

Quality & Safety

Standardized Abbreviations Available Online

Joint Commission has a standard requiring hospitals to use standardized abbreviations. The Medical Executive Committee approved the use of the abbreviation book written by Neil M. Davis as St. Mary's Hospital's official abbreviation guide. This means only abbreviations listed in the book are allowed to be used.

For easy reference of the abbreviation book, the online version is available in **Epic under Links\Clinical Resources\Medical Abbreviation book** and also on the **St. Mary's intranet under Clinical Resources and Medical Library**.

Physician Good Catch Update

Allergies

- Celebrex ordered despite documented allergy. Caught by pharmacist.
- Valium ordered despite documented allergy. Caught by patient.

F/U: These were both from order sets with the medications automatically defaulted/ordered, and the orders were not unchecked/unordered despite alerts given. Breakdowns include clinic nurses not having guidelines to uncheck defaulted meds patients are allergic to and physicians bypassing alerts. The former is being brought to Medical Staff EHR Leadership Team. The latter is being looked at to see if nonessential alerts can be removed from EPIC.

Note: There have also been several errors recently with patients receiving meds they were allergic or intolerant to. Not caught by physician, pharmacist or nurse.

Peds dosing

Multiple good catches re: meds orders on Peds patients with dangerously high doses (e.g. antibiotics, pain meds).

F/U: It is safest to use a Peds order set whenever possible when entering meds on peds patients. A group is looking into this issue also.

Note: There have been actual errors made related to this also.

Forgotten orders

- Physician progress note stated intent to discontinue acyclovir IV dosing but did not discontinue order. Pharmacist called physician. Acyclovir discontinued.
- Physician described stopping patient's Coumadin rx in note but order not discontinued. Pharmacist called physician who indeed meant to discontinue Coumadin.

Risky order

Heparin SQ ordered on a leukemic patient whose platelets were only 14,000. Pharmacist called physician who didn't remember ordering the heparin. Was part of admission order set (VTE section).

For any questions, suggestions or concerns, please email or call Barb Oswald, RN, ext 6677.

The Environment of Care Corner

Does it *ever* seem like there are so many overhead codes called in the hospital? What do those colors mean?

I. Code Red- Fire or Smoke

1. Listen to audio page to learn location of fire.
2. Close all doors, including fire doors, and keep closed.
3. Proceed slowly through a smoke/fire door if it is necessary to leave your area. All smoke/fire doors are marked with red reflective tape around the door frame.
4. Do not use elevators.
5. If you discover a fire: call 258-7777

II. Code Gray- Tornado

1. Stay away from windows and glass.
2. Patients will not be moved out of rooms. Close curtains or blinds in patient room

III. Code Pink- Infant or child abduction

1. Search in the area and report anyone fitting the description to switchboard.
2. If you suspect that you have identified the missing infant/child or suspect, immediately call 258-7777

IV. Code Yellow- Bomb threat has been received by the hospital

Call 258-7777 if you see any suspicious items and do not touch the article.

V. Code Blue- Medical emergency- unresponsive person

VI. Emergency Operations Plan

Report to your onsite supervisor- or medical Staff office for direction.

VII. Code orange- Hazardous material spill

1. Listen to audio page to learn location of spill.
2. Report to the medical staff office for direction.