

‘Neither a Borrower Nor a Lender Be’ When Drugs Are Involved

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PROBLEM: The phrase “Neither a borrower nor a lender be” originated from Shakespeare’s famous play, *Hamlet* (1603), during which Lord Polonius gives this advice to his son, Laertes, who is heading back to school. Because our world is vastly different today, this advice might seem outdated or irrelevant, but when it comes to patient safety, Shakespeare’s advice is timeless; medications should never be borrowed from or lent to another staff member or patient.

This advice seems simple enough to follow, but health care practitioners can be tempted to borrow a “missing medication” (a dose that should have been available) or the first dose of a new medication from another patient’s cassette, a discharged patient’s unused medications, or another patient care-unit. Borrowing a drug as a workaround to speed the process of administering medications because of excessive wait times related to the pharmacy-dispensing process increases the risk of an error, especially if a drug intended for one patient is given to another.

We might think that the introduction of profiled automated dispensing cabinets (ADCs)—which allow the pharmacist to review and approve drugs before they are given—and unit-dose dispensing would have curtailed the practice of borrowing medications. However, a survey originally conducted by the Institute for Safe Medication Practices (ISMP) in 2002 (and repeated in 2008) found that almost half of the 1,296 nurses who participated in the 2008 survey still borrowed drugs when doses for their patients appeared to be missing on the unit.¹

Because there are many opportunities

for errors, the ideal system of administering medications is one in which there is more than one practitioner between the drug’s administration and the patient. For example, while screening orders, a pharmacist might detect a prescribing error such as an inappropriate dose, a drug allergy, or a drug–drug interaction. While checking medications before administration, a nurse might detect a pharmacy-dispensing error. While reviewing the patient’s medication administration record (MAR), a physician might detect the inadvertent discontinuation of a drug.

Most pharmacies have a system of checks before a drug is dispensed. Computer software helps to screen the order for appropriateness and safety, and multiple staff members aid in preparing medications and checking them against the order before they are dispensed. However, this safety system is bypassed when doses are borrowed from other patients or when they are obtained from an ADC before a pharmacist has screened the order. In such cases, the system cannot provide adequate checks to capture errors before they reach the patient.

SAFE PRACTICE RECOMMENDATIONS: Borrowing medications is not just a nursing problem; it’s a complex, interdisciplinary clinical issue that requires ongoing teamwork and excellent communication among nurses, pharmacists, and other health care practitioners. We can consider the following four-pronged approach to address this ongoing problem in hospitals:

1. Identify and eliminate the reasons for borrowing. A prohibition against borrowing medications through an institution’s policy is not enough to ensure patient safety, because the reasons for this behavior are often rooted in deficiencies of the system. It is important to learn why nurses or other practitioners think they might need to borrow medications from unauthorized sources and to address these causes in a collabora-

tive manner. If the turnaround time for dispensing medications (or for reviewing orders to allow access to ADCs) is perceived to be a problem, steps can be taken to identify the scope of the problem; address vulnerabilities; and gain consensus among nurses, pharmacists, physicians, and hospital leaders regarding acceptable time frames for drug delivery or reviewing orders. Any misconceptions about the clinical significance of providing therapy within the acceptable time frame for starting new drug therapy should be addressed and cleared up. If the pharmacist is awaiting clarification of an order, he or she should contact the nurse to explain the cause of a delay.

2. Decrease staff acceptance of borrowing. Nurses and other practitioners should understand the risks and consequences of borrowing medications, and pharmacists should understand the risks and consequences of delays in reviewing orders and in dispensing medications. Conditions that contribute to delayed order reviews and dispensing should be reported, to the leadership, because they may encourage and reward the practice of borrowing medications. This information should be applied to improve the medication-use system.

3. Determine the reason for a missing medication. Missing doses of medications are an inconvenience and could be related to system problems with restocking of ADCs or delivery of the medications to patient-care units. However, a drug might be missing or not available for other reasons, for example:

- The drug was already given to the patient but was not noted on the medication administration record (MAR).
- The dose was given to another patient on another unit.
- The medication time or frequency was scheduled incorrectly and is being reviewed.

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- The order was incorrectly interpreted or was transcribed incorrectly onto the MAR or onto another patient's MAR.
- The pharmacy did not dispense the drug because of a safety problem (e.g., the wrong dose was prescribed or the patient was allergic to the medication).
- An additional dose in the 24-hour cart fill was used to replace a previously dropped dose or a dose that had been vomited.
- The drug was misplaced (e.g., was removed from the tube and left at the station).
- The pharmacy never received the order.
- A discontinued drug was still listed on the MAR.

4. Eliminate unauthorized access to drugs. Staff members should discourage the accumulation of discontinued or unused medications in patient-care units. A secure container or an ADC compartment should be provided in which the staff can place medications from discharged or deceased patients as well as other discontinued or unused drugs. Frequent pharmacy rounds should be conducted to collect these drugs, including refrigerated items. Profiled ADCs should be used, and stringent criteria should be established for the removal of medications. Override reports should be monitored for accuracy and correctness.

REFERENCE

1. Cohen H, Shastay AD. *Nursing 2008* Survey Report: Getting to the root of medication errors. *Nursing2008* 2008;38(12):39-47.

The reports described in this column were received through the ISMP Medication Errors Reporting Program (MERP). Errors, close calls, or hazardous conditions may be reported on the ISMP Web site (www.ismp.org) or communicated directly to ISMP by calling 1-800-FAIL-SAFE or via e-mail at ismpinfo@ismp.org. ■