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Virginia Department of Behavioral Health & Developmental Services

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Medication Management Safety Tips

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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.

Startling Facts

- ✓ In 2000, the Institute of Medicine's book, *To Err Is Human: Building a Safer Health System* estimated that approximately 1.5-million preventable "adverse drug events" (ADEs) occur annually.
- ✓ According to the landmark 2006 report "Preventing Medication Errors" from the Institute of Medicine, these errors injure 1.5 million Americans each year and cost $3.5 billion in lost productivity, wages, and additional medical expenses.
- ✓ The Center for Disease Control in 2013, reported that there are more medication errors in healthcare, than any other type of error.
- ✓ Forbes Magazine reported in 2013, that medication errors happen all the time, an estimated one million each year, contributing to 7,000 deaths.

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.

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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. Although many errors arise at the prescribing stage, some are intercepted by pharmacists, nurses, or other staff. Anyone in the process from prescriber to patient can make a medication error and can also help to reduce these errors!

What can be done to reduce errors?

Below is a review of some medication administration safety principles and some safety tips to help improve medication administration.

1) **Be focused and vigilant when preparing medications**.
   a. Avoid distractions: don't answer the phone, don't answer the door, and don't talk to anyone other than the individual. Create a no-interruption zone, which is a physical place designated to preparing medications without interruptions.
   b. Prepare only one individual's medicine at a time.

2) **Thorough training of all caregivers on agency policies regarding medication administration and recordkeeping policies surrounding medication administration records (MARs) can reduce preventable errors.**
   a. Ensure that each employee/caregiver has completed agency-related training on all policies relating to medication administration and medication administration records (MARs).
   b. Implementing a provider policy which requires a medication administration refresher course for all employees. The DBHDS Office of Licensing Regulation *12VAC35-105-450*. Specifically addresses employee training and development.

> *"The provider shall provide training and development opportunities for employees to enable them to support the individuals served and to carry out the responsibilities of their jobs. The provider shall develop a training policy that addresses the frequency of retraining on medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. Employee participation in training and development opportunities shall be documented and accessible to the department."*

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3) **Check for allergies**
   a. First: always ask the individual about allergies, types of reactions, and severity of reactions.
   b. Second: check the individual's records.

4) **Use two patient identifiers at all times.**
   a. Always follow agency policy for patient identification.

5) **Be diligent in all medication calculations.**
   a. Errors in medication calculations have contributed to dosage errors, especially when adjusting or titrating dosages.
   b. Check all medication administration calculations twice.

6) **Avoid reliance on memory; use checklists and memory aids.**
   a. If possible, follow a standard list of steps for every patient.
   b. Post the 7 Rights of Medication Administration in your pre-designated medication administration area, so it can be easily viewed by all employee/caregivers.

7 Rights of Medication Administration

1. **Right Medication**
2. **Right Patient**
3. **Right Dosage**
4. **Right Route**
5. **Right Time**

6. Right Reason
7. Right Documentation

plus #8…. Right Response

7) **Communicate with the individual before and after medication administration.**
   a. Introduce yourself to the individual and provide information to the individual about the medication before administering it.
   b. Give the individual an opportunity to ask questions. Include family members if appropriate and/or legally required. Provide drug specific literature to patient and family and family and direct them to the prescriber or pharmacist for drug specific questions outside your scope or practice.

8) **Avoid workarounds and short-cuts.**
   a. A workaround or shortcut is a process that bypasses a procedure, policy, or problem in a system. For example, a caregiver might be tempted to "borrow" a medication from another individual if they are waiting on an order to be filled by the pharmacy.

9) **Ensure that the correct medication was obtained / delivered from the Pharmacy.**
   a. Ensure that all parties receiving medications check that it is the correct medication, the correct dose – frequency – route (as ordered, and it scheduled to be administered at the correct time of day.
   b. Ensure that staff understand and follow the provider's policy and consistent / standard protocol for obtaining / receiving medications.

10) **Ensure medication has not expired.**
   a. Medication may be inactive if expired. Check expiration dates before each administration.

11) **Always clarify an order or procedure that is unclear.**
   a. Always ask for help whenever you are uncertain or unclear about an order.
   b. Consult with the pharmacist who filled the prescription, the individual's nurse, the individual's primary care physician or specialist or other health care providers to resolve all questions

12) **Use available technology to administer medications.**
   a. Bar-code scanning (eMAR) has decreased errors in administration by 51%, and computerized physician orders have decreased errors by 81%. Technology has the potential to help decrease errors.
   b. Use technology when administering medications, (if possible), but be aware of technology-induced errors.

13) **Report all near misses, errors, and adverse reactions to your supervisor and document in the individual's records.**
   a. Reporting allows for analysis and identification of potential errors which can lead to improvements and sharing of information for safer care of individuals

14) **Be alert to error-prone situations and high-alert medications which can cause harm to an individual.**
   a. Be alert to error-prone situations and high-alert medications which can cause harm to an individual.

What is a HIGH ALERT Medication?

High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients.

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15) **If an individual questions a medication and claims it is not the right medication, stop and do not administer it.**
   a. If an individual questions a medication or claims it is not the "right" medication, **STOP**!!
      i. address the individual's concerns
      ii. review the physician's order
      iii. review the MAR
      iv. check with the pharmacist, and
      v. review the individual's personal identifiers.

   b. If you are still unsure, notify the medical professional in charge of the patient.

16) **Research the possible side effects of each medication using a reputable source.**
   a. Ask the prescriber for information on side effects when the medication is prescribed and at follow – up appointments.
   b. The pharmacist should provide you with drug specific information when the prescription is filled and can answer questions.

Reputable Web- based Sources

National Institutes of Health, National Library of Medicine (2019). Medline Plus database. Retrieved from https://medlineplus.gov/druginformation.html

- MedlinePlus is the National Institutes of Health's Web site. Medline Plus is produced by the National Library of Medicine, the world's largest medical library.

Drugs.com (2019). Find drugs and conditions database. Retrieved from https://www.drugs.com/

- Drugs.com has a searchable database and is the largest, most widely visited, independent medicine information website available on the Internet.

U.S. Food & Drug Administration (2019). Drugs @ FDA database. Retrieved from http://www.fda.gov/drugsatfda

- The Drugs@FDA website includes a searchable database of most of the drug products approved since 1939

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