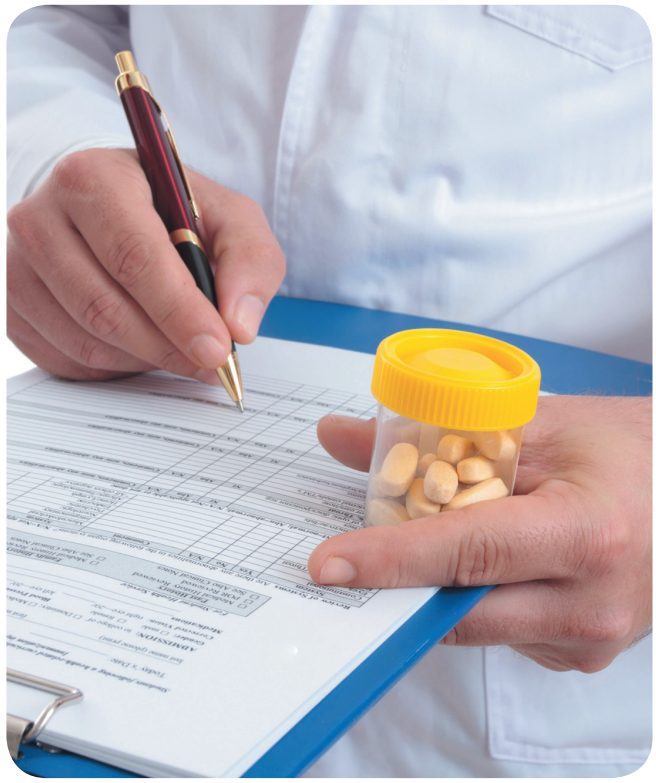
by Linda Williams, RN

Was the medication given?



Errors in medication administration are all too common in healthcare facilities, a fact that's documented in many medical journals and studies. In addition, medication handling is a frequent focus of the survey process, and it ranks high in the complaint categories reported to nursing home ombudsmen.

Some ways medication errors can occur include staff workload and fatigue, which result in disruptions while passing medications; lack of follow-through with the five rights of administration (resident, medication, time, drug, and route); incorrect technique; and inappropriate, missing, or untimely documentation. Mistakes can happen when a drug is prescribed, transcribed, dispensed, administered, or omitted.

Healthcare providers must become proactive and be aware of what, how, and why medication errors and omissions occur. Otherwise, their worst nightmare—finding out about an error through a surveyor, lawsuit or a resident's decline—can occur, which is what happened in the following situation. Please take the time to review this facility's circumstances and make changes as appropriate in your facility.

The situation

An 87-year-old woman was admitted to a nursing facility with a history of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, cardiomegaly, and dementia. For the next few months, she was consistently disoriented and required assistance with all of her activities of daily living. However, she could communicate her needs and participated in scheduled activities.

Unfortunately, the woman's son lived in a neighboring state and could only visit her on occasion, never staying very long. One Friday, he arrived just as the woman was finishing her lunch. She told him that she wasn't feeling well, and so he asked a nurse aide to take her to her room and help her to bed. He left the facility and came back the following morning only to find his mother sitting in a wheelchair in her room with her head on her bed. His mother did not seem to want to converse, so he didn't stay long, concluding that she was still ill. When he left, he notified the staff of her condition and told them where he was staying if they needed to contact him.

That evening, the son received a phone call informing him that his mother was being sent to the hospital for shortness of breath. The son immediately went to the hospital and agreed to have her admitted for treatment of CHF, hypoxia, and anemia. The woman was given intravenous antibiotics and a diuretic. The son stayed by her side for a little while, then decided to go back home to get more clothing and return. By the time he arrived at his house, the

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hospital physician called to notify him that his mother had passed away. The physician told him that his mother "died in her own fluids" and the official cause of her death was listed as pneumonia and CHF with contributing conditions of severe anemia and atrial fibrillation.

Before returning to the nursing facility to collect his mother's belongings, the son spoke to a niece that had previously worked at the facility. He told her what the physician had said and wondered whether his mother received all of the medication she was supposed to have? The niece advised him to demand a copy of the Medication Administration Record (MAR), as well as the medications themselves. Upon arriving at the facility, the son did as he was told, and discovered there were some gaps in the documentation where some of the medications were supposed to be given and there seemed to be extra doses of her diuretic, potassium, and calcium pills. As a result, the son sought legal counsel and filed a wrongful death lawsuit against the facility for negligence in not administering the woman's life-saving medications as prescribed. The son asked for $750,000 to settle the case.

At the deposition, the facility's director of nursing testified that state law required that upon the death of a resident, the facility should make an accounting of all prescription medications in the room, and then send them back to the pharmacy for appropriate disposal. When the son arrived, the medications had not yet been counted and so no one knew the exact numbers of medications that he took.

A physician expert also testified that he did not believe an alleged failure to appropriately medicate the woman had anything to do with her death. In fact, the physician thought that if anything, she was overmedicated. Chest x-rays showed clearly that the woman had interstitial lung disease or fibrosis and there was evidence that she had suffered from severe anemia for years. Upon her final admission to the hospital, the woman had developed atrial fibrillation, a new condition in which the top of her heart was not beating regularly. In his opinion, the woman's disease state was severe and ultimately fatal. Instead of proceeding to trial, both parties agreed to mediate the case and a settlement for a fraction of the demand was reached.

Risk management steps to protect your residents and facility

Every nurse knows that one of the best ways to reduce the chance for medication errors is to initial the MAR as soon as a medication is given. If the nurse waits until the entire medication pass is completed, the documentation may be skipped, leaving it to speculation whether the drugs had been given. Unfortunately, gaps in documentation happen all too frequently in some nursing facilities.

Good documentation is the responsibility of all staff members, whether it is a CNA documenting daily cares on a flow sheet, a dietary person documenting a resident's meal consumption, or a licensed person documenting a medication that was given. To better protect your facility in the event of a liability claim, all staff members should be continually consulted, trained, and held accountable for their documentation practices. Furthermore, the documentation practices of staff members should be continually monitored to determine if they are following the practices and procedures in your facility. To assist you in this matter, the following steps should be incorporated into your employment practice policies and procedures:

1. Written job descriptions should be amended to include what the documentation expectations are per applicable position.
2. New employees should be oriented to the employee handbook, which also should state what the documentation expectations are (per position), as well as the documentation review process and consequences for non-compliance.
3. It is important that the documentation of new employees be audited to ensure standards are met during the first 90 days of employment.
4. Finally, the documentation practices of staff members should be an integral part of the employee's review process.

By taking these necessary risk management steps, you can protect your residents and facility, now and into the future. ■

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The GuideOne Center for Risk Management is dedicated to helping churches, senior living communities, and schools/colleges safeguard their communities by providing practical and timely training, and resources on safety, security, and risk management issues. For more information, phone (877) 448-4331, ext. 5175, or e-mail slc@guideone.com. More information is available on the Center for Risk Management's Web site at www.guideone.com.