Sharp HealthCare
Medication Safety
Test Questions

Instructions: Record your answers to post test questions on the 2008 Clinical Faculty Answer Sheet and return to Staffing Resource Network.

1. An Adverse Drug Event, or ADE, is any harm, expected or unexpected, related to a medication.
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2. JCAHO requires that at least TWO patient identifiers must be used, neither of them being the patient's room number. Acceptable identifiers include
   A. Patient name and account number.
   B. Patient's date of birth.
   C. In Behavioral Health Services areas, a patient photo ID is appropriate.
   D. All of the above.
   E. None of the above. It is appropriate to use only the patient's room number rather than the patient's name, since so many names are so similar these days.

3. JCAHO requires that verbal and telephone orders be:
   A. Written down immediately, then read back to the issuer of the order, then actively confirmed by the issuer as having been correctly understood.
   B. Called out very loudly and repeatedly into the phone by the issuer, since C. patient care areas are very noisy.
   C. Used liberally in all possible circumstances to avoid any written orders.

4. Insulin errors and related harm can be effectively prevented by:
   A. Not accepting orders that express dosage with a "U", often confused for a "0", causing ten-fold overdoses. Clarify and confirm the dosage using "Units".
   B. Labeling syringes after drawing up a dose, with patient ID, drug name and dose.
   C. Treating ONE patient at a time...prepare dose, administer, document...next patient.
   D. Carefully reading product labels and using SHC's insulin reference badge cards.
   E. All of the above.

5. Opioid errors and related harm can be effectively prevented by:
   A. Remembering that morphine is not HYDROmorphone (Dilaudid).
   B. Remembering that morphine 5mg IV equals only 1mg HYDROmorphone IV.
   C. Carefully checking brand and generic names and order transcription accuracy.
   D. All of the above.

6. High-risk medications are those most associated with preventable harmful events that include:
   A. Insulins, opioids (e.g., HYDROmorphone), anticoagulants (e.g., Heparin, B. Warfarin), cancer chemotherapy, and paralyzing agents, among others.
   B. Colace, milk of magnesia, Fleets enema.

C. D5W, Normal Saline.

7. When using zeroes in dosages, "Lead...don't follow!". In medication dosages, always use a zero before the decimal point (lead), and don't use one after the decimal point (don't follow) for whole numbers. Correct, clear, and acceptable medication dosage expressions are:
A. "1 mg" ...don't use "1.0 mg" (looks too much like a "10").
B. "0.5 mg" ...don't use ".5 mg" (looks too much like "5").
C. Both A and B.

8. Selected error-prone abbreviations and dosage terms have been associated with serious errors. JCAHO requires that they be clarified prior to order processing (except in true emergencies). These include, but are not limited to:
A. "U" should be spelled out as "units".
B. "QOD" should be expressed as "every other day".
C. “MS" should be spelled out as "Morphine".
D. "QD" should be spelled out as "daily".
E. All of the above.

9. Which of the following methods do you feel could result in reporting of a medication safety event or is considered a hazardous condition?
A. Harmless events: tell your pharmacist or use the Medication Safety Hotline, at 858-499-MEDS.
B. Harmful events: A QVR is always required.
C. Hazardous conditions which may result in an error or patient harm: tell your pharmacist or use the Medication Safety hotline.
D. All of the above.

10. Effective means of preventing medication errors and serious patient harm include:
A. Requesting a co-worker to please perform a DOUBLE-CHECK of the dosage to be administered, and its calculation.
B. Reading product labels carefully and completely, not relying upon familiar colors, fonts, etc.
C. Checking transcriptions carefully.
D. Not accepting verbal or telephone orders for cancer chemotherapy agents except in emergencies.
E. All of the above.

11. A medication error may be due to:
A. The failure of a medication plan to be completed as intended.
B. The use of an incorrect medication plan.
C. Both A and B.
D. Neither A nor B. Medication errors occur for totally mysterious reasons.