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Pharmacist's Letter
Hospital

Reinforce Safeguards to Prevent ADC Med Errors

You'll see **renewed efforts to prevent med errors with automated dispensing cabinets (ADCs)**.

Despite recent ISMP safety strategies...errors are still occurring.

Continue to focus on ADC (*Omnicell*, *Pyxis*, etc) overrides.

Educate nurses to only override if a delay for a pharmacist's review could cause harm...such as naloxone for opioid overdose.

And explain that a witness and override reason need to be documented in the ADC...such as drug indication, patient ventilation status, etc.

Be extra cautious with NON-profiled ADCs...where all meds are on override. Expect restricted use, such as peri-op and procedural areas...and to stock limited med quantities and concentrations.

Remind peri-op staff to double-check the patient's profile...to ensure they're pulling the right drug under the right patient.

Work with administrative leaders to implement additional ADC safeguards...to help promote these best practices.

Point out that many ADCs require at least 5 letters when searching for meds during overrides. But this comes with limitations...such as spelling errors...and unstandardized medication names.

Help create a standardized list of medication names across ADCs, computer systems, etc, to streamline searches and maintain consistency. Use hands-on training if name changes occur...and be open to feedback.

Configure interactive alerts to select clinically relevant info BEFORE pulling a med...such as confirming a drug indication or notating a patient's condition.

For example, require documentation of ventilation status BEFORE removing a neuromuscular blocker, such as succinylcholine or rocuronium. Only stock these in necessary units, such as ORs and ICUs.

And make sure indications are REQUIRED for certain medication overrides, such as pulling midazolam for an ICU patient trying to self-extubate.

Expect your hospital to review ADC overrides regularly...and reassess unit-specific override lists at least annually.

Implement strategies to prevent other common causes of errors.

For example, consider using tall man lettering for look-alike/sound-alike meds, such as hydrOXYzine and hydrALAZINE...or cloNIDine and clonazePAM.

And take steps to combat alert fatigue, such as making sure any pop-up alerts are clinically relevant.

Take our CE, Medication Error Prevention, for in-depth guidance to help prevent errors.

Key References:

-ISMP. Call to Action: Standardization and Smarter Logic Needed to Prevent Drug Name Selection Errors. May 31, 2024. https://home.ecri.org/blogs/ismp-alerts-and-articles-library/call-to-action-standardization-and-smarter-logic-needed-to-prevent-drug-name-selection-errors (Accessed July 3, 2024).
-ISMP. Targeted Medication Safety Best Practices for Hospitals. February 21, 2024. https://home.ecri.org/blogs/ismp-resources/targeted-medication-safety-best-practices-for-hospitals (Accessed July 12, 2024).

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-Bakker T, Klopotowska JE, Dongelmans DA, et al. The effect of computerised decision support alerts tailored to intensive care on the administration of high-risk drug combinations, and their monitoring: a cluster randomised stepped-wedge trial. Lancet. 2024 Feb 3;403(10425):439-449.

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