

Medication Error Prevention & Medication Administration Annual Update

Module 3

Student Guide

Online Version



Agency for Persons with Disabilities

2022

Contents

Module 3: Medication Errors.....	1
Module 3: Objectives	1
Medication Errors: Definition	1
How Medication Errors Occur.....	1
Prescribing Errors.....	2
Dispensing Errors	3
Administration Errors.....	4
Rights of Medication Administration.....	6
Adhering to the Rights of medication administration will prevent medication errors.	6
Right Client.....	6
Right Reason	6
Right Medication.....	6
Right Dose	7
Right Time	7
Right Route	7
Right Documentation.....	8
Eleven Tips to Help You Avoid Medication Errors	8
Questions	13
End of Module 3.....	13

Module 3: Medication Errors

Module 3: Objectives

In this module, you will learn:

- The three common causes of medication errors.
- How a Medication Assistance Provider can prevent medication errors.
- The Rights of Medication Administration.

Medication Errors: Definition

The National Coordinating Council for Medication Error Reporting and Prevention defines a medication error as:

“any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer.”

Florida Administrative Code Rule 65G-7.006 – Medication Errors – lists those actions that are considered medication errors when committed while caring for clients of the Agency for Persons with Disabilities (APD).

We will cover these later in this presentation.

How Medication Errors Occur

There are several ways that a medication error can occur in the medication process. We will focus on the three most common causes.

- Prescribing errors
- Dispensing errors
- Administration errors

Prescribing Errors

The following errors are commonly linked to the prescriber, which can be an MD, PA, DO, or an APRN.

Errors can be caused by:

- The wrong drug, the wrong dosage, or the wrong route.
- Using abbreviations (QD, QID, and QOD), and using symbols like “U” for units.
- Illegible handwriting.

The chart on the next page shows some of the abbreviations you may see on orders or prescriptions from the health care provider.

The pharmacy will spell these out on the medication label and will not use abbreviations.

When comparing the label to the order or prescription, you must be sure that they **mean the same thing**. If you have any questions or concerns, you should call the pharmacist and ask for assistance to clarify the order.

Abbreviation	Meaning
a.c.	before meals
BID	twice a day
cap	capsule
gtt	drop
H.S. or h.s.	hours of sleep
mg	milligram
ml	milliliter
od	right eye
os	left eye
ou	both eyes

Abbreviation	Meaning
po	by mouth
p.c.	after meals
prn	as needed
QD	every day
QOD	every other day
Tab	tablet
Q3h	every 3 hours
QID or qid	four times per day
TID or tid	three times per day
d/c or D/C	discontinue

Fortunately, the use of abbreviations like these has decreased recently with the use of electronic ordering by health care providers.

Preventing medication prescribing errors

Check the prescription or the order to ensure it is what you expected for this client:

- Is it the **medication you thought the client would get**?
- Is it the **right dose**, and is it in the **correct form** (such as liquid, tablet, or cream)?
- Is it ordered for the **correct number of times per day**?
- Can you tell **how much to give the client**?

Dispensing Errors

The Pharmacist:

- Receives the order from the prescriber.
- Processes the order.
- Delivers the order to client or staff.

According to a nationwide study, there are about **4 dispensing errors per day** in a pharmacy filling 250 prescriptions daily. An estimated 51.5 million errors occur during the filling of 3 billion prescriptions each year.

This represents a 1.7% error rate – which sounds low – until you think that one of those 4 errors could be with the prescription you are picking up for yourself, your loved ones, or your client!

Preventing Dispensing Errors

Communication is the key to preventing dispensing errors.

ALWAYS check a prescription as soon as you receive it.

- Is it **what** you expected to get?
 - Correct **name**? Correct **strength**?
- Do you understand the **label directions**?
- Does the label direct you to give the **amount of medication** you expected?
 - Number of pills to give? Amount of liquid?

If the answer to any of these is NO – SPEAK TO THE PHARMACIST

Administration Errors

The Medication Assistance Provider, or MAP, has a very important job to do. As the person administering medications or supervising the self-administration of medications, the final opportunity to prevent an error rests in the MAP's hands.

The MAP must be alert, and catch errors made in the prescribing and dispensing processes.

The MAP must be very careful not to make errors while giving medications or supervising the self-administration of medications.

The best way for the MAP to avoid errors in medication administration is to

- Know your **client!**
- Know **what medication** you are giving.
- Know **why** you are giving the medication.
- Know the **side effects** of the medication.
- Know any **special instructions**.
- Know what to do in an **emergency**.
- Know **who to call** if you have questions.

The MAP must **check the order** against **what is dispensed** to make sure the correct medication has been provided.

The MAP must answer the following questions before starting to give medications:

- **Which client** are you assisting?
- **What medication** are you giving the client, and **why are you giving it?**
- What could be the **side effects** of this medication?
- Are there any **special instructions**? Should the client take with food? Should the client chew the medication?
- Do you have a **plan for emergencies**?
- **Who do you call** if you have questions?

Being **prepared** to give medications in a **calm** and **quiet place** is vital to preventing errors.



Minimize distractions. They are one of the major causes of medication errors.

- **No cell phones** – put it away when giving medications!
- **One person** at a time
- **No TV watching** while giving medications
- **No conversations** with anyone but the client
- **When giving medications** do not do anything else at the same time

Rights of Medication Administration

Adhering to the Rights of medication administration will prevent medication errors.

Right	Ask yourself...
Right client	<ul style="list-style-type: none">Are you giving the medication to the person it was prescribed for?
Right reason	<ul style="list-style-type: none">Do you know why you are giving the medication?Is it the reason for which it was ordered?
Right medication	<ul style="list-style-type: none">Is the medication you are giving the correct medication?
Right dose	<ul style="list-style-type: none">Are you giving the right amount of the medication?
Right time	<ul style="list-style-type: none">Is it time to give this medication?Is the medication supposed to be given in the morning or at night?
Right route	<ul style="list-style-type: none">Are you giving an eye medication in the eye, or in the ear?
Right documentation	<ul style="list-style-type: none">Did you document that you gave the medication on the MAR immediately after giving it?

Right Client

- Always make sure that you have the right client.
- If possible, ask the client to state their name.
- Do not ask “is your name Jane Client?” Many people will nod yes even when the answer is “no.”
- Having a picture of the client in their medication profile is also helpful.
- Match the name of the client with the name on the medication label.

Right Reason

- Make sure you are giving the medication for the right reason.
- If Tylenol is ordered for fever you may not give it for headache, backache, or knee pain.
- If Ativan is ordered as needed for anxiety as evidenced by pacing, you absolutely may not give it to help the client go to sleep.

Right Medication

- Match the medication name on the label with the medication name on the MAR.
- Bear in mind that one medication may have multiple names. Benadryl is also Diphenhydramine, Tylenol is Acetaminophen.
- Be sure this information matches.
- If you are not sure, stop. Ask someone or call the pharmacist.
- Look it up. Check the information that was provided with the medication by the pharmacy.
- Double check by asking the client if the medication looks like what they usually take.

Right Dose

- Match the dose or dosage on the container with dosage on the MAR and on the order or prescription.
- Dosage may be listed as cc or ml (they mean the same), mg, teaspoons, tablespoons, puffs, pills, etcetera.
- Be sure this information matches.
- It is easy to give the wrong number of pills. Pay attention.
- Be diligent to catch dose changes after the client goes to the doctor, or is discharged from an inpatient facility.

Right Time

- Match the time on the medication label with the time listed on the medication administration record.
- Be careful to give doses labeled AM in the morning and PM in the afternoon or evening.
- The right time is the time the medication is scheduled for on the MAR. To allow some flexibility, a medication may be given from one hour before to one hour after the scheduled time and still be considered on time.


Right Route

- Match the route on the medication label with the route listed on the MAR.
- Be sure this information matches.

- Confirm that the client can take medication by the route ordered.
- The most common mistake with route is confusing ear drops for eye drops and vice versa. It helps to stop and think about why you are giving the medication.
- Remember which routes you are validated for: Oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, and topical.

Right Documentation

- Each medication that is given **must** be documented on the MAR **immediately** after administration or supervision of self-administration.
- If you do not document someone else may give the same medication to the same client, or it will appear that the client missed their medications for that time period.



agency for persons with disabilities
State of Florida

Medication Administration Record (MAR)

Name: _____ Month: _____, Year: 20____

Allergies: _____

Medication	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
Drug Name, Dosage, Route																												
Prescribed By:																												
Drug Name, Dosage, Route																												
Prescribed By:																												

Eleven Tips to Help You Avoid Medication Errors

Tip 1: Avoid Distractions.

Do not do the following:

- Talk on the phone
- Text
- Surf the web
- Play games
- Talk to anyone other than the client receiving the medication
- Watch television

- Listen to the radio
- Perform other tasks like cooking or supervising residents

Tip 2: Do not multitask.

Multi-tasking means doing more than one thing at a time

Multi-tasking is a **distraction** – you run the risk of causing medication errors that could harm the client when you allow distractions.

Safe medication administration requires that you master the art of *single-tasking* – focusing on **one** thing at a time. Many people boast of how well they can multitask, but research shows that it can be dangerous.

Think about it for a moment: you rush to do so many things at once, but you end up doing none of them well.

Tip 3: Give medication to one client at a time.

- In a quiet place designated for medication administration
- Avoid interruptions

Tip 4: Prepare medications for one client, when the medication is due.



Never pre-pour medications to give later.

Tip 5: Only administer medication you have prepared yourself.



Never administer medications someone else has prepared.

Tip 6: Prepare medications in a well-lit area.



You must be able to read the MAR and the medication label.

Tip 7: Keep an eye on poured medications – give them immediately to the client.



- A client may pick up medications left unattended and take them or hide them somewhere.
- Another client might find and swallow them if they are hidden.
- Always keep an eye on poured medications; give them immediately.
- Remember to return each client's medication to its original storage location as soon as you are done giving that client's medication.



Never leave medications unattended.

Tip 8: Not all spoons are created equal.

- Dosing devices are calibrated or marked at different intervals.
- The calibrations are used to measure how much liquid there is in the dosing device.
- You compare the calibration with the desired dose and match it with the doctor's order.
- The spoon in your drawer is not calibrated and you cannot be sure that you are giving the correct dose.
- It is essential to use the dosing device dispensed with the medication.



Dosing Cup



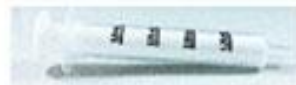
Oral syringe
with colored cap



Dosing Spoons



Medicine Dropper



Oral dosing syringe for infants

Tip 9: Know your client and their preferences.

- Some clients may refuse to take their medications because of taste or size.
- Get to know your clients and learn what works for them when taking their medications.
- Swallowing may be an issue for some. You must have an order to crush a medication because some medications cannot be safely crushed.
- Some clients may be able to swallow whole pills in thicker liquids, or with pudding or applesauce.
- You may break or cut only **scored** pills in half if required to make the correct dose. Unscored pills do not have the medication distributed evenly across the pill, or may be designed to be taken whole.

You may break a pill in half without an order if it is scored (has a line across it).



Tip 10: Do not alter medications without an order.

- Long-acting medications are delivered through the digestive system over time. If crushed, the client gets the entire dose at once, which can be very dangerous. This is why you need an order to crush or alter a medication.
- Always match medication label to the order to the MAR. Every time you give the medication.
- Read the special instructions the pharmacy attaches to the label. These labels give you more specific instructions about giving the medication than the order, such as give with food, or do not take milk products, calcium, or antacids for two hours before or after taking this medication. There are many more examples of these, and they should be followed for the medication to work well.

Tip 11: When a medication is DISCONTINUED, highlight the discontinued doses on the MAR to prevent giving the medication in error, or accidental initialing of the MAR.

- Highlight the discontinued doses on the MAR as taught in your initial Medication Administration Training Course.

[illegible]

- If a medication is **CHANGED** to a different dose or number of times per day, it is also highlighted in the same way. The new order is written in the next available MAR space.

Medication	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Drug Name, Dosage, Route	7am				CH	CH	CH	CH	CH	MP	MP																					
Depakote 500mg tablet, give one tablet by mouth each morning for 7 days													changed 11/11/19 MP																			
Start 11/4/19																																
Prescribed By: J. Johnson MD 11/3/19																																

Remember:

- If you do not know what the medication is for, or why you are giving it, STOP and look it up.
- Know about the person who you are giving the medication to.
- Read the special instructions that the pharmacy may add to the label, such as take with food or remain sitting for thirty minutes after swallowing or take on an empty stomach
- Know the potential side effects of the medications you give.

PREVENTION OF MEDICATION ERRORS IS IN *YOUR* HANDS!

Questions

If you have questions about medication administration or 65G-7, the medication rule, please contact your local APD Medical Case Manager.

End of Module 3

You have completed Module 3 of the Medication Error Prevention and Mediation Administration – Annual Update course.