



Improvement Plan In-Service Presentation

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Agenda and Outcomes

The concern to be addressed today is the increase in medication errors on the unit over the past 6 months with increasing severity. The most recent medication error nearly resulted in a resident overdose. This is considered a close call as defined by the Ohio Department of Medicaid (*Ohio Department of Medicaid*, n.d.). This is a high-risk situation because it could cause a resident to be harmed in the future. We have identified a root cause of interruptions and distractions during medication administration. Today will be a refresher of the “five rights” of medication administration which each nurse will be expected to incorporate into their daily medication administration regimen. Our goal is to decrease and eliminate medication errors and injury to our residents and sanctions from the state.

Agenda and Outcomes (cont'd)

The following topics will be covered

- Safety Improvement Plan
- Your (nurse) role and Importance of your role
- The “five rights” of medication administration
- New Process and Skills Practice
- Soliciting Feedback (Questions)

Safety Improvement Plan

- The current issue facing out facility in the nursing facility is an increase in medication errors over the past 6 months.
- The most recent medication error resulted in a near resident overdose or “close call.”
- We will follow the Plan-Do-Study-Act (PDSA) Model since we must take immediate action to change this trend (Donnelly & Paul Leland Kirk, 2015).
- We must address this issue immediately because of the increased risk of patient harm.
- There is increased risk of state sanctions due to medication errors

NOTE: Our “close call” can be considered a high-risk situation because it could cause resident harm in the future as defined by the Ohio Department of Medicaid (*Ohio Department of Medicaid*, n.d.). The PDSA Model will allow us to develop a corrective action plan with the nurse taking a lead role in developing a plan, carrying out the plan and identifying the consequences of the plan and deciding what modifications are needed to the plan (Donnelly & Paul Leland Kirk, 2015).

Audience's Role and Importance to the Process

- At the end of this in-service each nurse will be able to define medication error, identify methods to prevent medication errors
- Each nurse is expected to take a lead role in decreasing the incidence of medication errors and to be professionally accountable.
- This in-service serves as a refresher on the “five rights” of medication administration.
- We also want to be sure that each nurse is aware that if the resident refuses a medication it must be documented in the medication record.
- It is not our goal to make judgments about the person(s) involved in the medication error.
- We are aware of the stressors in the work environment and encourage the nurses to support one another through increased communication and working cooperatively together (Scott, 2016).
- We are encouraging nurses to avoid short cuts and to identify any issues encountered when administering medication
- **NOTE:** A medication error is any error that happens at any point in the medication process (Martyn et al., 2019).

Audience's Role and Importance to the Process

- By working together the nurses will be able to make sure that all orders are transcribed and sent to the pharmacy for filling.
- The nurses can have a positive impact on the correct administration of medications by checking medications such as narcotics with another nurse prior to administration (Martyn et al., 2019)
- **NOTE:** Education on the “five rights” of medication is vital to our success. The “five rights” is an accepted guide to ensure that the right patient gets the right medication at the right dose at the right time and by the right route (Martyn et al., 2019).

New Process and Skills Practice

- The new or refresher process we want to introduce is known as the “ Five Rights” of medication administration
- Right patient- How can this be confirmed? What other ways can identify be confirmed? Ask the patient to tell you their name and date of birth
- Right medication-How can this be confirmed? Reading medication record and medicine packaging. Use magnifying glass.
- Right time and right dose and the right route-Confirmation includes comparing the medication administration record to the actual provider order (Medication reconciliation when readmitted to facility). Confirmation can also include checking certain medications, such as narcotics, with another nurse prior to administration.
- Patient identification activity. What other ways can patient identification be verified? wrist band if used in the facility, posting member’s picture on their medication administration record with their name and date of birth on it
- **NOTE:** The “five rights” is an accepted guide for safe medication administration (Martyn et al., 2019). It is important that the strategies we employ are not complicated or time-consuming.

New Process and Skills Practice

- What if the patient refuses medications? Techniques to address patient refusal of medications can vary.
- What other strategies can be used if the patient refuses medication? Explain any change in color or shape of medications due to generic versus brand name. Showing the patient a picture of the medicine in the medication handbook that is on the medication cart. Written notes for the patient can be used if the patient is hard of hearing. Helping the patient understand why the medication is needed
- Group activity: Medication names that sound alike and medications that look alike: (GlyBURIDE and GliPIZIDE). Tall man lettering has the potential to avoid confusion of very different compounds, such as LaMICtal and LamISIL (Bonner, 2016)
- What could go wrong here? Example: MS 2.0 mg po. QD. MS could be Morphine Sulfate or Magnesium Sulfate, the zero after the decimal could be mistaken for 20 rather than 2.0. The QD could be mistaken for every day, QOD-every other day or QID-4 times a day

Soliciting Feedback

- Since the nurses employed within the facility varies between 3 year and 16 years, their feedback on what checks they are currently doing during medication administration and the limitations they have identified to date is important to the success of implementing the “five rights.”
- What are their thoughts on using a checklist or cognitive aid during medication administration while employing the “five rights.”
- Assure the nurses that the information solicited during this in-service will be shared with management so they can be incorporated into the plan of corrections.
- Encourage the staff to communicate with one another to help solicit positive change.
- Suggestions offered by the attendees included a “Do not interrupt” sign or vest to be used during medication administration

Speaker notes

- The administrator, Mr. Silva identified an increase in medication errors on the unit over the past 6 months which has culminated in an error that nearly resulted in a resident overdose.
- This medication error constitutes a “close call” because it could have resulted in harm to a resident (*Ohio Department of Medicaid*, n.d.). Because of the nature of this event and the steady increase, a team including the nurse manager and nurses was developed to define and address the root cause of the medication errors. The goal of the team was to create the timeline of the harmful event using facts and to determine if the contributing factors at the time of the medication error increased the likelihood of the error (*Ohio Department of Medicaid*, n.d.).
- The Plan-Do-Study-Act model identified by Donnelly & Kirk was used to develop a corrective action plan with the nurses taking a lead role in developing a plan, carrying out the plan, identifying the consequences of the plan and determining the modifications to the plan ((Donnelly & Paul Leland Kirk, 2015).

Speaker Notes

- Medication errors have been increasing over the past 6 months and because of the nature of the most recent medication error there is immediate need for implementation of a correction plan.
- This in-service is to re-educate the nurses on the “five rights” of medication administration which is a primary responsibility of the nurse (Martyn et al., 2019).
- Although nurses are educationally prepared and professionally accountable for medication administration it does not preclude them from being affected by the stressors of the work environment (Martyn et al., 2019).
- Each nurse must take the responsibility to confirm the patient’s identity before any medicine is given. Martyn found that this step was often skipped and the patient was only identified by the nurse calling their name (Martyn et al., 2019). There is more to medication administration than just identifying the patient.
- The “five rights” is an accepted guide for safe administration of medication to ensure the right patient gets the right medication at the right time at the right dosage and by the right route (Martyn et al., 2019)

Speaker notes

- The workload of the nurses at Clarion Court can be challenging and it is important that the nurses be willing to manage their time by working collaboratively and cooperatively with each other to make sure that all orders are transcribed correctly and sent to the pharmacy provider for filling.
- The nurses can work together on confirming medication time, dosage and route by comparing what is in the medication administration record with the actual provider order and checking certain medications, such as narcotics with another nurse prior to administration (Martyn et al., 2019).
- Another component related to the “five rights” is the patient’s right to refuse. The nurses may need to use their negotiation skills with the patient during the medication administration process. If they are not successful, they need to make sure they clearly document the patient’s refusal in the patient’s record (Martyn et al., 2019).

Speaker notes

- It is important that the nurses work collaboratively together to address the impact of being interrupted or distracted during medication administration (Scott, 2016).
- Working together the nurse can identify actions that can simplify the process by eliminating unnecessary steps, using a checklist or cognitive aids along with enhanced communication techniques and documentation.
- Management is committed to providing the nursing staff with the necessary support to make the corrective action plan successful in decreasing the frequency of medication errors.
- To garner success each nurse must be willing to view this plan as a positive way and commit to using their skills to promote the success of this plan for the benefit of the health and safety of each patient in the facility.

NOTE: During the development of this assessment, I used Summon the Capella University Library internal search engine. I searched databases within the Nursing and Health Sciences and selected the advanced option of medication errors to assure that results were peer-reviewed and published within the past 5 years.

References

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