



Nurse Advise-ERR™

Educating the healthcare community about safe medication practices

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Intimidation presents serious safety issues

This year, a popular television show, *ER*, demonstrated the importance of assertive communication when there are concerns about the safety of an order. In one episode, a physician ordered **PROCARDIA** (nifedipine) to be given sublingually (by piercing the capsule and placing the liquid under the tongue) to a patient with severe hypertension. The *ER* resident questioned the order after recognizing that this route of administration could lead to significant and irreversible hypotension.

In fact, many hospitals have stopped using immediate-release nifedipine. On occasion, the immediate-release form is used to treat hypertensive emergencies in children, who are asked to chew and swallow the capsule. The safety concerns in adults do not appear to be applicable to children who have more resilient cardiovascular systems. There's also data to support the use of immediate-release nifedipine to inhibit uterine contractions in pregnant women. Otherwise, sublingual (or chew and swallow) administration is unsafe.

On the show, the *ER* resident's concern about administering the medication sublingually was met with intimidating resistance. In reality,

we don't need a fictitious healthcare setting to remind us that this happens more frequently than we'd like to admit. And intimidation — both subtle and clearly abusive forms — plays a role in our decision-making. It creates stress, which naturally influences our willingness to speak up about a potential problem. More often, it causes us to rationalize that an order must be correct, even if we suspect something is amiss, to avoid a confrontation.

Your assertiveness may clearly save a patient's life.

In the end, the fictitious patient on *ER* did not receive the medication sublingually. Likewise, if you have concerns about the safety of a medication, follow your institution's policy for questioning orders, involve your pharmacist, and don't give any drug until you're sure it's safe.

Patients have paid a high price for intimidation. It's been proven over and over again that, in the course of a fatal error, at least one person suspected that something was wrong and either didn't mention it, or was too easily convinced that their concern wasn't valid. Your assertiveness may clearly save a patient's life.

Please take a few minutes to complete our survey on page 3 about your experiences with intimidation.

safetysidebar

Almost half of all prescribing errors are caught before they reach the patient, often by nurses who question orders. But the following phrases should be considered a "red flag" when given in response to a questionable order.

- ▶ "The attending told me to order it that way."
- ▶ "The patient says that's how he takes it at home."
- ▶ "It was published in ... (e.g., JAMA)."
- ▶ "This is a special case."
- ▶ "The patient's been titrated up to that dose."
- ▶ "The patient is on a protocol."
- ▶ "The dose is from the patient's old chart."
- ▶ "That's the way the dose is written in the progress notes."
- ▶ "It's on the list of medications the patient gave me."
- ▶ "We always give it that way."

If you suspect a problem, don't let these types of answers dissuade you from protecting your patients' safety. Follow up until all doubt has been removed from your mind. Those who have been involved in serious errors often wish that they had taken the opportunity to do just that.

to the point

▶ **"Out of this nettle, danger, we pluck this flower, safety."**

William Shakespeare

safetywire

⚡ What does IU mean to you? If you said "international units," you'd be correct. But this abbreviation could spell danger for patients. This order for **BICILLIN L-A** (penicillin G benzathine) 600,000 IU was misread as 600,000 units IV.

Bicillin 600.000 .IU ; im x 1 Luckily, one of the nurses on the

unit was aware that this drug should never be administered IV. However, we've published other cases where this drug has been given IV, resulting in death from a pulmonary emboli. Never abbreviate "international units" as IU. Instead, simply use the word "units" (not U), which is acceptable. Cont'd on bottom of page 2 ▶

Double Trouble

Know your patient's diagnoses to prevent errors

With so many different medications on the market, not a week goes by that we don't hear about confusion between two products with similar names. Below are just a few examples that help illustrate the problem:

- ✓ A nurse misheard a verbal order for **NEURONTIN** (gabapentin, an antiepileptic) 400 mg BID as **NOROXIN** (norfloxacin, an antibiotic) 400 mg BID and administered several doses in error.
- ✓ A patient told a nurse he was allergic to **LODINE** (etodolac, an anti-inflammatory medication), but she misheard the patient and documented an allergy to iodine on the patient's chart.
- ✓ A pharmacist misread a handwritten prescription for tizanidine (**ZANAFLEX**, for muscle spasticity) as tiagabine (**GABITRIL**, an antiepileptic) and dispensed this drug in error to the patient.
- ✓ A pharmacist misread a handwritten order for **ZYVOX** (linezolid, an antibiotic) 600 mg BID as **ZOVIRAX** (acyclovir, an antiviral for herpes simplex/zoster infections) 600 mg BID, but a nurse noticed the error before the patient received the wrong medication.
- ✓ A pharmacy technician accidentally stocked an automated dispensing cabinet with 100 mg tablets of chlorpromazine (an antipsychotic) instead of chlorpropamide (an antidiabetic). Four patients received the wrong drug.

The usual dose, frequency and route of administration are similar for some drugs with look- and sound-alike names, which increases the risk of a mix-up. And if the prescribed medication is new, you may mistakenly see a more familiar drug name on the order form, or mishear the drug name when receiving a verbal order. Tragically, some of these errors, like mix-ups between chlorpromazine and chlorpropamide, have resulted in fatalities.

Knowing your patient's diagnoses is one key to preventing these types of errors. Drugs with look- and sound-alike names are rarely used for the same indication. So you are less likely to make an error if you consistently match your patient's medications to their diagnoses, and make sure that each drug's intended purpose makes sense for your patients. Also, after admitting new patients, be sure to let pharmacy know each patient's diagnoses, including chronic conditions (e.g., hypertension, asthma, diabetes), so they are less apt to misread an order. Some nurses fax the admission assessment form or a unique essential patient information form to the pharmacy for this purpose. Others enter both acute and chronic conditions in the hospital computer system so the information is available to pharmacists. Finally, each time you administer a medication, mention the drug's intended purpose so that patients can alert you to any potential problems.

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Editors: Judy Smetzer, RN, BSN; Susan Paparella, RN, MSN; Hedy Cohen, RN, BSN, MS; Michelle Mandrack, RN, BSN; Michael R. Cohen, RPh, MS, ScD; Russell Jenkins, MD.
Institute for Safe Medication Practices, 1800 Byberry Road, Suite 810, Huntingdon Valley, PA 19006. Tel. 215-947-7797; Fax 215-914-1492; E-MAIL: nursing@ismp.org.

To report medication errors to ISMP, please call 1-800-FAIL-SAF(E).

naturally speaking



Bleeding with ginkgo. The "memory enhancer" herb ginkgo biloba has been associated with bleeding problems. One of its components inhibits platelet aggregation, so patients who take this product along with antiplatelet or anticoagulant drugs increase their risk of bleeding. In one reported adverse event, a young man suffered spontaneous bleeding from his right eye after taking ginkgo for just 1 week. He also took 325 mg of aspirin daily. The bleeding did not recur after he stopped taking the ginkgo, although he continued to take aspirin. There have also been reports of bleeding in patients who were not taking other antiplatelet or anticoagulant drugs. One incident involved a young woman who experienced a bilateral subdural hematoma after long-term ginkgo use. Ginkgo can also inhibit monoamine oxidase (MAO). Patients who take prescription or over-the-counter sympathomimetics (e.g., pseudoephedrine, phenylephrine) could experience severe hypertensive episodes if MAO is inhibited. So patients taking ginkgo should observe cautions about foods high in tyramine (e.g., cheese, red wine), as if they were taking a prescription MAO inhibitor.

safetywire continued



Pink faxes. To help alert pharmacists that they are dealing with pediatric medication orders, some hospitals use a dedicated fax machine that prints the orders on lightly colored paper (e.g., pink). Nurses send all pediatric orders to this fax machine. The color differentiation immediately alerts the pharmacy staff that they are dealing with orders for a pediatric patient. So the doses are verified and the drugs are often on a fast track for delivery to the unit. Lightly colored fax paper can also be used for stat orders.



Readership survey results. Thanks to over 400 nurses who completed our recent readership survey. Look for highlights in December!

ISMP Survey on Workplace Intimidation

Please take a few minutes to tell us about your experiences with intimidation in the workplace. The purpose of the survey is to elicit information about how frequently healthcare practitioners encounter intimidation, the form it takes, and its overall effect on medication safety. For the purpose of this survey, "intimidation" is defined as: Any overt or covert interaction between healthcare professionals that results in either an intended or unintended reluctance to speak up about concerns, question patient care, or share an opinion on a subject. Please visit www.ismp.org/Survey/NewsLetter/Survey200311.asp to submit your responses online by **January 9, 2004**. If you do not have access to the Internet, you can also fax responses to 215-914-1492.

(1) Please tell us how frequently in the past year you've encountered potentially intimidating behaviors.

Key: Often = more than 10 times this year; Sometimes = 3-10 times this year; Rarely = 1-2 times this year; Never = no occurrences.

Potentially Intimidating Behaviors	By Physicians/Prescribers				By Others (e.g., pharmacist, nurse, supervisor)			
	Often	Sometimes	Rarely	Never	Often	Sometimes	Rarely	Never
a. Reluctance or refusal to answer your questions, return phone calls or pages								
b. Condescending language or tone of voice								
c. Impatience with questions								
d. Strong verbal abuse								
e. Negative or threatening body language								
f. Reporting you to your manager (actual or threat)								
g. "Just give what I/the attending ordered."								
h. Physical abuse								
i. Other: (describe)								

(2) If you answered "Sometimes" or "Often" to any item in question #1, how many different individuals committed the potentially intimidating behaviors? Please select NA if the question does not apply. 1-2 3-5 More than 5 NA

(3) Please tell us how frequently in the past year you've experienced the following potential effects of intimidation.

Key: Often = more than 10 times this year; Sometimes = 3-10 times this year; Rarely = 1-2 times this year; Never = no occurrences.

Potential Effects of Intimidation	Often	Sometimes	Rarely	Never
a. Despite concern (even if vague), I've assumed that a medication order is correct and safe rather than interact with a particular prescriber.				
b. Despite concern (even if vague), I've assumed that a medication order is correct and safe because of the stellar reputation of the prescriber.				
c. I've asked colleagues to help me interpret an order or validate its safety so that I do not have to interact with a particular prescriber.				
d. I've refrained from contacting a prescriber and attempted to clarify the safety of an order by researching the topic myself.				
e. I've asked another professional to talk to the prescriber (or other professional) about the safety of an order if it involves a particularly intimidating person.				
f. I've asked/suggested/allowed a physician to give a medication himself despite concerns (even if vague) about its safety.				
g. I've felt pressured to accept an order, dispense a product, or administer a medication despite concerns (even if vague) about its safety.				
h. Other: (describe)				

(4) Please respond "Yes" or "No" to the following statements related to intimidation in the workplace.

Statements	Yes	No
a. Past experiences with intimidation have altered the way I handle order clarification or questions about medication orders.		
b. My organization has clearly defined an effective process for handling disagreements with the safety of an order.		
c. The process for handling clinical disagreements allows me to bypass the prescriber or my supervisor if necessary.		
d. My organization deals effectively with intimidating behavior.		
e. My organization/manager would support me if I reported intimidating behavior by another professional.		
f. I've been involved in a medication error in the past year where intimidation played a role.		

(5) Please select the category that best describes you.

- a. **Practitioner type:** Staff RN Staff LPN/VPN Clinical Specialist Nurse Manager Nurse Educator Quality/Risk Other
- b. **Total years of experience:** Less than 2 years 2-5 years 6-10 year More than 10 years
- c. **Gender:** Female Male