Medication Safety and Communication Skills

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Lecturer: Dr Balakumar
Faculty of Pharmacy,
Philadelphia University-Jordan

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- Types of Errors: Possible Causes and Potential Solutions
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OVERVIEW

<u>This chapter explores</u>

→The **direct relationship** between the quality of **communication** and the level of patient **safety.**

→ Focuses on how weak communication influences medication safety

→ Illustrates how many drug misadventures are caused by weak communication.

Introduction to Medication Safety Issues

- According to an Institute of Medicine (IOM) report, between 44,000 and 98,000 Americans lose their lives to medication errors each year.
- Although the accuracy of this estimate has been called into question, its relative importance should be considered.
- Even if reality is just a tenth of that estimate, that is still a significant number of preventable deaths (and represents ten 747s crashing annually) due to error.
- The IOM report states that medication errors have a significant economic impact as well.
- The **annual cost** of drug-related morbidity and mortality in the United States has been estimated to be more than $140 billion.

MEDICATION ERROR !!

› The definition of medication error is

→**“. . . any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care provider, patient, or consumer”**

› <u>These perceptions **may directly affect …**</u>

→ **patient adherence** with prescribed therapy or may stimulate the use of alternative therapies.

→ Medication errors also cause tension between health care providers finger pointing may occur, and perceptions of professional competence may be altered.

→ When situations are not handled appropriately, trust evaporates and future interactions do not evolve in a positive way.

What to fix??

- **It is easy to say that medication errors are either simply the "system" problems or "people" problems.**
- All we need to do is to fix to decrease errors.
- **Examples**:
- The physician **writing** down his instructions **clearly** for the patient during the office visit, **NOT** relying on his/her memory.
- Using a better approach, the physician may **transmit** the prescription via an electronic physician order system to the pharmacy, thus eliminating any doubt about his intentions.
- Pharmacist has to **call** the physician about the instructions once he noticed that the dose was written in an unorthodox manner.
- Pharmacist has to carve out time to counsel patients and to **ask** he how he was supposed to take the medication. This was especially important since the new directions were different from her previous prescriptions.
- Pharmacist has to double check to see whether he **understood** that he had to change regimens in just a few days. This discussion may have caused patient to remember her physician's original instructions.
- Pharmacist has to encourage patient to **contact** him if he had any questions and to always **question** anything that did not look right.

Types of Errors: Possible Causes and Potential Solutions

- Medication errors typically involve complex relationships between systems, people, and communication processes.

FIRST: Communication with health care providers

SECOND: Communication with patients

1. COMMUNICATION WITH HEALTH CARE PROVIDERS - **Possible Issues**

› **Possible Issues** → Common issues involving **verbal** communication include:

- Distractions and noise that interfere with clear transmission and receipt of the message
- Heavy accents and language differences
- Use of terminology that other health care providers do not understand
- Speaking too rapidly for the listener to clearly comprehend
- Medications that sound alike when spoken (Zantac vs. Zyrtec)
- Numbers that sound alike (15 vs. 50; 19 vs. 90)

1. COMMUNICATION WITH HEALTH CARE PROVIDERS - **Possible Issues** (continued-1)

› Although written communication is often preferred over verbal communication to minimize errors, there are several issues that inhibit effective **written communication** as well.

› Examples of **written communication** issues include:

- Poor handwriting
- Medication names that look alike when written out (Celexa vs. Celbrex or Bisoprolol 10 mg and Buspirone 10 mg)
- Misplaced zeroes and decimal points in dosing instructions (.5 vs. 0.5; 1.0 vs. 10)
- Unclear abbreviations within patient care instructions

1. COMMUNICATION WITH HEALTH CARE PROVIDERS - **Potential Strategies**

› **Potential Strategies→** examples:

- Work load issues may prevent pharmacists from contacting physicians or nurses
- Elements within the work environment may promote distractions and prevent pharmacists from concentrating on their work
- The lay-out of the work area may not be appropriate
- The lighting within the pharmacy area may not be adequate
- Communication networks (phone, e-mail, text-messaging, etc.) may not provide easy access to professionals so that pharmacists can provide feedback
- Indirect communication (pharmacist talks to a nurse, who talks with the physician rather than the pharmacist talking directly with the physician)

1. COMMUNICATION WITH HEALTH CARE PROVIDERS- ***solving the problem***!!

- **Specific strategies to minimize errors include using:**
- Written communication rather than verbal communication or **computerized** physician order entry (CPOE) systems (which are even better than written communications).
- During the dispensing process, the work flow should include numerous **opportunities to check the contents** and label of the prescription.
- Several pharmacies use **bar coding** , as a means to check the accuracy of the dispensing process).
- Many pharmacists advocate using **“Tall Man Lettering”** when writing drug names that are similar to other agents for example, using glipizide and glyBURIDE rather than glipizide and glyburide within the prescription order and on the prescription label. Another example would be to use “chlorproPAMIDE” and “chlorproMAZINE” to differentiate between these two agents that look very similar but have very different uses.
- To minimize errors when taking verbal orders over the phone, you should **repeat** all components of a verbal order and place a checkmark on the prescription for each component as you read it back to the prescriber.

1. COMMUNICATION WITH HEALTH CARE PROVIDERS- ***solving the problem***!! (continued)

In institutional settings, such as long-term care facilities, hospitals, or ambulatory care centers, **communication between pharmacy and nursing** staffs must be clear to assure safe administration of the medication.

- For example, is the medication labeled clearly? Are doses appropriate? Are the instructions for delivery method (IM, IV) and administration times clearly articulated?
- Within these institutions, **staff members** need to be **trained** in the proper communication processes and **educated** about the potential causes of medication errors.
- You must **work closely** with these professionals to ensure accurate interpretation of orders and administration of medications.
- It is also critical to have access to the **most up-to-date drug information** references for health care providers, preferably in an electronic format, so that the most current information is used.

2. COMMUNICATION WITH PATIENTS- Possible Issues

› **Possible Issues** → Common issues involving **verbal communication** include:

- Inability of patients to understand pharmacists (accent, medical terminology, language and cultural differences, etc.)
- Hearing and vision impairments
- Environmental barriers (noisy pharmacy, no access to pharmacist) Common issues involving written communication with patients include:
- Patient's inability to read or comprehend material
- Lack of effective patient education material
- Inability to read label (sight impairments)

Other **pharmacist–patient communication** issues leading to medication errors include:

- Pharmacist's inability to make sure that the correct patient receives the right medication
- Patient's inability to clarify verbal and written information with pharmacists

2. COMMUNICATION WITH PATIENTS- Potential Strategies

- **Potential Strategies**
- Many situations involve patient interaction within the pharmacy while others occur after the patient leaves the pharmacy. Fortunately, many errors are discovered during the pharmacist–patient counseling interaction and are corrected before patients leave the pharmacy.
- Patients need to be actively involved with their drug therapy.
- Their participation could identify potential errors.
- Patients, and their caregivers, should realize that they have a stake in preventing errors.
- Patients should feel free to question situations that do not appear right and mention them to the pharmacist.

2. COMMUNICATION WITH PATIENTS- Potential Strategies (continued-1)

- When giving information to patients, you should allow patients the opportunity to repeat back key information in order to detect possible errors and misunderstandings.
- Counseling should be used to verify the accuracy of dispensing and to assess patient understanding of proper medication use.
- When giving verbal instructions, difficult drug names should be spelled out for patients.
- Written patient education leaflets should be given for future reference.
- Patient education material must be targeted at appropriate grade level. It is estimated that over 90 million Americans have limited health literacy skills.
- You should use the Internet or other technologies as effective mechanisms to communicate with patients.
- You should keep notes in your patient database about unique patient characteristics (hearing, speech, or vision impairments).

2. COMMUNICATION WITH PATIENTS- Potential Strategies (continued-2)

- You should also document past issues involving errors or nonadherence to therapy within the patient's profile.
- You should encourage your patients to keep a list of all their medications and instructions along with critical health information, such as drug allergies.
- Patients should refer to their lists every time they visit their physicians or pharmacists; being proactive will minimize patient risk.
- You should offer advice on how patients can minimize their exposure to medication errors.

2. COMMUNICATION WITH PATIENTS- Potential Strategies (continued-3)

- Patients need to know what the medication is used for, how to take it, what to expect, and other essential information.
- If their therapy changes from one visit to the next, patients should feel comfortable bringing it to your attention. Unfortunately, this does not occur all the time.
- You might use the “show and tell” technique of showing the medication to the patient and asking the patient what the medication is used for and how they are taking it. This approach can alert both the patient and you to possible issues before the patient leaves the pharmacy.
- In fact, one study found that 89% of the errors that had made it through the medication processing steps and the final pharmacist check were caught at the point of patient counseling when pharmacists showed the medication to patients and verified its indication of use with them.

General Strategies to Enhance Patient Safety

1- REPORTING ERRORS

- It is important to realize that most errors are caught by others. We rarely catch our own errors.
- Many errors are related to system issues rather than people issues. Thus, people must feel comfortable identifying, documenting, and reporting errors in a constructive environment.

2- USE ORGANIZED STRATEGIES TO MINIMIZE ERRORS

a. Failure Mode and Effects Analysis (FMEA)→ attempts to identify sources of potential failure within a specific system and the consequences of such failures. It can be used to evaluate previous failures or to prevent future failures. The goal of this risk management tool is to reduce the frequency of failures and their consequences.

b. Root Cause Analysis (RCA) → focuses on specific root causes of errors and not on the actual errors themselves; it attempts to identify the specific reasons for the error by asking a series of probing “why”-type questions to eventually find the root cause.

The United States Pharmacopeia (USP) Medication Errors Reporting Program → Relevant Websites

- IOM Report—To Err Is Human: http://books.nap.edu/html/to_err_is_human/
- IOM Report—Crossing the Quality Chasm: http://www.nap.edu/books/0309072808/html/
- The Annenberg Network: http://www.mederrors.org/
- National Patient Safety Foundation: http://www.npsf.org
- National Coordinating Council on Medication Error Reporting and Prevention http://www.nccmerp.org/
- Institute for Safe Medication Practices: http://www.ismp.org/
- AHCPR-Medical Errors & Patient Safety Subdirectory Page: http://www.ahcpr.gov/qual/errorsix.htm
- Quality Interagency Coordination (QuIC) Task Force: http://www.quic.gov/
- **USP Medication Errors Reporting Program: http://www.usp.org/patientSafety/mer/** 1-800-23ERROR
- MEDMARX: http://www.usp.org/patientSafety/medmarx/ 1-877- MEDMARX
- JCAHO leaflets “Speak Up: Help Prevent Errors in Your Care” and JCAHO “DO NOT USE” list: http://www.jcaho.org
- AHRQ brochure “20 Tips to Prevent Medical Errors”: http://www.ahrq.gov

When Errors Occur

1. INITIAL DISCOVERY
2. INITIAL CONTACT WITH PATIENT
3. FURTHER CONTACT
4. CONTACTING OTHER HEALTH CARE PROVIDERS

1. INITIAL DISCOVERY

- When an error occurs, you must make sure that the patient is not harmed or does not continue to be at risk. Thus, **timely intervention** is critical to an effective resolution.
- <u>The first general response to finding an error might be:</u>
- • **Avoidance:** “I didn’t make the error, it is not my responsibility to get involved.” “My boss should deal with it.”
- • **Blaming someone or something else:** “The physician’s poor handwriting was the problem.” “The computer system went down.”
- **Rationalizing that the error was not important:** “It is no big deal that I gave Terramycin tablets rather than capsules.”
- • **Rationalizing that the patient will call the pharmacy if there is a problem.**

2. INITIAL CONTACT WITH PATIENT

- The first few moments of contact with patients are critical in determining how the situation will eventually be resolved. You want to appear to be in control of the situation (that you are working to resolve the situation), but at the same time allow the patient to state his or her feelings. If the patient is in the pharmacy, go with him or her to a quiet area where other people cannot overhear.
- During the initial contact, you should make a simple, but clear statement that you are extremely sorry for the error.
- You should not place the blame on technology (“the computer didn’t catch the error”), other people (“the evening pharmacist made the error”), or the fact that you were too busy.
- If you found the error, you need to take the responsibility for trying to resolve it. If a technician made the error, you, as the pharmacist in charge, should not transfer blame to him or her since the error occurred under your watch.

2. INITIAL CONTACT WITH PATIENT (continued)

- Also, you **should <u>not</u> suggest that the patient might have contributed to the problem**, "You should have called before you took a dose of medication you thought was wrong." Do not minimize the importance of the error either, "Luckily, no harm was done. Taking the 1 mg strength of Xanax instead of the 2 mg wouldn't have hurt you." Patients are initially more concerned about the fact that an error has occurred regardless of its potential harm.
- Some errors can be remedied relatively **easily** ("please bring the prescription into the pharmacy and we will give you the new prescription" or "our staff will be bringing the new prescription out to your home later today"), while others might be more **complex** and may take time to resolve ("I need to discuss this situation with your physician before making a decision about what needs to be done").
- **<u>In situations</u>** that may take additional time, you need to convey that fact to the patient so that he or she feels that you are still concerned and are working toward a resolution and did not just forget about it.
- Finally, you should **thank the patient** for bringing the error to your attention, "Thank you for checking your medicine and telling us immediately that you had a concern." Even when patients think an error has occurred but has not (e.g., a different looking generic was dispensed), you should thank them for being vigilant and reporting the possible error.

3. FURTHER CONTACT

- Once the patient has a clear idea that an error has occurred and how it is being resolved, you may want to provide additional insights into why it occurred.
- Some patients might want to know **how** it occurred and what steps you are going to implement to prevent future occurrences. **It is best to monitor the patient's interest before launching into a detailed explanation.**
- You should be honest and upfront with the patient about the long-term consequences of the error.
- A sincere closing statement, such as "this rarely happens, but it happened with your prescription and I want to resolve it," may put the error in perspective. Patients need to hear that you found an error, you feel terrible about it, it does not happen that often, but it did happen to them, and you are going to try to resolve it.
- **You should also contact them at a later time to determine whether they have additional questions and update them with relevant information.**
- Finally, you should **WRITE** everything down for future reference (especially if litigation occurs). **Documentation** is also helpful for your quality assurance program and for the national reporting systems as well.

4. CONTACTING OTHER HEALTH CARE PROVIDERS

- You should alert physicians or other health care providers if they were involved with the original error (poor handwriting, wrong drug prescribed, prescribing two interacting medications, etc.) or if the patient requires treatment due to the damage caused by the error.
- Once again, you may be tempted to avoid contacting others since you may be embarrassed or concerned that your professional competence may be called into question.
- However, if you do not report it and they find out through the patient or some other means, then you will suffer additional consequences.
- Your colleagues will be observing how you handle the error. If they perceive that you are handling it appropriately, they will be inclined to forgive the error and move on. However, if not, they may not trust your veracity or professional competence in the future.
- Finally, revealing errors to other providers is helpful for their quality assurance efforts as well. They need to know how they may have personally contributed to the error and how communication and/or other elements of the “system” need to be improved to minimize future errors.

Summary

- Medication errors typically involve complex relationships between systems, people, and communication processes.
- They typically involve issues within and outside the control of patients, pharmacists, and other care providers.
- Patients are certainly concerned about medication errors.
- In fact, a recent study found that 69% of all hospitalized patients were concerned about “being given the wrong medicine” while staying in the hospital.
- As outlined above, pharmacists and their staffs need to be aware of the possible communication skill issues that may lead to medication errors.
- They should reflect on the errors that are identified within their practice setting and eventually use this information to improve the quality of care.
- The key is to develop and implement standards of practice that minimize errors, and to implement quality improvement systems in order to decrease the potential for error.

THANK YOU ☺