

## Continue the Journey to Improve Patient Care Join colleagues online and in person to share, discuss, and solve General Hospital's Challenges & Opportunities

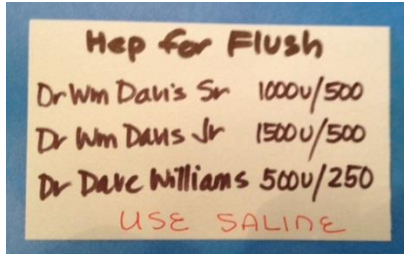
The new Director of Pharmacy at General Hospital asked one of the more senior technicians to accompany her on a visit to each of the areas where medications are administered. Several situations they encountered concerned the new Director, and she has asked her staff to a planning session to address 10 challenges. Your invitation to the case and the Medication Safety Collaborative is a click away: [Welcome to General Hospital](#).

1. Pediatrics is a growing service. Until the new pediatric nursing unit is built, the pediatric patients will be placed in a few rooms in one of the adult med-surg units.
2. While she was on the unit, a nurse asked if she could spend a few minutes talking to a newly-diagnosed diabetic. The patient's wife was on her way to pick him up, so the nurse asked her to provide the information then. In particular, she said that the patient was confused about timing of his daily and sliding scale insulins.
3. The oncology unit appears to be following their own policies, and not those she has seen written in the pharmacy and hospital policy manuals. She noticed a nurse entering a treatment room with several sterile preparations. One bag contained a yellow Medication Added label similar to:



4. Another drug was in a syringe. She checked the patient profile later, and realized that the patient was receiving both IV and intrathecal meds.
5. She observed nursing report concerning a patient to be discharged to a long-term care facility. The patient had multiple lines for several different routes, including a G-tube. The hospital unit nurse was explaining the use of an oral syringe to the LTC nurse. The LTC nurse wasn't familiar with an oral syringe, so they reviewed how to measure the patient's G-tube meds using a parenteral syringe.
6. The nurses in ICU said that medication errors weren't an issue; they haven't seen an error that harmed a patient in years.
7. The cath lab had never seen a pharmacist in the department before. When she looked at the stock, she saw heparin vials in several concentrations and vial sizes, and a card taped on the wall

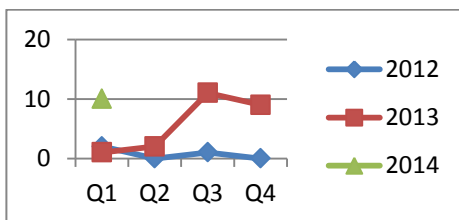
identifying the different concentrations that the three interventional cardiologists use for heparin flush during procedures:



8. In the anesthesia work room, she saw a punctured 250 mL saline bag with a purple Neo-Syneprine label on the counter:



9. She discovered that the Pharmacy-Nursing Committee used to meet regularly, but since Risk Management coordinates all error reporting, the only errors that pharmacy sees are dispensing errors reported by nursing units. Errors have increased since new automation was installed, from 1 or 2 per month to about 10 per month.

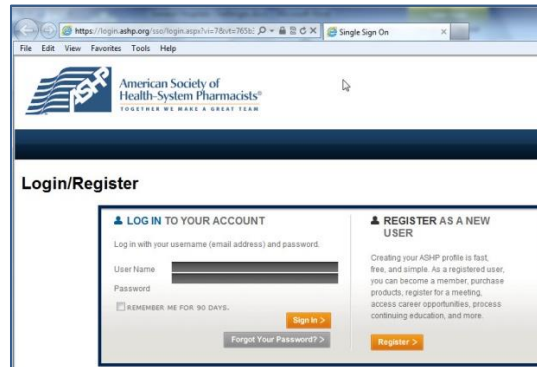


Med Errors per Quarter

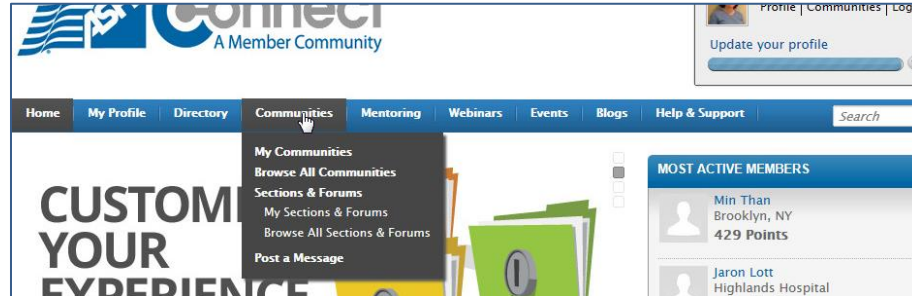
10. The only concentration of dopamine that has been used in the hospital is 400 mg/250 mL. That concentration is now backordered, but the purchasing tech obtained plenty of bags of 800 mg/250 mL.

## Follow these steps to join the discussion on the [Medication Safety Connect Community](#)

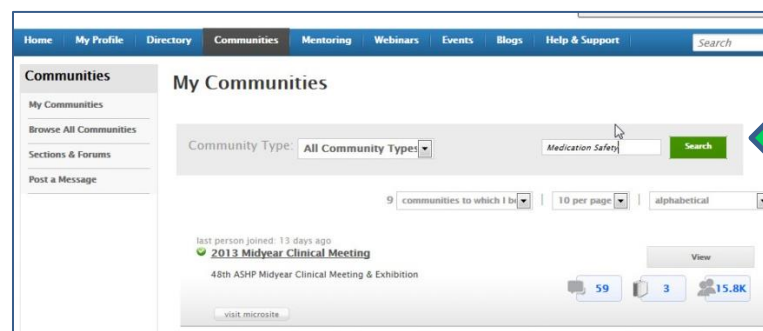
1. You will see this page. **Login** with your ASHP username/password or **Register** if you are new.



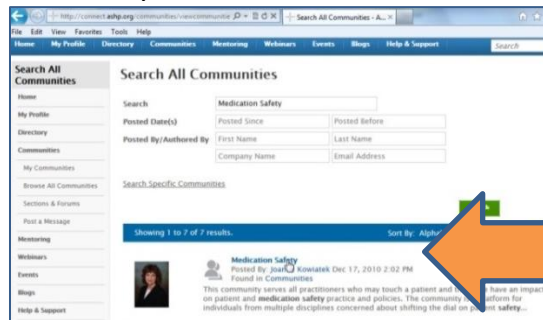
2. Now you are on the Connect homepage. Select the **Communities** tab



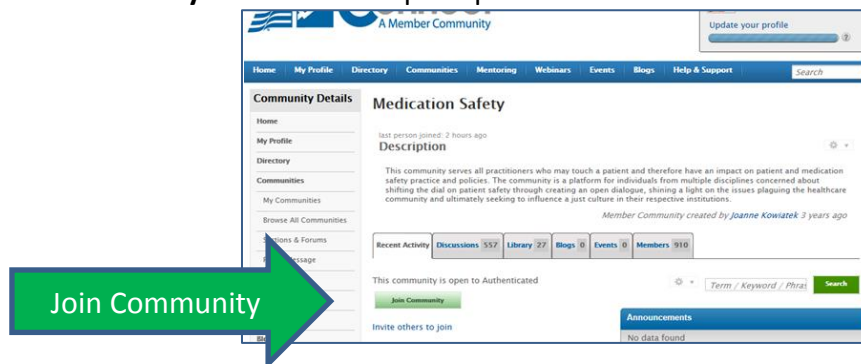
3. You are now on the **My Communities** page. **Type** Medication Safety in the **Search** box



4. Select the Medication Safety community.

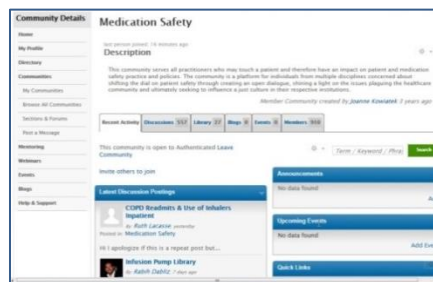


5. Select **Join Community** and follow the prompts



If you don't see Join, you are already a member and can omit this step.

6. You are now a member of the Medication Safety community! Check out the announcements and **Select the Discussion** tab to participate in the Collaborative Case with colleagues from around the world!



7. **Select** an existing message or start a discussion by selecting **Post a Message**. If you start a new thread put in the **Subject: Collaborative Case** – insert your topic.

