

Policy Proposal

Learner's Name

Capella University

Health Care Law and Policy

Policy Proposal

May, 2019

Policy Proposal

Despite being recognized as one of the region's top choices for health care, Mercy Medical Center has areas for opportunity. Medication errors in the medical and surgery unit have seen a 50% increase from 4 in 2015 to 8 in 2016. Nute suggests that medication errors may result in longer hospital stays and higher rates of mortality and morbidity (as cited in Kavanagh, 2017). According to Rafter, Hickey, Conroy, Condell, O'Connor, Vaughan, Walsh, and Williams, these errors may result in an increase in the cost of health care (as cited in Kavanagh, 2017). Incidents resulting from medication errors require additional resources and more care interventions, which leads to a decrease in the efficiency of health care services provided. Considering the expense medication errors can entail for patients and health care practitioners, there is a need for an organizational policy to address the shortfall in the reduction of medication errors.

Commented [A1]: Good introduction that meets the goal of "explaining the need for the organizational policy."

Strategies to Resolve Medication Errors

Medication Error Analysis

According to Zhan, Smith, Keyes, Hicks, Cousins, and Clancy, because of the fear of repercussions such as disciplinary action being taken, a large number of medication errors go unreported (as cited in Weant, Bailey, & Baker, 2014). However, learning from these errors will help reduce their recurrence and improve care interventions. Every reported error is an opportunity for the development of a countermeasure and will help avoid or reduce the impact of the same error in the future (Weant et al., 2014).

A health care system that exposes patients to medical errors needs to be critically evaluated. Failure mode and effects analysis is a technique that can be used to analyze incidents related to medication errors. Under this method of analysis, the medical center can commission the formation of a multidisciplinary committee that will review processes susceptible to errors.

Based on the inadequacies observed, the committee can classify the medication errors according to the priority in which they need to be addressed (Weant et al., 2014). As part of the analysis, the committee will review the steps in the process, the things that could go wrong, the reasons behind them, and the possible repercussions (Institute for Healthcare Improvement, n.d.). Based on these factors, the committee can recommend actions to reduce the possible errors in the process. The analysis will end with an evaluation of the prescribed actions for improvement (Centers for Medicare and Medicaid Services, n.d.).

Automated Dispensing Cabinets

An automated dispensing cabinet is a computerized medication distribution system that is installed in patient care units. It stores, dispenses, and electronically tracks drugs at the point of care. Using these cabinets can help the medical center profile patients, reduce the time taken to retrieve medication, and track inventory on a real-time basis (Weant et al., 2014). These cabinets usually contain high-alert and controlled medications and can only be accessed using an ID and a password. With the use of these cabinets, nurses will not have to walk long distances to collect the required medication (Rochais, Atkinson, Guilbeault, & Bussi eres, 2014).

The implementation of both these strategies can be affected by certain environmental factors. The efficacy of medication error analysis can be affected if error incidents are underreported or if errors are incorrectly documented. Barach and Small state that error incidents are usually reported verbally despite how frequently they occur. This can lead to an underreporting of errors (as cited in Elden & Ismail, 2016). Moreover, verbally communicating errors can lead to errors in documenting data. According to Claudia, Sharon, DeVSP, Merrell, and Gail, the scope for the improvement of patient safety will be limited if errors are discussed verbally (as cited in Elden & Ismail, 2016). With regard to the use of automated dispensing

cabinets, incorrect restocking is one of the problems that can arise, which can result in treatment delays. Apart from this, inaccurate documentation of doses retrieved from the automated cabinets can also affect timely treatment. This can lead to incorrect administration of medication (Hamilton-Griffin, 2016). Additionally, when care providers such as nurses are affected by heavy workloads and are preoccupied with various tasks at once, they are likely to get interrupted or distracted while collecting and administering medication from the cabinets. To ensure that these issues do not arise, the pharmacy can be asked to share an updated list of the stock on a daily basis. A staff member or nurse can be tasked to cross-check the cabinet stock against the list provided by the pharmacy. Further, reassessing the stock from time to time and using barcode technology for restocking medications can also reduce the possibility of such errors occurring (Pennsylvania Patient Safety Authority, n.d.).

Clinicians need to be provided with continuous education on new drugs, procedures, and policies so that the proposed strategies are effectively implemented. Apart from that, creating simulation environments will also instill confidence in care providers about their competency in medication administration. It is necessary to create a culture of safety within the organization, which will allow care providers to freely report errors without the fear of negative consequences and coercion.

Policy for Managing Medication Errors

Policy Statement

Medication errors pose a risk to patient safety and public health. This policy is a guide for health care practitioners to enable them to take appropriate action in the event of a medication error. The guidelines and recommendations will provide a framework to improve the practice of the two proposed evidence-based strategies.

Scope

The policy applies to nursing staff, medical staff, emergency and allied care practitioners, and staff employed at the pharmacy. All concerned individuals are responsible for the prescription, dispensation, and administration of medicines.

Guidelines for Implementing Evidence-Based Strategies

The multidisciplinary local patient safety committee (which includes professionals from various disciplines such as nursing, pharmacy, and medicine) should regularly go over the existing action plan to improve health care outcomes. The committee must assess apprehensions and go over events that possibly endanger patient safety. It should also analyze trends in medication errors as well as address systemic weaknesses (Polnariiev, 2016). According to Schlesselman, around half of all possible medication error events can be averted by patient education. Pharmacists can counsel patients when they are visited for consultations. Training sessions on counseling patients will aid the effectiveness of pharmacists' consultations. These training sessions should include an emphasis on asking open-ended questions to patients (as cited in Polnariiev, 2016) such as the following three prime questions: (1.) What did the physician tell you the medication is for?, (2.) How did the physician tell you to take the medication?, and (3.) What did the physician tell you to expect? The sessions should also emphasize listening to patients patiently, learning to identify inaccuracies in their responses, and demonstrating to them the use of medication devices (Lauster & Srivastava, 2013).

Before the administration of any medication, a review of medication orders by a pharmacist will ensure the safety of the hospital's medication system. Barcode verification should be put in place for the stocking of medications. Limited amounts of medication should be placed in the cabinets, and the cabinets should be refilled frequently (Hyland, Koczmara,

Commented [A2]: I think the idea of the multidisciplinary team is good; the active involvement of all key stakeholders will be critical to success.

Salsman, Musing, & Greenall, 2007). For the nursing staff, barcode verification will validate the 7 rights of medication administration: right patient, right drug, right dose, right time, right route, right reason, and right documentation. These 7 rights will be verified while administering medication. A nurse will scan the barcode on his or her identification badge, on the patient's wristband, and on the medication. Software will analyze the real-time data, and based on the database, it will generate approvals or warnings (Shah, Lo, Babich, Tsao, & Bansback, 2016).

When choosing and placing medications within automated dispensing cabinets, products that look alike should not be placed inside the same multiple-product drawer. Medications should be retrieved from the cabinet for one patient at a time and administered without delay. Training sessions about the right practices related to the use of automated dispensing cabinets should be organized for the staff. The staff must be educated about unsafe practices that can affect patient outcomes negatively such as retrieving medications in advance and retrieving medications for multiple patients. They must also be educated about the need to report problems such as similar drug name pairs being displayed on the drug selection screens on the cabinets (Hyland et al., 2007).

Stakeholder Involvement in Implementing Proposed Strategies

Assistance can be sought from key administrative personnel such as the chief executive officer, director of nursing, or chief operating officer. These individuals can form a quality committee where they can share their expertise and monitor the effective implementation of the proposed strategies. By establishing role accountability and articulating the organization's quality improvement norms from time to time, the key administrative personnel can reinforce a culture of safety among the health care staff (Parand, Dopson, Renz, & Vincent, 2014). The main nursing staff should also be involved because they deal with a lot of medication administration

problems firsthand. They can help in the identification of the inadequacies that cause medication errors (Blake, 2017). While receiving prescriptions at the pharmacy, pharmacists can check for discrepancies and contact the prescribers for any changes in orders before the prescriptions are filled out (The Health Foundation, 2012).

The involvement of the hospital administration and the care providers will lead to transparency in the implementation of the strategies. It will bring in multidisciplinary expertise, create room for debate and discussion, and ensure that the parties involved have a say in decisions concerning these strategies. Therefore, a partnership between the hospital administration and the care providers will ensure that the proposed strategies are implemented effectively.

Conclusion

Incidents resulting from medication errors can reduce a health care organization's efficiency. However, the implementation of medication error analysis and the use of automated dispensing cabinets can substantially reduce the chances of such errors occurring. Above all, the most important thing for the proposed policy to be effective is the creation of a culture of safety and quality improvement at Mercy Medical Center.

References

- Blake, R. W. (2017). Reducing medication errors through workflow redesign. *Journal of Nursing & Interprofessional Leadership in Quality & Safety*, 1(2), 5. Retrieved from <https://digitalcommons.library.tmc.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1006&context=uthoustonjqualsafe>
- Centers for Medicare and Medicaid Services. (n.d.). *Guidance for performing failure mode and effects analysis with performance improvement projects*. Retrieved from <https://cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceForFMEA.pdf>
- Elden, N. M. K., & Ismail, A. (2016). The importance of medication errors reporting in improving the quality of clinical care services. *Global Journal of Health Science*, 8(8), 243–251. Retrieved from <https://ncbi.nlm.nih.gov/pmc/articles/PMC5016354/>
- Hamilton-Griffin, K. (2016). *Developing improvement strategies on the use of automated dispensing cabinets to reduce medication errors in a hospital setting* (Doctoral dissertation). Retrieved from <https://search-proquest-com.library.capella.edu/docview/1810160234?pq-origsite=summon>
- Hyland, S., Koczmara, C., Salsman, B., Musing, E. L. S., & Greenall, J. (2007). Optimizing the use of automated dispensing cabinets. *The Canadian Journal of Hospital Pharmacy*, 60(5), 332–334. Retrieved from <https://www.ismp-canada.org/download/cjhp/cjhp0711.pdf>
- Institute for Healthcare Improvement. (n.d.). Failure modes and effects analysis. Retrieved from http://ucdenver.edu/academics/colleges/medicalschooll/facultyAffairs/moc/Forms/Documents/MOCPAP/FailureModesandEffectsAnalysis_IHI.pdf

- Kavanagh, C. (2017). Medication governance: Preventing errors and promoting patient safety. *British Journal of Nursing*, 26(3), 159–165. Retrieved from <http://library.capella.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=121207143&site=ehost-live&scope=site>
- Lauster, C. D., & Srivastava, S. B. (2013). *Fundamental skills for patient care in pharmacy practice*. Retrieved from https://books.google.co.in/books?id=r-4xBNa57WkC&pg=PA161&lpg=PA161&dq=Indian+Health+Service%E2%80%99s+%E2%80%9CThree+Prime+Questions%E2%80%9D&source=bl&ots=e7FJ3mTty0&sig=dJGwJMF6C2qUI-aNlKX_qSSpSvY&hl=en&sa=X&ved=2ahUKEwibhI6s0-neAhWHv48KHZmPCv0Q6AEwBnoECAUQAQ#v=onepage&q=Indian%20Health%20Service%E2%80%99s%20%E2%80%9CThree%20Prime%20Questions%E2%80%9D&f=false
- Parand, A., Dopson, S., Renz, A., & Vincent, C. (2014). The role of hospital managers in quality and patient safety: A systematic review. *BMJ Open*, 4(9). Retrieved from <https://ncbi.nlm.nih.gov/pmc/articles/PMC4158193/>
- Pennsylvania Patient Safety Authority. (n.d.). *Problems associated with automated dispensing cabinets*. Retrieved from http://patientsafety.pa.gov/ADVISORIES/documents/200509_21.pdf
- Polnariev, A. (2016). Using the medication error prioritization system to improve patient safety. *Pharmacy and Therapeutics*, 41(1), 54–59. Retrieved from https://ncbi.nlm.nih.gov/pmc/articles/PMC4699487/#__ffn_sectitle
- Rochais, É., Atkinson, S., Guilbeault, M., & Bussi  res, J.-F. (2014). Nursing perception of the impact of automated dispensing cabinets on patient safety and ergonomics in a teaching

health care center. *Journal of Pharmacy Practice*, 27(2), 150–157. Retrieved from <https://journals-sagepub-com.library.capella.edu/doi/10.1177/0897190013507082>

Shah, K., Lo, C., Babich, M., Tsao, N. W., & Bansback, N. J. (2016). Bar code medication administration technology: A systematic review of impact on patient safety when used with computerized prescriber order entry and automated dispensing devices. *The Canadian Journal of Hospital Pharmacy*, 69(5), 394–402. Retrieved from <https://ncbi.nlm.nih.gov/pmc/articles/PMC5085324/>

The Health Foundation. (2012). Evidence scan: Reducing prescribing errors. Retrieved from <https://health.org.uk/sites/default/files/ReducingPrescribingErrors.pdf>

Weant, K. A., Bailey, A. M., & Baker, S. N. (2014). Strategies for reducing medication errors in the emergency department. *Open Access Emergency Medicine*, 6, 45–55. Retrieved from https://ncbi.nlm.nih.gov/pmc/articles/PMC4753984/#__ffn_sectitle