Medication Error Reporting in the Home Setting

Background

Medication errors are a national issue that has been of great concern for the healthcare industry and the public for decades. The Institute of Medicine has estimated at least 1.5 million people are harmed annually with a concomitant cost of 3.5 billion healthcare dollars spent to treat the drug related injuries. This is a conservative cost as it does not include lost wages or lost productivity in the workplace created by those who have experienced adverse effects caused by a medication error. Medication errors erode the public's trust in the healthcare system and decreases patient satisfaction.

Patients receiving hospice and/or palliative care services must be recognized as being particularly more vulnerable to medication errors due to their serious illness and use of high risk drugs (e.g., opioids, psychotropics). Moreover, healthcare systems and individual clinicians may fail to report medication errors due to a lack of clarity regarding the definition of a medication error as well as concerns about punitive action if the institution or clinician reports the error.

Medication error reporting is essential to ensuring patient safety and preventing negative outcomes. Reporting processes should be non-punitive, timely, systems oriented, and confidential. Processes should extend beyond the act of reporting and include expert analysis that leads to the implementation of corrective action. To date, there is no national mandatory process for medication error reporting and many organizations do not record errors or conduct root cause analyses for trending. An effective medication error reporting system is a cornerstone for safe practice. Healthcare providers and institutions alike must become more proactive in preventing medication errors that may lead to significant adverse events.

Nurses are responsible to their patients to ensure the “five rights” (right patient, right medication, right dose, right route, right time) prior to the administration of any medication. Knowledge of individual patient’s allergies, medication indications, and contraindications, as well as any adverse reactions are basic responsibilities of practicing nurses.
In the clinical care environment of a patient’s home, there are a multitude of unique variables that may contribute to the challenge of not only causing an error to occur, but also in the actual identification and/or reporting process. Factors include, but are not limited to: patients who are visually impaired; patients who live alone with cognitive impairment; the presence of polypharmacy for older adult households who may be prescribed multiple medications; the lack of an individual care giver who can assume the professional role for medication administration in order to assure complete adherence to the prescribed regimen.

Another obvious contributing factor is the lack of around-the-clock supervision by a professional in the home who could identify medication errors of omission. Personal engagement with home care and hospice home care nurses have reported and documented in the medical records that a patient may have not taken the medication because it was felt to be burdensome or not needed based upon the patient’s or their care giver’s opinion.

The focus of this position statement is to heighten the awareness on the growing concern of medication errors and its impact on the health and safety of patients. HPNA recommends that providers of care execute due diligence in regards to the development of systematic medication error reporting and analysis to assure patient safety and support medication efficacy.

**Position Statement**

- Be knowledgeable of Federal, State, Local statutes and standards that are applicable to medication error reporting (e.g., The Joint Commission, CHAP) as well as Medicare and Medicaid Programs: Hospice Conditions of Participation (COPs).
- Develop policies and procedures for the purpose of reporting, analyzing and responding to medication errors to ensure due diligence toward optimal patient safety with medication administration.
- Assure resources that include a defined mechanism for collecting reports, database management capacity to investigate, technical infrastructure, method for classifying the medication error type, expert analysis and a capacity to disseminate findings and recommendations.
- Educate nurses about prescription and over-the-counter drugs relative to:
  - Correct dosing, frequency and route
  - Possible adverse drug side effects and/or potential drug-drug, drug-food, and drug-herbal interactions;
  - Duplicative drug therapy; and
  - The need for any/all laboratory monitoring (as applicable)
- Instruct all healthcare professional on the procedure to follow in the reporting of medication errors (i.e., through the use of incident or unusual occurrence report forms).
- Define individual nurse, healthcare professional as well as patients and their care givers responsibilities on all aspects of the medication error
reporting and education process of identifying, reporting, and analyzing data trends that may result in quality improvement initiatives.

- Evaluate the level of severity of medication errors caused by clinicians and other personnel in order to maintain an ethical, morale, and legal responsibility to safeguard patients.
- Assure that the process of medication error reporting remains non-punitive and focuses on a quality improvement approach.

**Definition of Terms**

*Medication error:* “A 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 healthcare professional, patient, or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems, including: prescribing; order communication; product labeling; packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use” as well as any inappropriate medication use or harm while the medication is in the control of the nurse. An incident report of a medication error can be related to the acts of: prescribing; transcribing; dispensing; administering; and/or monitoring.

*Home setting:* Any private residence, skilled nursing facility, adult home, assisted living facility, or any other place that the patient calls “home.”

**References**

10. COPS 418.54 (c) (6)

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This position statement reflects the bioethics standards or best available clinical evidence at the time of writing or revisions.

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