Partners in Safety – Engaging Patients to Promote Safe Medication Use

March 14, 2019
11:00 am – 12:00 pm PDT
Moderator/Host

Barbara Abeling, PhD, RN
Safety & Reliability Clinical Advisor
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Asma Ahmad
Administrative Assistant
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Housekeeping Items

• All lines will be muted. Raise your hand if you wish to be unmuted.

• The presentation slides and recording will be available within 1-3 business days.

• 1 CE unit will be provided to CHPSO/HQI/CHA Members:
  – Complete the survey by March 21, 2019
  – CE certs will be emailed by March 29, 2019
How to ask a question
Katayoon Kathy Ghomeshi, PharmD, MBA, BCPS, CPPS
Medication Safety Specialist
University of California, San Francisco Medical Center
Assistant Clinical Professor
UCSF School of Pharmacy
Partners in Safety-
Engaging Patients to Promote Safe Medication Use

Patient Safety Awareness Week 2019

Katayoon Kathy Ghomeshi, PharmD, MBA, BCPS, CPPS
Medication Safety Officer, UCSF Medical Center
Assistant Clinical Professor, UCSF School of Pharmacy
Objectives

- Explain the importance of partnering with patients for safe and effective medication therapy

- Describe strategies to include and engage the patient in safe medication use
Outline

- Getting to Know You
- Love at First Sight
- Proposal
- Engagement
- I Do
GETTING TO KNOW YOU
Why Are We Here?

Patient care is why we are all here
To Err is Human

A Brief History of Errors

– 2000: 44,000 – 98,000 preventable deaths due to error

– 2015: 1 in 2 surgeries has a medication error or adverse drug event

Just the Facts, Ma’am

Let’s ask Joe Friday… about the facts of medical error

- Personal experience with a medical error 21%
- Personal involvement with care of someone who’s experienced medical error 31%
- Patients informed of error by provider or facility 32%
- Patients who brought error to attention of medical personnel ~50%

Medication Safety Basics

- Prevent medication errors

- Prevent harm from medication use

  - Medication use processes: Procurement, storage, prescribing, order processing, preparing/compounding, dispensing, administering, monitoring, education
To Err is Human

Types of human error

- Slip
  - Error in execution
  - Skill-based error
- Lapse
- Mistake
  - Error in planning
  - Rule-based error
  - Knowledge-based error
Medication Errors

Errors of commission, errors of omission

• Examples:
  – Wrong patient, wrong drug, wrong dose, wrong route, wrong time

▪ Goals for medication errors are to:
  • Prevent
  • Detect
  • Mitigate harm
What’s the Harm?

A few terms:

- Adverse Drug Event (ADE)
- Adverse Drug Reaction (ADR)
- Medication Error

- National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)
- Agency for Healthcare Research and Quality (AHRQ)

Harm from drug use
Non-preventable harm from drug use
Preventable; may or may not result in harm

Can we be Free from Harm?!?!
Free from Harm

Safety Culture - the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to organizational health and safety management.

Just Culture - recognizes individual practitioners should not be accountable for system failings over which they have no control.
Safety Culture and Just Culture

Utilize a just culture to improve systems and hold individuals accountable for conscious choices

- System improvement: Identify contributing factors, utilize layered approach to risk reduction strategies, interdisciplinary

- Individual accountability: Assess if error is due to human error, at-risk behavior, or reckless behavior
Swiss Cheese Model

- Why are errors happening?
<table>
<thead>
<tr>
<th>Possible causes</th>
<th>Y/N</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Critical patient information missing? (age, weight, allergies, VS, lab values, pregnancy, patient identity, location, renal/liver impairment, diagnoses, etc.)</td>
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<tr>
<td>Critical drug information missing? (outdated/absent references, inadequate computer screening, inaccessible pharmacist, uncontrolled drug formulary, etc.)</td>
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<td>Environmental, staffing, or workflow problems? (lighting, noise, clutter, interruptions, staffing deficiencies, workload, inefficient workflow, employee safety, etc.)</td>
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<td>Lack of staff education? (competency validation, new or unfamiliar drugs/devices, orientation process, feedback about errors/prevention, etc.)</td>
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<tr>
<td>Patient education problem? (lack of information, noncompliance, not encouraged to ask questions, lack of investigating patient inquiries, etc.)</td>
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<tr>
<td>Lack of quality control or independent check systems? (equipment quality control checks, independent checks for high alert drugs/high risk patient population drugs etc.)</td>
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Did the patient require any of the following actions after the error that you would not have done if the event had not occurred?

- Testing
- Additional observation
- Gave antidote
- Care escalated (transferred, etc.)
- Additional LOS
- Other ____

Patient outcome:

---

LOVE AT FIRST SIGHT
Butterflies in the Stomach

- Patients nervous, anxious, confused, ill
- Place trust in medical professionals
- Place trust in healthcare
engagement  noun
en·gage·ment  |  \in-ˈɡāj-mənt\, en-

Definition of engagement
1  a  : an arrangement to meet or be present at a specified time and place
      /lə dinner engagement

      b  : a job or period of employment especially as a performer

2  : something that engages : PLEDGE

3  a  : the act of engaging : the state of being engaged

      b  : emotional involvement or commitment

      c  : BETROTHAL

4  : the state of being in gear

5  : a hostile encounter between military forces

https://www.merriam-webster.com/dictionary/engagement
Eliminating ADE - HQI Toolkit

- Key Improvement Team Members
- Executive Sponsor
- Clinical and Physician Co-Lead
- Quality Leader
- Content Specialists
- Ancillary Dept Representatives
- Frontline Staff Members
- Patient/Family Representative

Provide the voice of the patient/family
Review all patient/family education

http://www.hqinstitute.org/hqi-toolkit/eliminating-ade
There’s an App for That!
PROPOSAL
True North

UCSF Health

Mission
Caring – Healing
Teaching – Discovering

Vision
Be the best provider of health care services,
the best place to work and
the best environment for teaching and research.

Values
Professionalism – Respect – Integrity – Diversity – Excellence

True North Pillars & Strategic Priorities

Quality & Safety
• Achieve Zero Harm
• Continually Improve Patient Care

Our People
• Create an Optimal Work Experience

Financial Strength
• Lower Our Costs

Strategic Growth
• Expand Our Reach
• Optimize Access

Learning Health System
• Advance, Apply and Disseminate Knowledge

Redefining Possible
“I take the pink one in the morning and the yellow one at night”
Medication History

- SB 1254, Stone. Hospital pharmacies: medication profiles or lists for high-risk patients

- This bill would require a pharmacist at a hospital pharmacy to obtain an accurate medication profile or list for each high-risk patient upon admission of the patient under specified circumstances.

https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1254
Medication History

- May be performed by intern or technician under specified circumstances

- Hospital required to establish criteria on who is high-risk and timeframe for completion of medication profile/list
Medication Wreck-onciliation

What is on the list
What is it for
How is it taken

Adherence- what’s the issue?

Reconciliation performed at transitions of care
ENGAGEMENT
She/He Said Yes!

- Yes to engagement
- Yes to safe medication use!
Rules of Engagement

The patient comes first!

- Respect
- Listen
- Partner
I STOP for safety

S top the line, speak up

T ake time to ask, review, and check

O ptimize communication; use names, numbers, letters, and repeat back

P ush unresolved issues up the chain of command
### ISMP Assess Err Worksheet

**Critical patient information missing?**
(age, weight, allergies, VS, lab values, pregnancy, patient identity, location, renal/liver impairment, diagnoses, etc.)

**Miscommunication of drug order?**
 illegible, ambiguous, incomplete, misheard, or misunderstood orders, intimidation/faulty interaction, etc.

**Drug name, label, packaging problem?**
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Patient outcome:

---

Patient engagement can help!

ISMP Assess Err Worksheet, [https://www.ismp.org/tools/AssessERR.pdf](https://www.ismp.org/tools/AssessERR.pdf)
Bea Careful MRN:12345678 DOB: 3/14/2019

- Wrong Patient Errors
  - Look alike names
  - Look alike DOB
  - Newborn babies… name TBD
  - Newborn TWINS- similar name, same DOB!
  - Patient wristband for babies… or footband

- Appropriate Patient Identifiers
  - Location can change-
  - Multiple and/or incomplete charts
Wrong Drug Errors

- Look alike/Sound Alike names
- Allergies
- Pregnancy status

- Include indications
- Review type and severity of reactions
  - Allergy vs intolerance
Kara Mepleese MRN:33334444 DOB: 3/14/2019

- Wrong dose errors
  - Changes in concentration/volume
  - Number of tablets/capsules
  - Dosing weight, hepatic or renal dose adjustment
  - Age based dose adjustments
Emma Lissentuyu MRN:87654321 DOB: 3/14/2019

- Wrong route errors
  - Peripheral IV vs central line
  - Oral vs sublingual
  - Swish and swallow vs swish and spit
Taya Karovmee MRN:88889999 DOB: 3/14/2019

- Wrong time medication errors
  - Insulin before meals
  - Daily vs bedtime
Our Favorite Dish

High-alert medications

- Drugs that bear a heightened risk of causing significant patient harm when used in error

- Anticoagulants
- Opioids
- Insulin
I DO! DO YOU?
It’s Our Anniversary

20 years after To Err is Human

Where are we now?
2019 National Patient Safety Goals for Hospitals

- 1. Identify Patients Correctly
- 2. Improve Staff Communication
- 3. Use Medications Safely
- 6. Use Alarms Safely
- 7. Prevent Infection
- 15. Identify Patient Safety Risks
- Universal Protocol- Prevent Mistakes in Surgery

Direct Impact by Patient Engagement

Joint Commission Resources https://www.jcrinc.com/
Blunt End and Sharp End

Regulations, Policies, Systems, Administrators

Blunt End

Front Line Clinicians, Direct Patient Care

Sharp End

Patient
The Consumer Medication Errors Reporting Program (ISMP C-MERP) is an internationally recognized source for medication error information. When you report an error or safety concern, you make it possible for ISMP to uncover the causes of a problem that could affect thousands of patients like you. It only takes a few moments — and it’s simple and confidential. Help us prevent this error from happening again.

https://www.ismp.org/report-error/consumer
Risk Reduction and System Improvement

Steps in Medication Use:
- Planning/Procurement
- Storage
- Prescribing
- Order processing
- Preparing/Compounding
- Dispensing
- Administration
- Monitoring
- Education

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Focus on Systems
Focus on People

ISMP medication safety alert. Selecting the best error-prevention "tools" for the job. Feb 2006
Risk Reduction and System Improvement

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Focus on Systems

Focus on People

Post-discharge call
After-visit summary
Apps
Med history
Patient/family advisory council
Health literacy/teach back

ISMP medication safety alert. Selecting the best error-prevention "tools" for the job. Feb 2006
Roadmap to Safety

S- Safety Teams and Organizational Structure

A- Access to Information

F- Facility Expectations

E- Engagement of Patient, Client, Resident, and Family

Roadmap to Safety- Engagement

- Process to assess and address barriers to patient/family ability to understand their role in ADE prevention
  - E.g., cultural, language, hearing impairment, health literacy
- Patients/families educated on role in preventing ADE and prevention measures in hospital
  - E.g., barcode medication administration, explain purpose of meds, potential side effects, patient identifiers before med given
Roadmap to Safety- Engagement

- Process in place to assess patient/family level of understanding of education provided
  - E.g., teach back
- Process to encourage patients/family to speak up with concerns
  - And Process to report back on shared concerns

20 Tips to Help Prevent Medical Errors excerpt

• Make sure doctors know about every medicine you are taking
• Bring all of your medicines and supplements to your doctor visits
• Make sure your doctor knows about any adverse reactions you have had to medicines
• When your doctor writes a prescription for you, make sure you can read it
• Ask information about your medicine in terms you can understand
AHRQ Patient Engagement Resources

20 Tips to Help Prevent Medical Errors excerpt

• If you have you questions about the directions on your medicine labels, ask

• Ask your pharmacist for the best device to measure your liquid medicine

• Ask for written information about the side effects your medicine could cause

AHRQ Patient Engagement Resources

Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families

- Reduce errors and improve visit efficiency by setting the visit agenda together with Be Prepared To Be Engaged.
- Encourage safe medicine practices by Creating a Safe Medicine List Together.
- Improve communication and health literacy through Teach-Back.
- Support closed-loop and collaborative communication using the Warm Handoff Plus.

FDA and EMA Patient Engagement Cluster

- Food and Drug Administration and European Medicines Agency joint workgroup
- Share best practices involving patients along drug and biological regulatory processes

- Patients directly voice concerns of community
- Train selected patients/advocates to participate in agency work

https://www.fda.gov/forpatients/patientengagement/ucm507907.htm
I think this is the beginning of a beautiful partnership
What Have We Learned?

An engaged patient can promote safe medication use by:

• A. Stopping the Line if a wrong medication is ordered
• B. Communicating adverse drug effects to their provider
• C. Reporting issues concerning medication use
• D. All of the above

D. You guessed it! Patients can play an important role in promoting safe medication use

TRUE or FALSE: Patients are unable to support the 2019 National Patient Safety Goals - it is the sole responsibility of the hospital.

FALSE. While the hospital bears this responsibility, engaging patients can help support several of the current goals.
How to ask a question
# Upcoming HQI-CHPSO Webinars

<table>
<thead>
<tr>
<th>Date</th>
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<th>Topic</th>
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<tbody>
<tr>
<td>April 16</td>
<td>10:00 am – 11:00 am PDT</td>
<td>Family and Nurse Engagement on Rounds to Improve Safety: The Patient and Family Centered I-PASS Study</td>
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<tr>
<td>May 30</td>
<td>10:00 am – 11:00 am PDT</td>
<td>California Bridge: Treatment of Opioid Use in Acute Care</td>
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## Upcoming CHPSO Safe Tables

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<tr>
<td>March 27</td>
<td>10:00 am – 11:00 am PDT</td>
<td>Falls and Immobility</td>
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<tr>
<td>April 10</td>
<td>10:00 am – 11:00 am PDT</td>
<td>OB Triage Issues</td>
</tr>
<tr>
<td>April 24</td>
<td>10:00 am – 11:00 am PDT</td>
<td>ED Boarding of Psychiatric Patients</td>
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</table>
Follow-up Email

• Please complete our survey
  – Share potential topics for future meetings

• CE Information

• Slides

• Recording
Thank You!

Follow @CHPSO and @HQInstitute on Twitter!