PHARMACY PRACTICE

Medication Safety Alerts

David U and Valentina Jelincic

This column draws on US and Canadian experience and includes, with permission, material from the ISMP Medication Safety Alert!, a biweekly bulletin published by the Institute for Safe Medication Practices (ISMP), Huntingdon Valley, Pennsylvania.

COPING WITH THE SHORTAGE OF PHARMACISTS

Do we agree that there is a shortage of pharmacists in Canada? Do we agree that the shortage is placing pressures on both front-line and management staff? Do we agree that the situation may compromise medication safety? If you answered “Yes” to the preceding questions, perhaps we can agree on some basic strategies to deal with the problem.

The causes of pharmacist shortages in hospitals include limitations on staff numbers as a result of budget constraints, increases in the need for professionals with expertise to manage a growing number of pharmaceuticals and patient care programs, inability to attract professionals to the hospital setting, expansion of specialty services, and loss of direct patient care pharmacists to careers in other industries (e.g., consulting, the pharmaceutical industry, community practice, and academia).

Having manoeuvred through an era of hospital downsizing, consolidation, and mergers, the profession of pharmacy continues to provide essential services within health care institutions. Basic services, as well as expanded specialty programs for inpatients and outpatients, are being maintained by hospital pharmacies throughout Canada. Yet the shortage of pharmacists, coupled with shortages of doctors and nurses, increases the stress on all health care professionals and the patients under their care.

Rationalization of services and restructuring of departments have led to numerous situations where the shortages are keenly felt. Where medication dispensing and administration used to be subject to independent double-checks by more than one professional, there may now be only one individual involved in the process. Where a pharmacist was previously responsible for the pharmaceutical care of patients on only 1 or 2 nursing units, he or she may now be covering many units, including units without a dedicated pharmacist assignment. Where transcription of orders used to be done by nurses, nonprofessional staff (e.g., ward clerks) may now be performing the task, and if there is no pharmacist to review the orders in a timely fashion, transcription errors may not be discovered until after the patient has received an incorrect medication or dosage. All of these situations create opportunities for errors and consequent harm to patients. Similarly, they all create opportunities for increases in health care costs in the form of longer patient stays and possible litigation.

These challenges are not new. Recognizing the important role of pharmacists, most hospitals have increased the numbers of pharmacists, technicians and pharmacist-managed programs over the past decade, sometimes in compensation for the loss of other professionals. Yet shortages persist. How can you, as an individual hospital pharmacist, manage your workload and maintain patient safety?

Here are some suggested strategies:

• Work collaboratively with doctors, nurses, and other pharmacists and health care professionals — communication can help to avert errors. Point-of-care teamwork is ideal: orders are reviewed even
before they are written, and all members of the
team provide their expertise and input to the
management of patients.

• Involve and educate patients about their health and
medications. An informed patient will question
inconsistencies and changes in care, providing yet
another safeguard.

• Optimize the use of technology, not as a
replacement for professional tasks but as an aid to
professional decision-making and information-
sharing (e.g., computers and personal digital
assistants for quick access to drug information and
clinical notes, bar coding for drug distribution and
administration verification, computer-generated
medication administration records to minimize
transcription errors in drug orders).

• Discuss drug distribution and issues related to the
medication system within the pharmacy, and elicit
input from other health care professionals who may
be affected. Determine whether changes are
needed, what they should be, who should be
involved, and how the changes can be realized.

• Standardize medications and protocols (e.g., drugs,
doses, concentrations, and administration methods)
to minimize chances for misinterpretation.

• Carry out independent double-checks of medication
orders, drug formulations and calculations, and
dispensing.

• Optimize the functions of pharmacy technicians so
that pharmaceutical care activities can be performed
by pharmacists. This should help in preventing
order-level incidents, identifying adverse drug
events, and providing a review of dispensed
medications.

• Reinforce the importance of patient safety and
identify any situation that may compromise it. Keep
hospital administrators informed of the issues.

These are a few of the ways in which we can make
the best of the staff members we have. At the same time,
we need to continue looking for better and safer ways
to provide pharmacy services.

Quality is never an accident; it is always
the result of high intention, sincere effort,
intelligent direction and skillful execution;
it represents the wise choice of many
alternatives.—Willa A. Foster1

**SPECIAL FEATURE**

The special feature below is taken directly from ISMP
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"Maximize" safety when titrating
drug doses

**Problem:** Would you accept the following order:
"LEVOPHED (norepinephrine) drip, start at 1 mcg/min
and titrate to systolic BP greater than 90"? Do you
often see similar orders for norepinephrine and other
titrated medications? Do they appear on your
preprinted order forms? If yes, consider the
following event. An ICU [intensive care unit] nurse
titrated a dose of norepinephrine up to 38
mcg/minute to maintain a systolic blood pressure
greater than 90 mm Hg. This rate was maintained
throughout the night, at which point the patient had
so much peripheral vasoconstriction that irreversible
ischemia occurred in several of his toes, leading to
gangrene and eventual amputation.

Excessive vasoconstriction from pressor drugs
can lead to adverse cardiac effects as well as
peripheral vascular ischemia, especially if patients or
families desire full heroic measures regardless of the
consequences. Other factors also may contribute to
the problem. For example, concomitant medications
with similar modes of action, volume depletion, and
preexisting compromised circulation can contribute
to adverse effects when titrating pressor drugs. In
fact, in the example above, the patient who lost his
toes was severely dehydrated, which heightened his
potential for an adverse outcome.

Accepting orders for titration of medications
without dose limits is unsafe. The problem is, you
may get little help from drug information resources
in determining a maximum dose beyond which you’d
no longer increase cardiac effects, but which would
increase adverse peripheral effects. For example,
after looking at several reputable references, dose
ranges for norepinephrine were found as high as
210 mcg/min, with only a sentence warning about
the possible adverse effects. In other references, no
maximum dose is listed for the titrated medication.
Similar problems may be found when seeking
information on other titrated drugs, such as
epinephrine or phenylephrine.

**Safe Practice Recommendation:** Consider
bringing this issue to the Pharmacy and Therapeutics
Committee, or a similar multidisciplinary committee,
for discussion. Before the meeting, gather as much
information as possible about safe dose ranges for
medications that are titrated at your practice site. At
the meeting, set a dose limit at which the physician
must be called for each titrated medication. If a
titrated medication continues at or above the dose limit, it’s also advisable to require the physician to acknowledge the current dose at least every 24 hours by writing specific orders with a new dose limit at which he should be called. Be sure to include dose limits on preprinted orders, written protocols for titrated medications, internal reference materials such as nursing IV [intravenous] guidelines, medication administration records, and labels of titrated solutions. “Smart pumps” that alarm when dose limits are exceeded can remind the nurse to call the physician. Nurses also should assess peripheral circulation frequently when titrating medications to detect potential problems as early as possible. Finally, it may be helpful to establish minimum doses for titrated drugs to signal possible discontinuation when they are no longer needed.

Reference

David U, MScPhm, is President and CEO, the Institute for Safe Medication Practices Canada (ISMP Canada).
Valentina Jelincic, BScPhm, is a Consultant, the Institute for Safe Medication Practices Canada (ISMP Canada)
e-mail: davidu@ismp-canada.org
ISMP Canada home page: www.ismp-canada.org

have the money and the time to obtain a phenotypic or genotypic profile for every patient to determine genetic susceptibilities and prescribe the drug that best fits the profile?

Here is another perspective from which to examine the issue: How badly are we doing with currently available drugs, in terms of managing disease and limiting adverse effects? If our current record isn’t so good, maybe it’s because we are not using the available drugs properly. Maybe we don’t need a whole new generation of drugs that will also be used improperly.

The situation presented in Gattaca, a 1997 Sony film in which employment and mate selection in a futuristic society were based largely on nonconfidential genetic information, may simply represent a more advanced version of the scientifically engineered society described in Aldous Huxley’s Brave New World. However, I don’t believe that this new world will be upon us any time soon. In the next 20 years, we pharmacists should devote our efforts to making sure the drugs we have are used properly.

References

Scott E. Walker, MScPhm, FCSHP, is Editor of CJHP.