was to prescribe medications according to the drug formulary. The recommendation went on to be processed by the nurse and approved by a physician, however, the selected medication was inappropriate.

The reporter writes:

■ *The patient was already taking sertraline (“Zoloft®”), an antidepressant similar to citalopram. The patient had severe schizophrenia and was off the antipsychotic drug [slightly more than a week]... by chance, the patient had an appointment with the psychiatrist who noticed that these medication changes had occurred... the consulting pharmacist had mixed up escitalopram (“Lexapro®”) with aripiprazole (“Abilify®”).*

It appeared to the reporter that this change was approved by the physician and administered to the patient even though it was a duplication of antidepressant medications.

Items to Consider:

- What part of this medication ordering process broke down? How did other reviewing staff miss this error also?

- The Joint Commission Medication Management Guidelines (Long Term Care Accreditation Program) Revised Standard MM.01.01.01 through MM.08.01.01 (including updates), which addresses the appropriate management of psychotropic medications.



### A Word About Our Staff

Paul E. Boehm, M.S., R.Ph., a pharmacist member of the PSRS Medical Safety Expert Analyst team has a pharmacy career which includes extensive experience in the Department of Veterans Affairs, the U.S. Air Force, academia and the

community. Patient safety has driven him in the development of various pharmacy programs, training, and public health initiatives. Paul is extremely proud of his VA family, which includes former staff, friends, and associates. His visits to VA facilities continually renews his pride in the outstanding work performed by VA employees. Paul encourages everyone: “Stand up! Get involved! Make a difference by reporting safety concerns and improving care for all patients.” Paul and his wife, Judy, are both from North Dakota, but now, along with three wonderful children, call San Jose, California home.

Let us know if this issue was helpful. Send us a letter with your thoughts and if you acted upon any of this information at your local facility!

PSRS report forms and past issues of FEEDBACK are available on the VA intranet and the PSRS website.

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