March 2017

Health and Welfare Alert

Ohio Administrative Code 5123:2-17-02 requires all developmental disabilities employees to review Health and Welfare Alerts released by the department as part of annual training. All previous alerts are listed on the department's website.

Medication Administration #55-3-17

This alert is designed to highlight the importance of safe and effective medication administration practices in order to prevent outcomes resulting in risks to health and welfare. Medication passes are one of the most important support services that are provided to Ohioans with developmental disabilities.

Alex Myers

Alex Myers, a 20-year-old from Hamilton County, enjoyed theater, camp, meeting people, singing in the choir, and spending time with his family. In October 2013, Alex died as a result of a lethal medication error at a group home for people with developmental disabilities.

"You Are Your Brother's Keeper," produced by Alex's family, explains the risks associated with administering medications.

'Rights' of Medication Administration

Administering medications safely involves constant awareness of the risks, creating a system to avoid those risks, and committing to monitoring and maintaining safety standards. People administering medications must be aware of *The 6 Rights* of medication administration.

Right Person - Check the name on the medication order with the person's. Use two ways to identify the person.

Right Medication - Compare the medication label with the Medication Administration Record (MAR) three times.

Right Dose - Compare MAR with medication label three times to assure proper dosage and strength.

Right Route - Confirm patient can take or receive medication by ordered route (e.g., by mouth, eardrops).

Right Time - Confirm when last dose was given. Know how early or how late a medication can be given. Set an alarm.

Right Documentation - Chart the time, route and other information immediately after the medication pass before preparing another person's medication.

Common Medication Errors

- Giving someone the wrong medication
- Giving someone another person's medication
- Giving the wrong dosage of medication
- Giving medication at the wrong time or missing a dose entirely
- Giving medication no longer ordered

Other common issues

- Someone does not have enough support to self-administer medications
- Special instructions are not met for administering medication, such as taking it with or without food, using the proper route, etc.
- System of giving, getting, and documenting medications is flawed
- Prescriptions are not re-filled or new ones are not ordered

Causes and Contributing Factors

Failure to identify medications with significant risk

- Although any medication can cause serious side effects, medications identified with the strictest warning from the U.S. Food and Drug Administration, or "black box warning," can be lethal if given to the wrong person.
- Review safe medication administration practices to ensure appropriate precautions are in place.

One person is confused for another

- This can happen when multiple people live in the same home, or when staff do not realize that incoming or outgoing staff already administered medications.

Medications are prepared for more than one person at a time

- This practice is forbidden by rule. When medications are placed in cups and prepared for multiple people prior to administration, the risk of error increases exponentially.
- Medications must be prepared for one person at a time while using the Right Documentation.

Distraction or multi-tasking during medication administration

- Medication administration is not a time for completing more than one task. Complete focus must be given to providing the appropriate medication to the Right Person at the Right Time.
- When many people are seeking attention and the environment is hectic, mistakes can be made. It is always best to have a quiet and calm environment when preparing and administering medications.

Tips and Things to Remember

The medication administration system should be clear, consistent, and easily understood

- Have a system that prevents distraction to the person administering the medications.
- Mentor new staff in medication administration in the same environment and conditions that they will actually conduct the administration.
- Remind everyone of the importance of correctly administering medication. Conduct audits and medication monitoring safety checks, noting both positive results as well as opportunities for improvement.
- If for some reason there needs to be a change to the process, make sure that all are aware and the system is detailed well.

Monitor medication administration and step in if there are concerns

- If the person is not acting like himself or herself following a medication pass, take it seriously.
- Be alert to changes in the routine of a person or a group. See the Transitions Health and Welfare Alert for more information.
- Know signs and symptoms of adverse reactions.
- If there is ever doubt, contact 911 immediately.

Over time, a person's support needs, abilities, and medications may change, which can make administration of medication more difficult.

- Dosages and medications may change.
- The person may have relied on a spouse or another for help with medication but now lives on their own.
- Direct support provider schedules and service change.

Other supports that people with developmental disabilities rely on to help them correctly take their medication may not be readily apparent. Assuring appropriate supports are available is key to successful medication administration.