

Self-Assessment Test

Safety First: Practical Strategies for Minimizing Potential Errors with High-Alert and Dangerous Medications in the Hospital Setting

This program is located at <http://www.ashpmedia.org/symposia/safe>



This self-assessment test has been provided as a study aid only. At the conclusion of the internet-based program, click on “Take CE Test” to proceed to the ASHP Learning Center and take the on-line program post-test. You may print your CE statement immediately after successful completion of the post-test.

There are a total of 22 questions associated with this self-assessment test.

1. Which one of the following best describes a “high-alert” medication?
 - a. Is very expensive.
 - b. Is not on your institution’s drug formulary.
 - c. Is likely to cause a significant adverse effect if involved with an error.
 - d. Sounds or looks like another medication.

2. All of the following are medication attributes that increase the likelihood of error **EXCEPT**
 - a. Look-Alike /Sound-Alike.
 - b. Available in multiple concentrations.
 - c. Requires manual manipulating to prepare medication for administration.
 - d. Oral dosage form.

3. Which of the following medications can cause loss of limb if inadvertently administered intraarterially?
 - a. Insulin.
 - b. Ampicillin.
 - c. Dexamethasone.
 - d. Promethazine.

4. All of the following should be considered as part of your institution’s core list of “high-alert” medications unless you have a documented justification to exclude it from your list **EXCEPT**
 - a. Anticoagulants.
 - b. Narcotics.
 - c. Insulin.
 - d. Acetaminophen.

5. Which of the following is most useful to help define what medications are harming your patients?
 - a. List of most frequently dispensed medications.
 - b. Pareto chart listing the medications most frequently associated with clinically important reported medication errors.
 - c. List of most expensive medications.



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- d. List of look-alike or sound-alike medications.
6. Which of the following statements is **FALSE**?
- a. If all medications are “high-alert,” then no medication is “high-alert.”
 - b. Trying to do too much will often get in the way of progress.
 - c. Any medication if used exactly wrong can cause an adverse clinical outcome.
 - d. All medications on your “high-alert” list must be associated with a major program to reduce the likelihood of error.
7. Which of the following statements is **FALSE**?
- a. Your list of “high-alert” medications should be in writing.
 - b. Your “high-alert” list should be approved by an appropriate institutional committee such as the Pharmacy and Therapeutics Committee.
 - c. It is not necessary to determine if special “high-alert” processes are actually implemented.
 - d. The staff should receive education regarding your high alert medication list and associated special precautions.
8. Failure mode and effects analysis (FMEA)
- a. Is a retrospective technique for addressing process failures.
 - b. Is used to reduce risk points for failure in processes.
 - c. Identifies the effects and causes of process failures.
 - d. b and c.
9. All of the following are used to calculate the criticality index (CI) of a failure mode EXCEPT?
- a. Frequency of occurrence ranking score.
 - b. Severity of effects ranking score.
 - c. Probability of detection ranking score.
 - d. Number of doses dispensed.
10. Strategies identified by FMEA for improvement of processes should
- a. Decrease the likelihood of occurrence of failure modes.
 - b. Not negatively impact other processes.
 - c. Provide a short term solution to failure modes.
 - d. a and b.
11. Which of the following is a key to conducting a successful FMEA?
- a. Select a large, complex process to analyze.
 - b. Include all disciplines involved in the process.
 - c. Ensure that all root causes of failure are identified.
 - d. b and c.



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12. When evaluating the effectiveness of changes made in a process, improvement is shown if
 - a. Criticality Index values increase.
 - b. Outcome measures are favorable.
 - c. There is improvement over baseline measures.
 - d. b and c.

13. Which of the following is a pitfall that may negatively impact the success of FMEA?
 - a. Including front-line staff on the FMEA team.
 - b. Keeping detailed, organized documentation.
 - c. Confusing failure modes with causes.
 - d. Conducting a pilot test of strategies for improvement.

14. Which of the following is a TRUE statement?
 - a. Independent verification may only be used for medication administration.
 - b. Reducing reliance on memory is a strategy for improving medication safety.
 - c. Decreasing access to information helps to avoid medication errors.
 - d. Medication safety depends on the use of a wide variety of concentrations for an I.V. infusion medication.

15. Which of the following is TRUE in a “Just Culture?”
 - a. Benefits include increased error reporting and enhanced safety.
 - b. Managers add more incentives for at-risk behaviors.
 - c. Benefits include more effective operations and reduced error reporting.
 - d. Workers are discouraged from looking for safety risks.

16. Strategies to reduce errors associated with the use of high alert medications include all of the following EXCEPT:
 - a. Standardization.
 - b. Forcing functions.
 - c. Reducing reliance on memory.
 - d. Increasing use of floor-stock medications.

17. Which of the following applies to “tall-man” lettering?
 - a. It is a strategy used to differentiate and reduce confusion between similar medication names.
 - b. It should be used only in the pharmacy information system.
 - c. Only the FDA-approved list should be used; no other use is allowed.
 - d. Its use makes medication mix-ups more likely.



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18. To reduce reliance on memory during medication preparation, which of the following strategies may be used to avoid error?
 - a. Memo to staff outlining a new process.
 - b. Eliminate any prompts during order entry or on paper forms.
 - c. Use of a checklist.
 - d. Avoid a written procedure.

19. Which of the following statements is a TRUE statement?
 - a. How we implement technology in medication safety is not important, just that we implement it.
 - b. It is best to use only one error reduction strategy at a time when planning safety improvements.
 - c. The Formulary is not an appropriate tool to use for medication safety.
 - d. Combining error reduction strategies is beneficial to driving safe practices for high-alert medication use.

20. Which of the following statements is **TRUE** regarding use of technology to reduce errors with high-alert medications?
 - a. Interdisciplinary collaboration is essential when implementing technology for medication-use safety.
 - b. Testing is nice, but not necessary when implementing technology solutions.
 - c. Workarounds enhance safety when used with technology.
 - d. There is no need to involve front-line staff when planning and testing technology.

21. All of the following are strategies to reduce error during prescribing **EXCEPT**
 - a. Clinical decision support in a CPOE system.
 - b. Verbal orders.
 - c. Approved standardized order sets.
 - d. Forcing-functions, such as required order forms or required fields for CPOE.

22. When developing safety strategies for high-alert medications, which of the following is a **TRUE** statement?
 - a. All decisions and discussion should take place only within the pharmacy department.
 - b. The dispensing process is the only one which needs to be considered.
 - c. Assess all steps of the medication use process and consider combining different error-reduction strategies.
 - d. Technology planning and testing is best left to the information systems department.



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