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Did You Connect the Dots? Medication Safety

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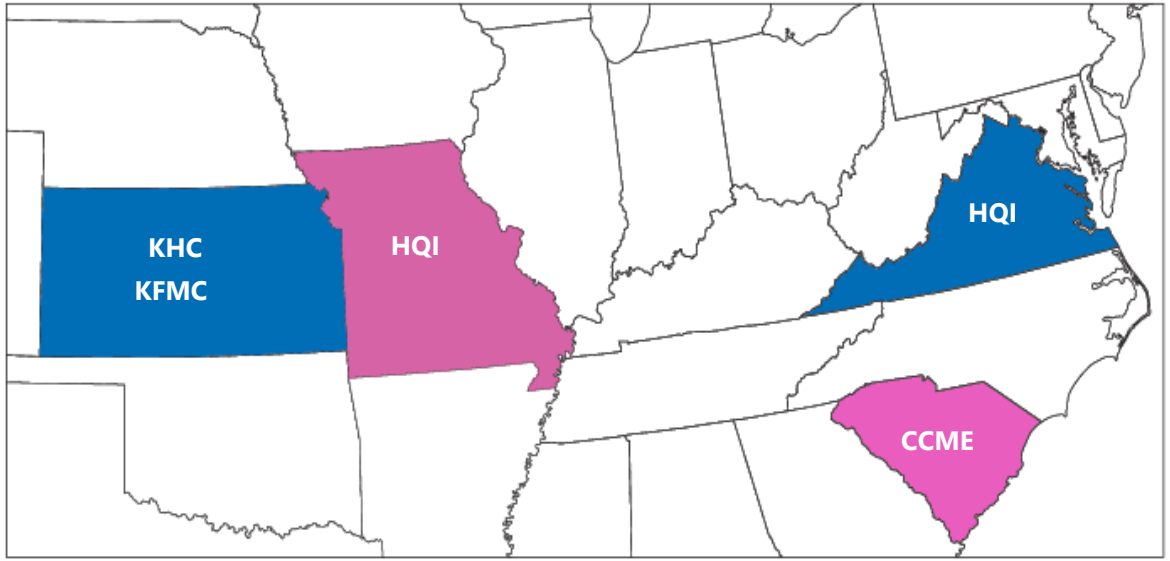

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Logistics – Zoom Webinar

To ask a question, click on the **Q&A** icon.

Raise your hand if you want to verbally ask a question.

Resources from today's session will be posted in **Chat**.

You may adjust your audio by clicking **Audio Settings**.

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Today's Speaker

Mary Chiles
RN, RAC-CT, QCP

Participants will:

- Discuss how adverse drug events (ADEs) result in survey citations.
- Discuss facility systems and processes that minimize risks associated with medications.
- Examine approaches to minimize the risk for medication errors.

Did You Connect the Dots? Medication Safety

- In February 2014, the Office of Inspector General (OIG) released its report *Adverse Events in SNFs: National Incidence among Medicare Beneficiaries*.
  - Revealed **one in three skilled nursing facility (SNF) beneficiaries were harmed** by an adverse event or temporary harm event within the **first 35** days of their skilled stay.
  - **The OIG determined that nearly 60 percent of those events were preventable.**

Key Definitions

- **Adverse Event:** An untoward, undesirable, and usually unanticipated event that causes death, serious injury, harm, or the risk thereof.
- **Adverse Drug Event:** An injury resulting from drug-related medical interventions.
- **Adverse Drug Reaction:** Harm directly caused by a drug at normal doses.

Key Definitions

- **Anticholinergic Effects:** Physical symptoms resulting from drugs that counter the action of acetylcholine including increased blood pressure, respiratory distress, clumsiness/unsteadiness, bloating/constipation/ileus, nausea/vomiting, dry mouth, delirium, drowsiness/lethargy/fatigue, urinary retention, hallucinations, memory problems, and blurred vision.
- **Prescribing Cascade:** Adverse reaction to one drug that goes unrecognized or is misinterpreted, resulting in the prescriber inappropriately prescribing a subsequent drug to treat the signs/symptoms of the adverse reaction.
- **Polypharmacy:** Multiple definitions exist, but most include reference to drugs without indication and the number of medications used (e.g., more than 10).

Key Definitions

Risk Factor: Issue or condition that increases the potential for an adverse event to occur.

- Resident level issues such as:
  - Medications prescribed
  - Age
  - Concurrent conditions
- System level issues such as:
  - Lack of staff knowledge related to high-risk medications
  - Unclear protocols to address lab results

ADE and Survey Outcomes

FY 2019 Survey Citations

F759 – Medication Error Rate > 5%
F760 – Free from Significant Medication Errors

State	F-759	F-760
Kansas	2.7%	8%
Missouri	17.8%	9.5%
South Carolina	10.9%	7.8%
Virginia	9.4%	12.5%

Source: https://qcor.cms.gov

Other Potential Survey Citations

The effect of the ADE may pose greater survey and/or liability risks than the actual deficiency of the error.

- Pain
- Injury
- Respiratory distress
- Behaviors
- Hospitalizations
- Death

First Step

Recognition that medication administration is a multifaceted process that involves many steps and individuals.

- Initial order
- Transcription/verification of order
- Dispensing of medication
- Delivery of medication
- Storage of medication

First Step, continued

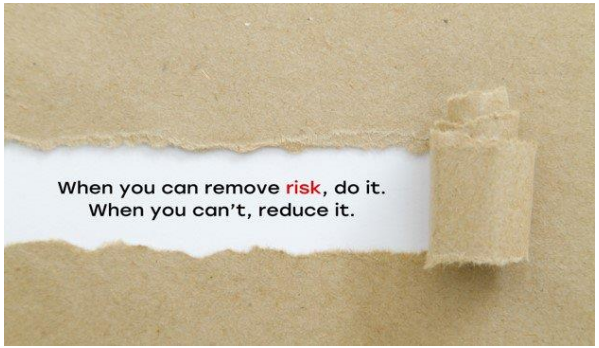
- Administration of medication - “5 Rights”
  - **Right resident, Right drug, Right dose, Right route, Right time**
- Resident acceptance/refusal of medication
- Documentation of administration
- Monitoring for effectiveness
- Monitoring for side effects
- Investigation of potential relationship to or with medications when resident experiences a change

Strategies to Reduce ADE

- Medication administration competency
- Monitoring for medication side effects
- Proactive risk meetings – early identification of resident change
  - Including direct care staff engagement
- Collaboration with providers
- Aggressive drug regimen review with pharmacy

Strategies to Reduce ADE

- Scheduled and ad hoc QAPI observations
- Recognition of identified opportunities with responsive action plans to reduce recurrence
  - Individual involved and others who may be involved



Monitoring "High Risk" Medications

- Opioids
- Insulin/diabetic
- Antibiotics
- Psychotropics
- Anticoagulants
- Others that may be unique to your residents or your facility

Establish a Sense of Transparency

- Create an environment of “no blame” and a system for accurate and timely discussion and reporting of resident changes and/or potential errors
- If an error was made – drill down to the root cause (dig deep)
  - Explore the 5 Whys

Establish a Sense of Reality

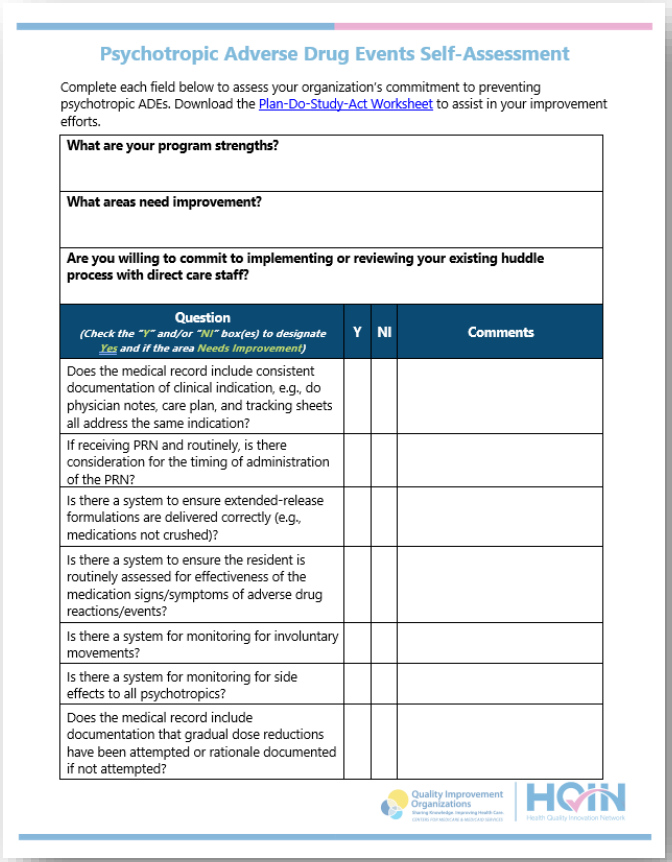
- Residents experience adverse drug events without an error being made
  - Your responsibility is to recognize the change, investigate and take immediate action to minimize adverse outcomes, and to take action to minimize a recurrence

Establish a Sense of Reality

- Medication administration errors occur with the best of nurses for a variety of reasons. Your responsibility is to:
  - Ensure that they have the right information, tools and competency to administer the medications
  - Ensure a sense of transparency without blame for timely reporting of an error
  - Help them understand why the error occurred
  - Explore systems/processes to minimize a recurrence

HQIN Adverse Drug Event Resources

Self-Assessments & Tip Sheets

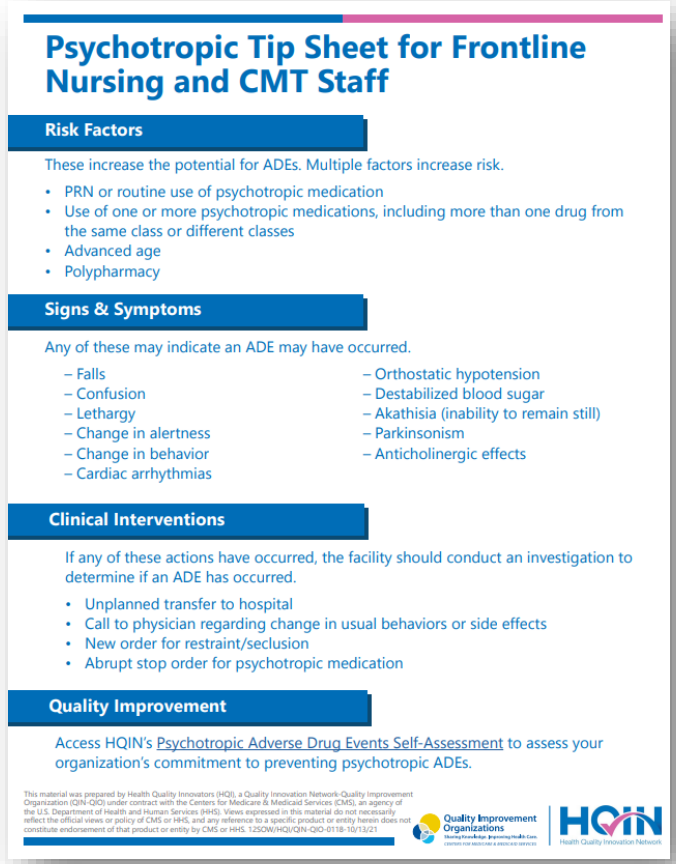


Psychotropic Adverse Drug Events Self-Assessment

Complete each field below to assess your organization's commitment to preventing psychotropic ADEs. Download the Plan-Do-Study-Act Worksheet to assist in your improvement efforts.

What are your program strengths?
What areas need improvement?
Are you willing to commit to implementing or reviewing your existing huddle process with direct care staff?

Question *(Check the "Y" and/or "NI" box(es) to designate Yes and if the area Needs Improvement)*	Y	NI	Comments
Does the medical record include consistent documentation of clinical indication, e.g., do physician notes, care plan, and tracking sheets all address the same indication?			
If receiving PRN and routinely, is there consideration for the timing of administration of the PRN?			
Is there a system to ensure extended-release formulations are delivered correctly (e.g., medications not crushed)?			
Is there a system to ensure the resident is routinely assessed for effectiveness of the medication signs/symptoms of adverse drug reactions/events?			
Is there a system for monitoring for involuntary movements?			
Is there a system for monitoring for side effects to all psychotropics?			
Does the medical record include documentation that gradual dose reductions have been attempted or rationale documented if not attempted?			



Psychotropic Tip Sheet for Frontline Nursing and CMT Staff

Risk Factors

These increase the potential for ADEs. Multiple factors increase risk.

- PRN or routine use of psychotropic medication
- Use of one or more psychotropic medications, including more than one drug from the same class or different classes
- Advanced age
- Polypharmacy

Signs & Symptoms

Any of these may indicate an ADE may have occurred.

- Falls
- Confusion
- Lethargy
- Change in alertness
- Change in behavior
- Cardiac arrhythmias
- Orthostatic hypotension
- Destabilized blood sugar
- Akathisia (inability to remain still)
- Parkinsonism
- Anticholinergic effects

Clinical Interventions

If any of these actions have occurred, the facility should conduct an investigation to determine if an ADE has occurred.

- Unplanned transfer to hospital
- Call to physician regarding change in usual behaviors or side effects
- New order for restraint/seclusion
- Abrupt stop order for psychotropic medication

Quality Improvement

Access HQIN's Psychotropic Adverse Drug Events Self-Assessment to assess your organization's commitment to preventing psychotropic ADEs.

This material was prepared by Health Quality Innovators (HQI), a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW/HQI/QIN-QIO-0118-10/13/21

FOR MORE INFORMATION

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