Reducing and Preventing Medication Errors in Assisted Living/Personal Care

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Objectives

- Identify the causes of medication errors in community dwelling settings
- Describe measures to reduce/prevent errors from occurring
- Understand the importance of enhanced communication between staff, resident and phyisicians.

What is a medication error?

A medication errors is defined as any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer.

Reference:

National Coordinating Council for Medication Error Reporting and Prevention (2012).

Right of Medication Administration

Six Rights of Medication Administration

- Right person
- Right drug
- Right time
- Right dose
- Right route
- Right documentation

Other Rights

- Right to refuse medications
- Right to know what they are taking

Wouldn’t it be nice if we had a…..

Statistics

- Limited true statistics on medication errors in AL/PC.
- Most recent statistics found were from 2016 and prior-best stats were from 2011
  - Med errors comprised half of AL violations
- Preventable medical errors (medications fall in here) is the third cause of death in the US-behind heart disease and cancer.
- Assisted living residents take an average of 12-14 medications per day (Pharmerica, 2018)
- Residents are moving in more chronically ill and debilitated than years past.

Types of Medication Errors

The obvious-typically follow one of the Six Rights

- Wrong dose/drug given to right resident
- Wrong person given someone else's medications
- Wrong time-doses given too close, or given with meals instead of before
- Wrong route-usually not an issue in our industry but it can happen
- Omission-not given or not documented
- Transcription-how the order is noted incorrectly

Types of Medication Errors

- The not so obvious to some perhaps:
  - Allergy errors-not caught by pharmacy or by staff
  - Administering expired or discontinued meds
  - Monitoring errors-not taking BP, pulse or glucose before administering
  - Compliance errors-residents not compliant with orders, staff not following systems resulting in errors.
  - Reconciliation errors-discrepancies not caught or reconciliation not done

Causes of Errors

- Lack of adequate training-training follow through, ongoing training
- Lack of monitoring processes-observations of staff, second check on meds or documentation
- Not following systems or processes in place
- Distractions
- Messy work space
- Ambiguous or illegible orders

Consequences of Errors

- Harm to the resident
- Staff turnover-due to number/type of errors (termination), or staff leaving (resignation) due to feelings surrounding the errors
- Harm to facility reputation-word gets out!
- Citations and penalties related to errors-affect on license (provisional or withdrawal of license)

Why aren't errors reported?

- Staff fear getting into trouble-Number one reason!

- Residents fear having their independence taken away if self-administering their own medications

Interventions to prevent errors

- First step is to have buy-in from every level of the organization-administration, care staff, housekeeping, etc-all members participate in activities designed to reduce errors including reporting what is seen.
- Communicate values and expectations-onboarding and ongoing
- Non-punitive medication error reporting policy-encourages staff to report themselves. Create a just and accountable environment.
- Simplify systems and processes-standardize.
- Keep carts and work stations clean-remove discontinued or expired medications
- Avoid ambiguities when writing or accepting orders-write out by mouth, or four times a day. Prohibited abbreviations. Educate your doctors on required items

Interventions to Prevent Errors (2)

- Legible orders
- Involve your pharmacies-quarterly auditing of carts/orders
- Know and follow exceptions-do not crush list, specific time meds, have current reference material available (PDR, Lippincotts)
- Keep training-new medications being used, changes in insulin devices, types of IV lines/ports that you may see.
  - Insulin pens are an easy target for surveyors.
    - Labels not correct or present
    - Date open not noted
    - Sharing (typically shared glucometers)

Interventions to Prevent Errors (3)

- Don't rely on memory-follow systems, 3 checks before administering a medication
- Minimize med pass interruptions-no phone calls accepted except emergency.
- Follow documentation best practices
- Reconcile medications when residents return from hospital or skilled
- Use of generic AND brand names to reduce confusion
- Make sure PCP is aware of prescriptions by specialist
- Make sure pharmacy has full profile of medications even if not filling (VA)

eMAR

- May not be the end all be all solution to reducing medication errors
- Have to have systems and processes in place to ensure orders properly checked in and have some process of not closing the resident pass until everything is documented.
- Staff do find work arounds!!!!!
- Must be consisted and diligent
- Often have built in reference information on medications
- Nursing leaders must be in the system every day

Quality Improvement Measures

- Training, training, training!
- Cart and MAR audits based on a schedule
- Nurse leaders completing observations on anyone passing medications (nurse or med tech)
- Tracking of errors-by error type
- Root Cause Analysis-human errors are best managed through analyzing and improving procedures.

Conclusions

- Best way to prevent or avoid errors is to:
  - have simple systems and processes in place,
  - hold staff accountable to follow them,
  - monitor the work
  - monitor the errors
  - complete root cause analysis when errors do occur.
  - be present in the process

QUESTIONS?????