

Help Reinforce ADC Safeguards

You'll play a pivotal role in **preventing med errors with automated dispensing cabinets (ADCs)**.

Mishaps are still occurring...especially with ADC overrides. Overrides mean multiple safety checks are skipped...including review of med orders by a pharmacist.

Alert the pharmacist if nurses need a med verified stat. Delaying verification can lead to unnecessary overrides...which can be dangerous.

Remember, staff should only override if a delay in pharmacist's review could cause harm...such as naloxone for opioid overdose...or midazolam for an ICU patient trying to remove their breathing tube.

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

Help create a standardized list of med names across all ADCs...to streamline locating the correct drug.

Scan all individual meds before restocking the ADC...to avoid commingling drugs. Notify the pharmacist if you find the wrong drug in the wrong pocket...and submit a safety report.

Add warning stickers to vials and IV bags, such as "high alert" or "paralyzing agent"...to draw attention to risky medications.

Pay attention to formulary changes. For example, your hospital may switch from carrying hydromorphone 1 mL syringes to 0.5 mL syringes.

Keep an eye out for look-alike/sound-alike meds. Hydroxyzine can be easily mistaken for hydralazine...clonidine for clonazepam...etc.

Be mindful of alerts...such as pop-ups confirming a drug's expiration date...or warnings that an incorrect med was scanned.

Use extra caution with ADCs in peri-op and procedural areas, since many drugs don't require pharmacist verification...and overrides are common.

Help remind peri-op nurses to double-check the patient's profile...to ensure they're pulling the right drug under the right patient.

And ensure there's a plan in place in case a peri-op nurse incorrectly wastes narcotics. This can be confusing...and also contributes to ADC errors.

Check out our resource, Automated Dispensing Cabinets and Devices, for more best practices with stocking and how to address other ADC issues.

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).
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- Bakker T, Klopotoska 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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