

Safe Medication Delivery

BY DONNA CONLIN-COATE, RN

In 1999, a somber report revealed the grim facts on medication errors: “To Err Is Human: Building a Safer Health System” concluded that as many as 7,000 Americans die from medication errors each year.¹ In July 2006, the IOM released a new report, “Preventing Medication Errors,” stating that the frequency of medication errors and related injuries was still a serious concern.²

As caregivers, we are responsible for the accuracy of medication administration. Observing the “five rights” of medication administration (right person, right medication, right time, right dose and right route) has long been the standard of practice to ensure the safety of this task. A medication error occurs when a drug is not administered as prescribed. Examples of medication errors include any deviation from the five rights.

RIGHT PERSON

Administer medication only to the person for whom it is prescribed. Every facility has a policy for correct identification. The most common method is using a picture of the resident. It would be ideal to place the photo in the front of each medication administration record (MAR). Make sure the photo is truly reflective of the person. Note facial characteristics and make sure the resident’s name and the name on the photograph match. If the resident’s weight has changed significantly, take a new picture. Encourage facility management to update photos in conjunction with quarterly care conferences or other quarterly meetings.

RIGHT MEDICATION

Identifying the right medication starts when you select the medication from the medication cart. Compare the medication label to the MAR three times prior to medication administration. If there is a discrepancy between the medication label and the MAR, re-check the physician orders before administering the medication. If you need further clarification, contact the physician and ask for a written clarification order. Be on alert for medications with sound-alike names (hydroxyzine and hydralazine or lorazepam and alprazolam), which elevate the chance for an error.

RIGHT DOSE

A physician determines medication dosage by evaluating lab values, symptoms, specific diagnosis and goals of therapy. Delivering the correct dose is critical to achieving desired therapeutic response. Use a calibration tool to measure liquid medications accurately. Check all dosages against the physician’s orders. A dosage error can occur in all medication forms. For example, Heparin injection has been mistakenly used as a Heparin flush. Coumadin dosages can change daily.

■ TIP BOX

Standardization Improves Safety

Resident safety is enhanced and liability reduced by standardizing your med pass system, regardless of the pharmacy provider you choose. Look at factors such as efficiency, error control, waste reduction, tamper evidence and reordering capabilities before choosing a system.

—Mark Keffeler, president, OPUS Medication Systems

RIGHT ROUTE

Some medications are available in multiple forms. Nitroglycerin is available as a capsule, a sublingual tablet and a transdermal patch. If you instruct a patient to swallow a sublingual tablet, you’ve made a medication error because the pill should go under the tongue. Your pharmacy label will specify the right route. Don’t change the route without a physician order.

RIGHT TIME

A common time error involves medication orders that indicate a medication should be taken before meals. You should administer these 30 minutes prior to the meal. If the medication order indicates that the patient take the drug after meals, you should administer it 30 minutes after a meal is completed.

Some pharmacies offer color-coded systems to help organize medication administration according to time prescribed. For example, all

scheduled morning medications would be in a pink cassette, whereas afternoon cassettes are green and evening cassettes are gray.

Another helpful idea is to color code the medication administration time on the MAR. For example, you could highlight all morning medications in a light color and evening medications in a darker color. If you use color-coded systems, highlight your MAR administration times in the same colors as on the system for easy visual identification.

TECHNICAL ADVANCES

Today’s technology can help close the gap of human error. One example is medication carts with computers. A computerized MAR reflects all medication changes up to the print date, which decreases the potential for a transcription error. Also, some Internet-based software systems contain a bar-coding system that accounts for the “five rights” of medication administration. Other medication software allows the caregiver to scan medications into a computer. This specialized computer then documents medication administration while counting down remaining doses and communicating refill needs to the dispensing pharmacy.

Whether we are using unit-dose medications or the latest pharmaceutical technology, we, as caregivers, are ultimately responsible for ensuring the accuracy of medication administration. ■

References are available at www.advanceweb.com/ltc.

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The purpose of this caregiver education handout is to further explain or remind you about correct procedures. This handout is a general guide only. If you have specific questions, be sure to discuss them with your supervisor. This handout may be reproduced for distribution to caregivers.

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