Health Trends



Virginia Department of Behavioral Health & Developmental Services

Office Integrated Health



Health and Safety Awareness Medication Management



Medication administration is a challenging responsibility, whether you are a licensed medical professional such as a nurse, a non – licensed care giver such as medication aide or a family member.

What is a medication error?

The Joint Commission (TJC) in 2012 defined medication errors as any preventable event that may cause inappropriate medication use or jeopardize patient safety in any way.

DBHDS Office of Licensing Standards in 2017 defined a Medication Error to mean an error in administering a medication to an individual and includes when any of the following occur: (i) the wrong medication is given to an individual, (ii) the wrong individual is given the medication, (iii) the wrong dosage is given to an individual, (iv) medication is given to an individual at the wrong time or not at all, or (v) the wrong method is used to give the medication to the individual.

Medication administration is a complex multistep process that encompasses:

- Prescribing
- Receiving the proper medication from the Pharmacy
- Transcribing for addition to a MAR
- Dispensing and Documenting
- Administering drugs and assisting with self administration of drugs
- Monitoring patient response and observing for side effects

An error can happen at any step!

What can be done to reduce errors? Below is a summary of some medication administration safety principles and tips.

- 1. Be focused and vigilant when preparing medications
- 2. Thorough training for all caregivers on agency policies
- 3. Always check for allergies
- 4. Use two patient identifiers at all times
- 5. Be diligent in medication calculations
- 6. Avoid reliance on memory; use check lists
- 7. Communicate with the individual before and after administration
- 8. Avoid workarounds and short-cuts
- 9. Ensure that the correct medication was obtained/delivered from the Pharmacy
- 10. Ensure medication has not expired
- 11. Always clarify an order or procedure that is unclear
- 12. Use available technology to administer medications like bar-code scanning
- 13. Report all near misses, errors, and adverse reactions to your supervisor and document in the individual's record
- 14. Be alert to error-prone situations and high-alert medications
- 15. If an individual questions a medication and claims it is not the right medication, stop and do not administer it.
- 16. Research possible side effects of each medication using reputable sources

The full Medication Management Alert can be found on the OIH webpage.



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Save the Date! **Skin Integrity and Oral Health Training** New Dates!

This FREE interactive workshop is for participants to learn how to deliver the best oral care for even the most challenging of clients; support individuals who need improved oral care, and prevent diseases of the mouth through good oral hygiene. Additionally, learn how to support individuals in preventing skin breakdown and acquire best practice skills for skin care. Upon completion, participants will have the information and tools to present the program in their home agencies for staff training. This interactive workshop is designed to "Train the Trainer". The curriculum and all of the tools needed to teach the class will be provided.



When:

Thursday, May 30th, 2019

Where:

Wall Residences **Danville Office** 100 N. Main St. Danville, VA 24540

Register Here:

Questions?

https://www.surveymonkey.com/r/BNJ2CJZ

Please email Susan Moon at susan.moon@dbhds.virginia.gov

The Office of Integrated Health is growing!



OIH is pleased to introduce five new Registered Nurse Care Consultants to the Community Nursing Team! RNCC's provide education, technical assistance, and support to case managers, support coordinators, and providers in the community.

> Susan Moon, BS, RN **RNCC** Lead Nurse Susan.moon@dbhds.virginia.gov

Welcome to the Team!

Brendan Mahoney, MSN, RN Brendan.mahoney@dbhds.virginia.gov

Jessa Layne, MSN, RN Jessa.layne@dbhds.virginia.gov

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