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DEPARTMENT OF HUMAN SERVICES

Standard Medication Administration Training Course

Transcript

Lesson 9b: Medication Errors - Trainers

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Title Slide

Slide 1 – This is Lesson 9b of the Commonwealth of Pennsylvania Medication Administration Training Course, "Medication Errors-Trainers"

Lesson Objectives

Slide 2 –
By the end of this lesson, you will be able to:

- Identify the types of medication errors.
- Explain the importance of reporting medication errors.
- Report medication errors in accordance with applicable regulations and agency policy.
- Describe how to evaluate medication errors.

Medication Cycle

Slide 3 – You have learned about the process of administering and documenting medication administration and how important the "5 Rights" are in making the medication administration process safer.

What is a Medication error?

Slide 4 – Mistakes can occur when the step-by-step process for administering medication is not followed. Often the medication administrator becomes very familiar with the medication that individuals are receiving on a daily basis and may start to take shortcuts, skipping steps to save time. It is a dangerous practice to skip steps and/or rely on memory to prepare and administer medication because mistakes in medication administration can harm an individual. You must follow all steps, including the four checks of the "5 Rights," every time that you administer a medication.

Slides 5 – Sometimes even when proper steps are followed, people may still make a mistake. Mistakes in medication administration are called medication errors. One way to think about medication errors is that they occur when one of the "5 Rights" is wrong. An example of a medication error would be to give Melissa Sullivan, medication for Megan Sullivan. This is an error because it is not the right individual. Each of the "5 Rights" is connected with one or more types of medication errors.
The National Coordinating Council for Medication Error Reporting or NCC MERP has defined the types of medication errors. Defining the type of medication error helps identify ways to prevent that kind of error from occurring again. Defining the type of error also gives a steady and unchanging way to evaluate the challenges in the medication administration process. This information can be used to improve medication administration practices.

Slides 6 – Let's look at the types of medication errors that can occur. The first set of error types that we will look at are directly related to one of the "5 Rights".
Wrong individual occurs when one individual gets another individual's medication such as in the example given earlier of Melissa Sullivan receiving Megan Sullivan's medication.

Slide 7 – Wrong medication occurs when there is an error related to the medication. There are three categories of medication errors under this type.

- **Wrong medication administered**. Examples of this would be administering Zyrtec instead of Zyprexa or clonidine instead of Klonopin, but this could occur any time that the wrong medication is accessed from the medication storage area and not just with look-alike or sound-alike names.

- **Extra dose of medication administered**. This typically occurs when one staff person administers the medication without documenting it and another staff person administers it again.

Transcript
• **Discontinued medication administered.** Medications can be stopped or discontinued. If the container of medication that is no longer being administered is left in the medication storage area and someone administers it, then this is also a type of wrong medication. When a specific medication for an individual has been stopped or discontinued, it must be removed from the medication storage area and documented as discontinued on the Medication Record in order to prevent this type of error.
Slides 8 – Wrong dose - This occurs when the individual gets too much or too little medication during a scheduled administration. If an individual is given two tablets instead of the ordered one tablet, this would be too much medication and the wrong dose. This can occur when there are changes in the strength of the medication. An example would be if 20 mg of Simvastatin was ordered for the individual and the pharmacy fills it initially with 20 mg tablets to give one tablet as the dose and then refills it with 10 mg tablets to give two tablets as the dose. If the medication administrator then gives only one 10 mg tablet, the individual will get too little medication.
Slide 9 – Wrong time - This occurs when the medication administration is too early or too late. Too early or too late means more than 1 hour before or more than 1 hour after the prescribed time. As a reminder, medication may be administered up to 1 hour before or 1 hour after the time listed or designated and still be considered on time. Outside of this 2-hour range is the wrong time. For example, Valproic acid due at 2 pm and given at 3:15 pm would be late. If it was administered between 1 pm and 3 pm, then it would be an on-time administration.
Slide 10 – Wrong route - This occurs when a medication is put into the body in a different way from the one specified on the prescription. This is an unusual error. However, it is important to pay attention to route because many medications may be administered by different routes. One example of this would be putting nasal drops in an eye. This type of error could result in eye damage and possibly loss of vision. Another example would be to administer a vaginal suppository used to treat a yeast infection by mouth.
Slide 11 – In addition to the error types that are directly associated with the "5 Rights," there are some other types of errors that commonly occur and may impact the health of the individual. Some, but not all of these, are related to special instructions associated with medications. **Wrong form** – This occurs when the individual is administered medication in a different form from the one prescribed. An example of a different form would be if an individual is ordered a liquid form of a medication but is administered a pill form of the medication. If an individual who has swallowing problems is ordered to take liquid ibuprofen, but instead is administered a pill, then this is the wrong form of the medication. The individual may have difficulty swallowing the pill.
Slide 12 - Wrong position - This occurs when the individual is not positioned in the correct way to receive the medication, such as not properly seated or lying down while receiving medication. Individuals should be sitting upright when an oral medication is administered to avoid choking. Alendronate, a medication used to strengthen weak bones, requires that the individual sit upright for half an hour after receiving it so that they don't develop stomach or esophageal ulcers. If the individual lies down before the 30 minutes has passed, then that would be an error in positioning.
Slide 13 – Wrong technique or method - This occurs when a medication is prepared for administration improperly. Some medications are time-released and should not be crushed. Other medications should not be mixed into any foods such as pudding or applesauce. In addition, some liquid medications settle to the bottom of the bottle and must be shaken prior to administration. Instructions for any of these methods of preparing medication will be provided on the pharmacy label. Do

Transcript
not crush medications or mix with foods for administration if there are no instructions on the pharmacy label to do so.
Slide 14 – Omission - This type of error occurs when the medication is not administered at the correct time. Omission is the most common type of error. For example, if a medication administrator realizes in the afternoon that they forgot to administer the morning dose of propranolol, this is an omission.
Slide 15 – The unavailability of medication can also create an error of omission. For example, if a medication has not been refilled and is not *present* to be administered when due, then this is an omission. The importance of recognizing this is to identify the system error in how the medication was refilled that lead to the unavailability. It is an opportunity to look at the whole system and prevent such an error from happening again. Your agency will have a policy for the initial filling and refilling of medications to ensure the medication is delivered in a timely manner. Best practice for this policy would be to designate a staff person responsible for ensuring that all medications are available so that omission errors do not occur.
Slide 16 – There are examples of missed medications or missed doses of medication that may be **misidentified** as omissions. • A refused dose • The individual is off-site • There was a written order to hold a dose • The new prescription was not received from the pharmacy yet.
Slide 17 – A refused dose As a reminder, if the individual refused to take the medication within the required timeframe, this is a refused dose. Do not force an individual to take medication. Consider how you can support the individual to take their medication as prescribed. You and the team should work to identify why the individual is refusing medication and ways to support the individual in taking the medication. For someone with multiple refusals, you may want to have written instructions from the health care practitioner on how to approach this situation when it occurs. Remember, though a refusal is not a medication error, it may have the same impact on an individual's health as a missed dose.
Slide 18 – An individual is off-site Sometimes individuals will be away from the home or off-site unexpectedly when the medication is due and not have their medication with them. This occurs when there are traffic accidents, delays in an appointment, or an individual is attending an unscheduled event. If there is an order from the health care practitioner about what to do if the medication can't be administered because of such an event or if the health care practitioner sends an alternate written order, then this is not an omission. Sometimes when an individual visits with family or friends the individual is not given their medication during the visit. This is not an omission either, because the responsibility of administering the medication was that of the family or friend. A previous lesson on documentation discussed how such a situation is entered in the medication record.
Slide 19 – Written Order to hold dose If there is a written order from the health care practitioner telling you to hold a dose of medication under certain circumstances, then this is not an omission. The health care practictioner may write an order instructing you to hold a dose or not administer a dose of medication for a number of reasons such as because of a planned medical procedure, blood work, or another medical condition. For example, there may be a written order that instructs you not to administer a dose of digoxin if the individual has a low heart rate. Holding this dose is not an error of omission.

Transcript
Slide 20 – New prescriptions not received from the pharmacy yet When a new medication is prescribed it should not be entered on the medication record until the new medication is received. The medication cannot be adminstered until it is received so even though there is an order for it, it is not an omission until the medication is received from the pharmacy. Best practice should be a policy at the agency designating which staff person is responsible for following up and making sure the medication is obtained in a timely manner. The policy should also include notification of the health care practitioner if there is a delay in obtaining the medication.
Slide 21 – Listen carefully to the following scenario. Afterward, you will answer the questions. Chuck and Shannon were both assigned to administer medications on their shift. They split the job and each took half of the individuals to administer medication. Chuck started getting medications ready, but Shannon got called away to address an issue. When Shannon returned she started to prepare medications. In the meantime knowing that Shannon was busy on the phone, Chuck started to administer some of the medication designated for Shannon to administer. Chuck gave April her levothyroxine and then continued to the next individual.
Slide 22 – Using the medication record, Shannon prepared April's levothyroxine and administered it. She continued to administer her other medications while Chuck went back to document his administrations. When Shannon returned to document her administrations, she discovered that Chuck had initialed the box for April's levothyroxine. After discussion, they realized that they had both given April a dose of levothyroxine Click Continue when you are ready to go to the question.
Slide 23 – What type of Medication Error was made? A) Wrong Individual B) Wrong Dose C) Wrong Medication D) Wrong Time E) Wrong Route F) Wrong Form G) Wrong Position H) Wrong Technique Once you make your selection, click Check.
Slide 24 – C) Wrong Medication because an extra dose of medication was administered. We learned that 'extra dose of medication administered' is one of the categories of medication errors listed as "Wrong Medication." This typically occurs when one staff person administers the medication without documenting it and another staff person administers it again. Click Continue when you are ready to go to the next question.
Slide 25 – Following the steps of medication administration how could the error have been prevented? A) Chuck should have completed the 4th check of the medication administration process and immediately documented the administration of Levothyroxine. B) Chuck should not have administered her medications because he didn't know how long she would be gone. C) Chuck and Shannon should have communicated verbally when Shannon got called away. D) Consider having only one staff assigned to adminster medication at a time. Once you make your selection, click Check.
Slide 26 – A) Chuck should have completed the 4th check of the medication administration process and immediately documented the administration of Levothyroxine.
Slide 27 – Follow agency policy for: • reporting medication errors to supervisors • documenting the medication errors Errors should be reported as soon as they are discovered.

Transcript
Reporting Medication Errors
Slide 28 – Reporting requirements may differ between types of service locations; however, the principles and reasons for reporting are the same. Discovery and reporting of medication errors should be seen as an opportunity to improve processes around medication management and administration. The evaluation of each medication error can lead to the identification of weaknesses in medication administration processes and allow for their correction and retraining of staff which will prevent future errors**.**
Slide 29 – Evaluating the reasons for medication errors is important to prevent future errors. There are many ways to do this, but the principles are the same. The goal is to identify why the medication error happened and to make changes in the current policies and procedures to prevent the error from happening again.
Slide 30 – The focus is on understanding the occurrence: what happened, why it happened and how it happened. It is important to focus on the error itself and not only on the staff person involved. Unclear, outdated or incomplete policies and procedures often result in the same error being made by multiple staff persons.
Slide 31 – The occurrence of a medication error may be the result of multiple factors. Human error is one factor that may be involved in a medication error. Staff who have not mastered the skills of administering medication may make repeated errors because of not following proper procedures or process. This may be approached as a competency issue and additional training on the proper procedures should be provided. More commonly, system or process failures contribute to the error. The evaluation of the error should include not only the action of the staff, but the process itself. Errors that arise as a result of the process are called System errors. System errors can involve the structural design of the medication administration procedures of an agency or technical issues involving the set-up of the physical environment or the use of equipment. Issues within the work environment can lead to systemic causes of medication errors. These include insufficient staffing, lack of clear assignments and also distractions like the phone or doorbell ringing, poor lighting, or a disorganized work environment.
Slide 32 – Reported errors offer two types of information: information about what happened in order to fix the problem and a way to identify whether the correction worked.
Slide 33 – As stated on their website, The NCC MERP encourages a patient safety environment that rewards reporting, places high value on open communication and shared learning, and allows caregivers to report hazards and errors without fear of reprisal for human error.
Slide 34 – Medication administrators who know that they will be punished for a medication error in the form of docking pay, termination, or other disciplinary procedures will be less likely to report errors. Though at times disciplinary action may be necessary, whenever possible initial steps should include evaluating the policy or procedure, being supportive, and re-educating staff.
Slide 35 – Errors should be reported. By not reporting errors, that information is lost and with it is lost the chance to make procedural changes and prevent further errors. The focus should be on encouraging reporting of errors even though this may initially increase the counted number of errors. Organizations that do not promote reporting may have a low number of reported errors; however, they are still making errors even though they may not get reported. Each of these errors has the potential to harm someone. Making error reporting a quality goal encourages reporting, as has been shown in other industries such as air travel. The primary goal is the safe administration of medication. Accurate reporting helps provide the information to improve the process.

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Transcript
Review the policy relating to reporting medication errors for the service location where you work to ensure all needed information is contained in the report so that the error can be evaluated.
Evaluation of Medication Errors
Slide 36 – Employ critical thinking to evaluate the medication error. Provide detailed answers to the following questions related to the error including: • who • what • where • when • why These answers will identify the elements that contributed directly or indirectly to the medication error. Identify elements related to a medication error and then identify potential solutions to prevent the error from happening again.
Slide 37 – It is also important to consider the nature and severity of the error. Factors include the location and/or timing of the error. Establishing a sequence of events from the actions that lead up to the error will provide the basis for understanding the reason for the error. Evaluation of these factors can help identify a plan of action to prevent the error from reoccurring.
Slide 38 – The goal of evaluating a medication error is to improve the safety of medication administration. This is achieved by responding to errors that have already occurred and also identifying practices that could potentially lead to errors. Errors are best addressed shortly after they occur. Sometimes you may identify one reason for the error that will have a clear solution. Other times there may be more than one cause of the error identified and more than one solution.
Summary
Slides 39 – This lesson about medication errors covered key points that included: • Medication errors are an opportunity to learn and improve the medication administration process. • Medication errors can occur if you fail to follow all the steps in the process including the four checks of the 5 Rights • Evaluating the reasons for errors and potential solutions to prevent a recurrence. • The need to be familiar with medication error reporting requirements for the service location at which you work.
Next Step
Slides 40 – Now that you have completed the lesson, it is time to take the quiz. Please click on the link below to access the quiz.