Medications

April 2015

Home Health VNA
Merrimack Valley Hospice
HomeCare, Inc.

The Leaders in Home Health and Hospice Care

Objectives

- The participant will be able to describe medication reconciliation
- The participant will be able to describe contributing factors to medication errors
- The participant will be able to describe the six rights of safe medication administration

Objectives

- The participant will be able to describe the Comfort Kit procedure
- The participant will be able to discuss pharmacy services

Medication Reconciliation

- Medication reconciliation is important to providing quality care
- Medication reconciliation is a three step process
- It is important to identify the barriers patients may have when taking medications and ways to overcome them

Why is Medication Reconciliation so important?

- The number one problem in treating illnesses is patients' failure to take prescribed medications correctly
- In the US, 50-70% of patients do not take medications properly
- 10% of hospital admissions relate to not taking meds properly, 23% of all nursing home admissions

Statistics

- 22% take less than what is prescribed
- 12% do not fill their prescription at all
- 12% do not take the medication at all
- after buying the prescription
- 29% stop taking the medication before it runs out
- 12-20% take other people's medication

Medication Reconciliation

- Medication reconciliation is the process of identifying the most accurate list of all medications a patient is actually taking – including name, dosage, frequency and route. The information is then used to determine which medications the patient should be taking per physician orders.

Medication Reconciliation Three Step Process

- Verify – Collect an accurate medication list
- Clarify – Clarify any questions about drug/dose/frequency
- Reconcile – Communicate with physician about any identified medication questions or concerns

Health Literacy

- Health literacy is the ability to read, understand and act on health information in order to make appropriate health decisions

- Poor health literacy results in medication errors, impaired ability to remember and follow treatment recommendations, and reduced ability to navigate within the health care system

Why focus on medications?

- Medication use has become increasingly complex
- There has been a substantial increase in the number and variety of medications available
- Medications have different routes of delivery and variable actions (long-acting, short-acting)

Why focus on medications?

- Sometimes the same formulation of a particular drug is sold under more than one trade name, which can cause confusion
- Although treatments for chronic disease have improved over the years, there are more patients with multiple co-morbidities that need multiple medications

Why focus on medications?

- This increases the risk of drug interactions, side-effects and mistakes in administration
- The process of delivering medications to patients often involves a range of health-care professionals
- Communication failures can lead to gaps in the continuity process

Medication Error

- **Any preventable event that may cause or lead to inappropriate medication use**

- **A medication error may result in:**
  - An adverse event, in which a patient is harmed
  - A near miss, in which a patient is nearly harmed
  - Neither harm nor potential for harm or patient harm

Medication Administering

- Administering a medication may include obtaining the medication and having it in a ready-to-use form
- This may involve counting, calculating, mixing, labeling or preparing the drug in some way
- Administering always includes the need to check for allergies and to make sure that the correct dose of the correct medicine is given to the correct patient via the correct route at the correct time

Medication Administering Contributory Factors for Medication Errors

- Classic administration errors are the wrong drug being used, or the wrong dose of a drug being given to the wrong patient, by the wrong route, at the wrong time.
- Not administering a prescribed drug is another form of administration error
- Other administration errors include inadequate communication & documentation or calculation mistakes eg for IV drugs

Medication Monitoring

- Medication monitoring involves observing the patient to determine whether the medication is working, being used correctly and not causing harm

Medication Monitoring Contributory Factors for Medication Errors

- Errors in this area include inadequate monitoring for side-effects, not ceasing medication once the prescribed course has been completed or is clearly not helping the patient, and not completing a prescribed course of medication

- There is a particular risk of a type of communication failure when a patient changes, or moves from hospital to community setting or vice versa

Patient Contributory Factors for Medication Errors

- Certain patients are particularly vulnerable to medication errors
- These include patients with specific conditions (e.g. renal dysfunction)
- Patients taking multiple medications, particularly if these medications have been prescribed by more than one health-care provider

Patient Contributory Factors for Medication Errors

- Patients with a number of health problems
- Patients who do not take an active interest in being informed about their own health and medications
- Patients with memory issues (Alzheimer patients)
- Patients who cannot communicate well, including unconscious patients

Patient Contributory Factors for Medication Errors

- Patients who do not speak the same language as the staff, are also particularly vulnerable to medication errors

Staff Contributory Factors for Medication Errors

- Inexperienced personnel
- Rushing, as in emergency situations
- Multitasking
- Being interrupted mid-task

Staff Contributory Factors for Medication Errors

- Fatigue, boredom and lack of vigilance
- A lack of checking and double-checking habits can also lead to medication errors
- Poor teamwork
- Poor communication between colleagues

Medication Design Contributory Factors for Medication Errors

- Some medications can be easily confused
- Pills are similar in appearance (eg color, shape)
- Have similar names

Medication Design Contributory Factors for Medication Errors

- Ambiguous labeling
- Different preparations or dosages of similar medication may have similar names or packaging

Medication Design Contributory Factors for Medication Errors

- Difficult-to-read dose information on vials
- Lack of measuring instruments (e.g. spoons for syrups)

Remember the 6 Rights of Safe Medication Administration

1. **Right person**
   a. Check the first and last name of the patient
   b. Does the name match the medical order?
   c. Does the name match the name on the medical administration record
   d. Does the name on the medication container match?

Remember the 6 Rights of Safe Medication Administration

2. **Right medication**
   a. Check the name on the medication container
   b. Does the medication match the medical order?
   c. Does the medication match the name on the MAR?

Remember the 6 Rights of Safe Medication Administration

3. **Right dose**
   a. Check the strength and dosage
   b. Is it half-tablet, whole tablet or multiple tablets?
   c. Is it alternating doses at different times or on different days?

Remember the 6 Rights of Safe Medication Administration

4. **Right time**
   a. Check the frequency
   b. Was the time-critical medication given within 30 minutes (earlier or later) than scheduled?
   c. If a second dose of a p.r.n. medication is needed is it too early?

Remember the 6 Rights of Safe Medication Administration

5. **Right route**
   a. Check the route
   b. If eye or ear drops is it right side, left side or both sides?
   c. Is the pill sublingual or swallowed? Can it be crushed or chewed?
   d. Have transdermal patches or injection sites been rotated?

Remember the 6 Rights of Safe Medication Administration

6. **Right documentation**
   a. Check that all documentation is complete and legible
   b. Is the medical order current?
   c. Did you document on the MAR immediately after administering medications?
   d. Have you documented results of p.r.n. medications administered?

Remember the 6 Rights of Safe Medication Administration

- Review “Six Rights of Safe Medication Administration” fact sheet

Some ways to make medication use safer

- Check patient allergies prior to administering any medication
- High-risk medications and situations require extra vigilance with checking and double-checking

Some ways to make medication use safer

- Double-checking own and colleagues' actions contributes to good teamwork and provides additional safeguards

- Computerized prescribing does not remove the need for checking

Some ways to make medication use safer

- Computerized systems solve some problems (e.g. illegible handwriting, confusion around generic and trade names), but also present a new set of challenges

Some ways to make medication use safer

- Never administer a medication unless there is 100% certainty about what it is
- Patients should be encouraged to be actively involved in their own care and medication process

Some ways to make medication use safer

- At each visit, ask the patient if there are any problems or issues with medications
- Check all medications for expiration dates

Some ways to make medication use safer

- Patients should be educated about their medication(s) and contribute significantly to improving the safety of medication use

- Teach patient to report any signs and symptoms that may be related to medication adverse or side effects or lack of effectiveness

Comfort Kits

- Comfort kits are prescribed by patient's attending physician (preferred) or Medical Director (MD or NP)

- Effective and safe use of comfort kit medications requires a responsible caregiver(s) who understands their use, documents doses given, and calls Hospice with questions and problems

Comfort Kits

- **Comfort kit medications and/or dosages are altered by the Hospice team based upon clinical and psychosocial situations, such as:**
  - Substance abuse by patient and/or caregivers
  - Needs cautious and full assessment by IDT before prescribing a kit
  - May require a family meeting, lockbox and controlled substances contract

Comfort Kits

- **Comfort kit medications and/or dosages are altered by the Hospice team based upon clinical and psychosocial situations, such as:**
  - Dementia. Majority of comfort kit medications (opioids, anticholinergics, benzodiazepines) can cause serious side effects in patients with all types of dementia. Haloperidol can worsen symptoms in patients with Parkinson's disease and dementia with Lewy bodies and should be eliminated from the kit.

Comfort Kits

- **Comfort kit medications and/or dosages are altered by the Hospice team based upon clinical and psychosocial situations, such as:**
  - Severe renal failure: morphine is contraindicated and hydromorphone should be substituted for short acting relief of pain and dyspnea

Comfort Kits Procedure

- Comfort Kits are ordered upon admission or during the Hospice stay
- The Admission Nurse will identify the need for the Comfort Kit upon admission and obtain an order from the attending physician
- If the need for a Comfort Kit arises during the Hospice stay, the primary nurse will obtain an order from the attending physician

Comfort Kits Procedure

- If the attending physician is not available to provide a timely order for a Comfort Kit in an urgent situation, an order may be obtained from the Medical Director (MD or NP)

- The availability of a responsible caregiver will be assessed at admission by the Admission Nurse, and throughout the Hospice stay by the primary nurse and other members of the IDT

Comfort Kits Procedure

- Upon admission and throughout the Hospice stay, the patient and caregivers will be assessed for signs/symptoms of substance abuse by the members of the IDT

- The presence of diagnoses of dementia and severe chronic renal failure will be assessed on admission and throughout the Hospice stay to identify situations where the use of the standard Comfort Kit is contraindicated

Comfort Kit Order Set in MobileWyse

- **There is a Comfort Kit Order Set in MobileWyse**

- **You choose which meds to accept**
  - Acetaminophen 650 milligram oral Q4h PRN fever
  - Acetaminophen 650 milligram rectal Q4h PRN fever (1 suppository)
  - Bisacodyl 10 milligram rectal PRN Constipation (1 suppository)
  - Fleet Enema 1 unit rectal PRN Constipation

Comfort Kit Order Set in MobileWyse

- **You choose which meds to accept**
  - Haloperidol 0.5-1 milligram oral/SL !6h PRN Nausea/vomiting/agitation (2mg/1ml)
  - Hyoscyamine 0.125 milligram sublingual Q4h PRN secretions/noisy respirat (.25mg/ml)
  - Lorazepam 0.25-1 milligram oral/SL Q 6h PRN anxiety or agitation (2mg/1ml)
  - Roxanol 5-20 milligrams oral/SL Q2h PRN pain/respiratory distress (20mg/1ml)
  - Senna S 1-4 tablets oral Bid PRN Constipation Orders for Discipline and Treatments SN: 1-2x/wk x 13 wks

Pharmacy Services

- Pharmacy services needed by Hospice patients/families/caregivers and Hospice staff are available 24 hours a day.
- Medications are available through contracts between specific pharmacies and Merrimack Valley Hospice

Pharmacy Services Procedure

- The Hospice nurse contacts the patient's attending physician for medication orders
- The attending physician must submit a verbal or written order to the pharmacy for the medication (may be communicated via RN case manager)
- The pharmacy assumes responsibility for safely and accurately preparing, dispensing and delivering the ordered medication

Pharmacy Services Procedure

- The pharmacy delivers the medication to home care patients or notifies the patient/family/caregiver when the medication is available for pick-up or delivery
- The pharmacy dispenses a quantity of medication consistent with the patient's life expectancy as well as appropriate dosage and frequency of the medication as per MD order

Pharmacy Services Procedure

- Education on drug use and adverse effects is provided to the patient by the pharmacy and the RN Case Manager or designee

Medications

- Under no circumstances will a nurse leave the patient's home with medications