Topic 11

Improving medication safety
Rationale

- Medication use has become increasingly complex in recent times
- Medication error is a major cause of preventable patient harm
- As future health-care workers, you will have an important role in making medication use safe
Learning objectives

- To provide an overview of medication safety
- To encourage students to continue to learn and practise ways to improve the safety of medication use
Knowledge requirements

- Understand the scale of medication error
- Understand the steps involved in a patient using medication
- Identify factors that contribute to medication error
- Learn how to make medication use safer
- Understand the benefits of a multidisciplinary approach to medication safety
Performance requirements

Acknowledge that medication safety is a topic and an understanding of the area will affect how you perform the following tasks:

- Use generic names where appropriate
- Tailor your prescribing for each patient
- Learn and practise thorough medication history taking
- Know which medications are high-risk and take precautions
- Be very familiar with the medication you prescribe and/or dispense
- Use memory aids
- Remember the 5 Rs when prescribing and administering
- Communicate clearly
- Develop checking habits
- Encourage patients to be actively involved in the process
- Report and learn from medication errors
Definitions (1)

- **Side-effect**: a known effect, other than that primarily intended, relating to the pharmacological properties of a medication
  - e.g. opiate analgesia often causes nausea

- **Adverse reaction**: unexpected harm arising from a justified action where the correct process was followed for the context in which the event occurred
  - e.g. an unexpected allergic reaction in a patient taking a medication for the first time

- **Error**: failure to carry out a planned action as intended or application of an incorrect plan

- **Adverse event**: an incident in which a patient is harmed

*Source: Conceptual Framework for the International Classification for patient safety*
Definitions (2)

- **Adverse drug event:**
  - May be preventable (e.g. the result of an error) or
  - May not be preventable (e.g. the result of an adverse drug reaction or side-effect)

- **Medication error may result in ...**
  - An adverse event if a patient is harmed
  - A near miss if a patient is nearly harmed or
  - Neither harm nor potential for harm

- **Medication errors are preventable**
Steps in using medication

- Prescribing
- Administering
- Monitoring

Note: these steps may be carried out by health-care workers or the patient; e.g. self-prescribing over-the-counter medication and self-administering medication at home
Prescribing involves …

- Choosing an appropriate medication for a given clinical situation, taking individual patient factors into account, such as allergies

- Selecting the administration route, dose, time and regimen

- Communicating details of the plan with:
  - Whoever will administer the medication (written-transcribing and/or verbal)
  - And the patient

- Documentation
How can prescribing go wrong?

- Inadequate knowledge about drug indications and contraindications
- Not considering individual patient factors, such as allergies, pregnancy, co-morbidities, other medications
- Wrong patient, wrong dose, wrong time, wrong drug, wrong route
- Inadequate communication (written, verbal)
- Documentation - illegible, incomplete, ambiguous
- Mathematical error when calculating dosage
- Incorrect data entry when using computerized prescribing e.g. duplication, omission, wrong number
Look-a-like and sound-a-like medications

2 examples:

- Avanza (mirtazapine, antidepressant); Avandia (rosiglitazone, diabetes medicine)
- Celebrex (celecoxib, anti-inflammatory); Cerebryx (fosphenytoin, anticonvulsant); Celexa (Citalpram, antidepressant)
Ambiguous nomenclature

- Tegretol 100mg
- S/C
- 1.0 mg
- .1 mg

- Tegreto 1100 mg
- S/L
- 10 mg
- 1 mg
Avoiding ambiguous nomenclature

- Avoid trailing zeros
  e.g. write 1 not 1.0

- Use leading zeros
  e.g. write 0.1 not .1

- Know accepted local terminology

- Write neatly, print if necessary
Administration involves …

- Obtaining the medication in a ready-to-use form; may involve counting, calculating, mixing, labeling or preparing in some way

- Checking for allergies

- Giving the right medication to the right patient, in the right dose, via the right route, at the right time

- Documentation
How can drug administration go wrong?

- Wrong patient
- Wrong route
- Wrong time
- Wrong dose
- Wrong drug
- Omission, failure to administer
- Inadequate documentation
The 5 Rs

- Right Drug
- Right Route
- Right Time
- Right Dose
- Right Patient
Calculation errors

Can you answer the following question?

A patient needs 300 micrograms of a medication that comes in a 1 ml ampoule containing 1 mg of the drug. What volume do you draw up and inject?
Monitoring involves …

- Observing the patient to determine if the medication is working, being used appropriately and not harming the patient

- Documentation
How can monitoring go wrong?

- Lack of monitoring for side-effects
- Drug not ceased if not working, or course completed
- Drug ceased before course completed
- Drug levels not measured, or not followed up
- Communication failures
Do you know which drugs need blood tests to monitor levels?
Which patients are most at risk of medication error?

- Patients on multiple medications
- Patients with another condition, e.g. renal impairment, pregnancy
- Patients who cannot communicate well
- Patients who have more than one doctor
- Patients who do not take an active role in their own medication use
- Children and babies (dose calculations required)
In what situations are staff most likely to contribute to a medication error?

- Inexperience
- Rushing
- Doing two things at once
- Interruptions
- Fatigue, boredom, being on “automatic pilot” leading to failure to check and double-check
- Lack of checking and double checking habits
- Poor teamwork and/or communication between colleagues
- Reluctance to use memory aids
How can workplace design contribute to medication errors?

- Absence of a safety culture in the workplace
e.g. poor reporting systems and failure to learn from past near misses and adverse events

- Absence of memory aids for staff

- Inadequate staff numbers
How can medication presentation contribute to medication errors?

- Look-alike, sound-alike medications
- Ambiguous labeling
Ways to make medication use safer

What you can do to make medication use safer:

- Use generic names
- Tailor prescribing for individual patients
- Learn and practise collecting complete medication histories
- Know the high-risk medications and take precautions
- Be very familiar with the medications you prescribe
- Use memory aids
- Remember the 5 Rs
- Communicate clearly
- Develop checking habits
- Encourage patients to be actively involved
- Report and learn from errors
Use generic names rather than trade names
Tailor your prescribing for each individual patient

Consider:

- Allergies
- Co-morbidities (especially liver and renal impairment)
- Other medication
- Pregnancy and breastfeeding
- Size of patient
Learn and practise collecting complete medication histories

- Include name, dose, route, frequency, duration of every drug
- Ask about recently ceased medications
- Ask about over-the-counter medications, dietary supplements and complementary medicines
- Make sure what patient actually takes matches your list:
  - Be particularly careful across transitions of care
  - Practise medication reconciliation at admission to and discharge from hospital
- Look up any medications you are unfamiliar with
- Consider drug interactions, medications that can be ceased and medications that may be causing side-effects
- Always include allergy history
Know which medications are high risk and take precautions

- Narrow therapeutic window
- Multiple interactions with other medications
- Potent medications
- Complex dosage and monitoring schedules

Examples:
- Oral anticoagulants
- Insulin
- Chemotherapeutic agents
- Neuromuscular blocking agents
- Aminoglycoside antibiotics
- Intravenous potassium
- Emergency medications (potent and used in high pressure situations)
Be very familiar with the medications you prescribe

- Do some homework on every medication you prescribe

- Suggested framework
  - Pharmacology
  - Indications
  - Contraindications
  - Side-effects
  - Special precautions
  - Dose and administration
  - Regimen
Use memory aids

- Textbooks
- Personal digital assistant
- Computer programmes, computerized prescribing
- Protocols

Free up your brain for problem solving rather than remembering facts and figures that can be stored elsewhere.

Looking things up if unsure is a marker of safe practice, not incompetence!
Remember the 5 Rs when prescribing and administering

Can you remember what they are?

- Right Drug
- Right Dose
- Right Route
- Right Time
- Right Patient
Communicate clearly

- State the obvious
- Write clearly and legibly
- The 5 Rs
- Close the loop
Develop checking habits (1)

- When prescribing a medication
- When administering medication:
  - Check for allergies
  - Check the 5 Rs
- Remember computerized systems still require checking
- Always check and it will become a habit!
Develop checking habits (2)

- Some useful maxims …
- Unlabelled medications belong in the bin
- Never administer a medication unless you are 100% sure you know what it is
- Practice makes permanent, perfect practice makes perfect

Start your checking habits now!
Encourage patients to be actively involved in the process

- When prescribing a new medication provide patients with the following information:
  - Name, purpose and action of the medication
  - Dose, route and administration schedule
  - Special instructions, directions and precautions
  - Common side-effects and interactions
  - How the medication will be monitored

- Encourage patients to keep a written record of their medications and allergies

- Encourage patients to present this information whenever they consult a doctor
Report and learn from medication errors
Safe practice skills for students to develop and practise …

- Whenever learning and practising skills that involve medication use, consider the potential hazards to the patient and what you can do to enhance patient safety.

- Knowledge of medication safety will impact the way you:
  - Prescribe, document and administer medication
  - Use memory aids and perform drug calculations
  - Perform medication and allergy histories
  - Communicate with colleagues
  - Involve and educate patients about their medication
  - Learn from medication errors and near misses
Medications can greatly improve health when used wisely and correctly

Yet, medication error is common and is causing preventable human suffering and financial cost

Remember that using medications to help patients is not a risk-free activity

Know your responsibilities and work hard to make medication use safe for your patients
For discussion

- Are you aware of any incidents in which a patient was harmed by medication?
- Describe what happened
- Was the situation a result of a side-effect, adverse drug reaction or medication error?
Calculation errors (1)

- Can you answer the following question?

A 12 kg, 2-year-old boy requires 15 mg/kg of a medication that comes as a syrup with a concentration of 120 mg/5mls. How many mls do you prescribe?
Can you answer the following question?

A patient needs 300 micrograms of a medication that comes in a 1 ml ampoule containing 1 mg of the drug. What volume do you draw up and inject?
Example case (1)

- A 74-year-old man sees a community doctor for treatment of new onset stable angina
- The doctor has not met this patient before and takes a full past history and medication history
- He discovers the patient has been healthy and only takes medication for headaches
- The patient cannot recall the name of the headache medication
- The doctor assumes it is an analgesic that the patient takes whenever he develops a headache
Example case (2)

- But the medication is actually a beta-blocker that he takes every day for migraine; this medication was prescribed by a different doctor.

- The doctor commences the patient on aspirin and another beta-blocker for the angina.

- After commencing the new medication, the patient develops bradycardia and postural hypotension.

- Unfortunately, the patient has a fall three days later due to dizziness on standing; he fractures his hip in the fall.
What factors contributed to this medication error?

- Two drugs of the same class prescribed unknowingly with potentiation of side-effects
- Patient not well informed about his medications
- Patient did not bring medication list with him when consulting the doctor
- Doctor did not do a thorough enough medication history
- Two doctors prescribing for one patient
- Patient may not have been warned of potential side-effects and of what to do if side-effects occur
How could this situation have been prevented?

- Patient education regarding:
  - Regular medication
  - Potential side-effects
  - The importance of being actively involved in their own care - e.g. having a medication list

- More thorough medication history
Case (1)

- A 38-year-old woman comes to the hospital with 20 minutes of itchy red rash and facial swelling; she has a history of serious allergic reactions

- A nurse draws up 10 mls of 1:10,000 adrenaline (epinephrine) into a 10 ml syringe and leaves it at the bedside ready to use (1 mg in total) just in case the doctor requests it

- Meanwhile the doctor inserts an intravenous cannula

- The doctor sees the 10 ml syringe of clear fluid that the nurse has drawn up and assumes it is normal saline
Case (2)

- There is no communication between the doctor and the nurse at this time.

- The doctor gives all 10mls of adrenaline (epinephrine) through the intravenous cannula thinking he is using saline to flush the line.

- The patient suddenly feels terrible, anxious, becomes tachycardic and then becomes unconscious with no pulse.

- She is discovered to be in ventricular tachycardia, is resuscitated and fortunately makes a good recovery.

- Recommended dose of adrenaline (epinephrine) in anaphylaxis is 0.3 - 0.5 mg IM, this patient received 1mg IV.
Can you identify the contributing factors to this error?

- Assumptions
- Lack of communication
- Inadequate labeling of syringe
- Giving a substance without checking and double-checking what it is
- Lack of care with a potent medication
How could this error have been prevented?

- Never give a medication unless you are sure you know what it is; be suspicious of unlabelled syringes
- Never use an unlabelled syringe unless you have drawn the medication up yourself
- Label all syringes
- Communication - nurse and doctor to keep each other informed of what they are doing  
  e.g. nurse: “I’m drawing up some adrenaline”
- Develop checking habits before administering every medication … go through the 5 Rs  
  e.g. doctor: “What is in this syringe?”
Example case (1)

- A patient is commenced on oral anticoagulants in hospital for treatment of a deep venous thrombosis following an ankle fracture.

- The intended treatment course is 3-6 months though neither the patient nor the community doctor are aware of the planned duration of treatment.

- Patient continues medication for several years, being unnecessarily exposed to the increased risk of bleeding associated with this medication.
Example case (2)

- The patient is prescribed a course of antibiotics for a dental infection.
- 9 days later the patient becomes unwell with back pain and hypotension, a result of a spontaneous retroperitoneal haemorrhage, requiring hospitalization and a blood transfusion.
- International normalized ratio (INR) reading is grossly elevated, anticoagulant effect has been potentiated by the antibiotics.
Can you identify the contributing factors for this medication error?

- Lack of communication and hence continuity of care between the hospital and the community
- Patient not informed of the plan to cease medication
- The interaction between antibiotic and anticoagulant was not anticipated by the doctor who prescribed the antibiotic even though this is a known phenomenon
- Lack of monitoring; blood tests would have detected the exaggerated anticoagulation effect in time to correct the problem
How could this error have been prevented?

- Effective communication
  - e.g. discharge letter from hospital to community doctor
  - e.g. patient information

- Memory aids and alerting systems to help doctors notice potential adverse drug interactions

- Being aware of common pitfalls in medications you prescribe

- Monitoring medication effects when indicated
How could the patient help prevent this error?

- Asking more questions:
  - “How long will I need this new medication for?”
  - “Will this antibiotic interact with my other medication?”

- How can the doctor encourage the patient to ask more questions?