Oklahoma State Department of Health

MDS News You Can Use

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Quality Improvement & Evaluation Service

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Medication Safety

We all know that following safe medication administration practices can literally mean the difference between life and death. However, studies reveal that adverse medication errors continue to occur and lead to hospital readmissions. Therefore, a review of safe medication practices will assist you in promoting the resident's highest practicable level of well-being and ensure you are providing excellent quality of care.

There are many things that we can do to try and decrease problems associated with medications and one of those is reviewing the **10 Rights of Medication Administration**, which includes:

1. Right Patient
2. Right Medication
3. Right Dosage
4. Right Route
5. Right Time
6. Right Documentation
7. Right Client Education.
8. Right to Refuse
9. Right Assessment
10. Right Evaluation

CMAs and nurses are encouraged to review these rights on an annual bases and more frequently if problems are identified.

For safe medication administration, you should identify the resident each time medications are administered. If the resident is able to respond, have them repeat their name for you or double check that you have the right medication for the right resident.

To ensure the right medication is given means that the drug is verified with the written order / prescription and the label that is on the prescription.

The right dosage is also verified with the written order / prescription.

The right route means you have verified the route you are to administer the medication.

Providers order medications at different times for many reasons. If a medication causes drowsiness, it should be ordered at bedtime. If it is a fast acting insulin it may be ordered at meal time. So verify you are administering medications at the right time.

Nurses should document medication administration. This should include injection sites, any PRNs administered, along with the results of the medication given. The person administering the medication is the only person that should document on the MAR (medication administration record) that it was given.

Knowledge of medications – other names, normal usage and dosage, common side effects, etc., is crucial for safe administration. If staff is aware of the reason a physician ordered a medication, they can identify the effectiveness of the medicine and can decrease adverse complications. For example, if Neurontin is ordered for neuropathy, but staff believe it is ordered for seizures, staff may believe the medication is effective because the resident is seizure free, although pain may be unrelieved.

Know the residents history and current diagnosis. If they suddenly have Losartan on the MAR, and no history of hypertension with a baseline

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Medication Safety

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BP of 98/50, you would want to take a closer look.

It is important to know that if you are giving Losartan, Lasix, Valium, and Norco at one time, this can definitely adversely affect the resident. Evaluate the medications yourself and follow up with the appropriate person.

Complications can be allergic reactions, interactions, adverse reaction, overdose, wrong medication, wrong person, wrong route, wrong time (a diuretic given at 8 pm can definitely cause problems).

A person who is dispensing medications needs to have the time necessary to prepare for medication and safely administer medications per physician's orders. The individual administering medications also needs to be able to correctly document all medications. Giving a medication can be detrimental if a previous nurse failed to document the administration of a medication. Also, documenting the effectiveness of medications is vital. If a medication needs to be increased, decreased, or changed, the staff or physician may not be aware of this if there is not documentation present.

Over the years, we have all had things occur that have made the importance of the 10 Rights of Medication Administration so important. Here are a few:

1. When a resident, was asked if he were John Doe, he said "No, I'm John Wesley Hardin". Thankfully other staff familiar with the person said that the resident was John Doe, not the famous gunslinger John Wesley Hardin. And, this was verified with a picture from the chart.
2. A nurse was verifying insulin for a CMA who stated "I have 50 units of NPH;" however, the nurse noticed the insulin was clear. The insulin was in fact Regular.
3. A nurse read a dose wrong, and actually gave a person 10 tablets instead of 1.
4. Right route - A physician (years ago before Diflucan and Nystatin were around) would have his patients chew a vaginal suppository for a thrush diagnosis. Always check the route. The first time the nurse saw this, she called the physician thinking it was a mistake.
5. The urologist ordered medication for a resident to decrease nighttime frequency. While looking at the record the nurse noticed Lasix was being administered at 8pm. When staff checked with the ordering physician, he said that the first dose should be no later than 6 am, the last dose 2 pm, and discontinue the Detrol. The right time is very important.
6. Resident reported a headache, staff checked the MAR but did not see any documented prn medications, so went to take the person a dose of Imitrex. The resident reported the off going nurse had given that medication 30 minutes prior. Documentation is critical for patient safety!
7. Resident reported he was not going to take medications the nurse brought to him because these were not his medications. Resident had been educated on medications and refused them, which was his right. Nurse evaluated and discovered it was someone else's medication.
8. Nurse was to administer Capoten but checked resident's blood pressure prior to administration and identified BP of 94/52; medication was held. Assessment is important!

Nurses and CMAs should review and follow safe medication practices to protect every resident in their care and also protect themselves and the facility they work for.

http://www.newhealthadvisor.com/10-Rights-of-Medication-administration.html

10 Rights of Medication Administration:

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Social Media Safety

Over the last few years, with the common use of cellphones, there has been an increase in unauthorized pictures or videos of residents and placed on social media.

This is horrifying to many residents, families, staff, and people in the community. These invasions of residents privacy, rights, and HIPAA violations have been brought to light by concerned people and media.

Many states have enacted laws concerning this, or are in the process of doing so and there are cases where the people responsible have been prosecuted

In response to this critical issue, on August 5, 2016 CMS released a memorandum that stated:

"**Freedom from Abuse:** Each resident has the right to be free from all types of abuse, including mental abuse. Mental abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s).

Facility and State Agency Responsibilities:
This memorandum discusses the facility and State responsibilities related to the protection of residents. Specifically, at the time of the next standard survey for both the Traditional survey and QIS, the survey team will request and review facility policies and procedures that prohibit staff from taking, keeping and/or distributing photographs and recordings that demean or humiliate a resident(s)."

"Each nursing home must develop and implement written policies and procedures that prohibit all forms of abuse, including mental abuse. Each nursing home must review and/or revise their written abuse prevention policies and procedures to include and ensure that nursing home staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate a resident(s). This would include using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and recordings on social media."

"Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being..."

(Code of Federal Regulation, 42 FR 483.25)

Hospital Readmissions

In addition to the new regulations, SNFs are also challenged with learning the SNF Quality Reporting Requirements (QRP) and Value-Based Purchasing (VBP) criteria that will eventually impact your reimbursement.

The 30-Day Potentially Preventable Readmission Measure is one that will be implemented in the near future, but nursing homes should begin now identifying how to reduce hospital readmissions.

One study published in the US National Library of Medicine identified that adverse drug events contributed to hospital readmissions. Reasons cited includes prescription errors involving diuretics, analgesics, or antithrombotic medications, and inadequate patient monitoring.

In order to help prevent adverse drug events, it is recommended that you complete a comprehensive review of residents who are on any diuretics, analgesics, antithrombotic medications, along with antipsychotic medications. Implement gradual dose reduction when possible. Review residents closely for adverse drug interactions or inappropriate prescribing practices. Many residents are prescribed medications during the hospital that should be gradually reduced and discontinued.

Taking these steps will help ensure safe and proper administration of medications. Close monitoring and assessment of the resident will help prevent adverse drug events that may lead to hospital readmissions and impact on your reimbursement.

MARK YOUR CALENDAR

Nursing Home Quality Measures and SNF-QRP Requirements

08-10-2017

at

Eastern OK County Technology Center Choctaw, OK

Register by July 17, 2017

Sign up for MDS trainings online using our QR Code.

Payroll-Based Journal (PBJ)

The Centers for Medicare and Medicaid Services (CMS) has long identified staffing as one of the vital components of a nursing home's ability to provide quality care. Over time, CMS has utilized staffing data for a myriad of purposes in an effort to more accurately and effectively gauge its impact on quality of care in nursing homes. Staffing information is also posted on the *CMS Nursing Home Compare* website, and it is used in the *Nursing Home Five Star Quality Rating System* to help consumers understand the level and differences of staffing in nursing homes.

Facilities that do not meet these requirements will be considered noncompliant and subject to enforcement actions by CMS. Note: If a facility uses a vendor to submit information on behalf of the nursing home, the nursing home is still ultimately responsible for meeting all the requirements.

Source: PBJ Long Term Care Facility Policy Manual Version 2.3, April 2017.

Reminder

Remember to occasionally pull CASPER reports in order to compare them to software generated reports. CASPER reports are housed with CMS and are utilized for the survey process. What appears on the CASPER reports is a result of MDS assessments submitted and accepted records in the Federal Database and could be different than what appears on your software generated reports. Utilize the validation report to ensure the submitted assessments have been accepted.

Also, remember to pull the early release Nursing Home Compare Reports, along with the 5-Star Reports, which are located in the folder labeled: OK LTC NH XXXX.

It is suggested that you go to this folder monthly, as items are released monthly.

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Automation Tip

Effective June 26, 2017, passwords to CASPER need to be refreshed every 60 days and will be deleted after 365 days of no activity.

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