Medical errors are 8th leading cause of death in the United States.
- Medication errors are the most common type of medical errors.
- This accounts for more than 7000 deaths annually.

FACT:
The multifactorial and multidisciplinary nature of Medication Safety Remains a Challenge in an Academic, Acute Care Hospital that requires a transdisciplinary/transformational approach.

Medication Safety is a National Health Care Priority.
Nursing is in a Pivotal Position to Promote a Transdisciplinary/Interdisciplinary practice model that will establish a sustainable Medication safe environment.

Definitions

- **Medication Error**: “Any error occurring in the medication-use process, regardless of whether injury occurs” (Bates 1995, p. 200). The medication prescribing process involves multiple steps, including decision making, prescribing, procuring the drug, dispensing, patient adherence and monitoring the patients’ response (Wessell et al., 2010).

- **Adverse drug event (ADE)**: generally considered to be any injury due to medication (Bates, 1995, p. 200).

- **Transdisciplinary Model**: A transdisciplinary team approach to safe medication practices emphasizes mutual learning, training and education, and the flexible exchange of discipline-specific roles, with everyone sharing a common goal.
What is “Transformational Learning”?

- "Transformational learning involves experiencing a shift in thoughts, feelings and actions; a vision of alternative approaches to living. Learning can only be considered transformative if it involves a fundamental questioning or reordering of how one thinks or acts." (O’Sullivan, E. 1999) (Brookfield, S.D. 2000)
- In the context of safe medication administration, Managers were able to acquire new knowledge, incorporate it into their practice, and transfer this knowledge to staff RNs through mentoring.

Objectives

- Define the dimensions or factors that influence medication safety
- Identify 2 Methods to engage RNs in safe medication administration.
- List 3 measurable outcomes when evaluating medication safety.

Demographics

- People > age 65: fastest growing segment of the population
- By 2030 20% population will be > age 65
Contributing Factors in Medication Management in the Older Adult

- Multiple Medical Problems
- Age Related Co-Morbidities
- Physiologic Changes
- Multiple Medications
- Family/Caretakers also older: This influences resource requirements

First step in Medication Safety for Older Adults

- Minimize the Medications!
- Staff should be educated on evaluating patients on admission for appropriateness of medications.
- Five medications or Less is the goal.

Inpatient & Outpatient Older Adults

- Medication Safety applies to both
- Inpatient complicated by fast paced environment, and acuity of patient.
Medication Errors
- Occur during the process of medication: prescribing, dispensing, preparation, administration, monitoring

Most medication errors occur at patient care “transition” points.
These include:
- Admission
- Transfer from one unit to another
- Discharge

46% of medication errors occur during transitions

Nurses serve as key interceptors at each of these transitions.
Using Transformational Learning, Leadership Implemented:

“Debriefing”

Using Transformational Learning, Leadership Implemented:

“Huddles”

Using Transformational Learning, Leadership Implemented:

“Peer Review”
Psychiatric RN Liaison Service

- Psychiatric RNs from inpatient psychiatric unit that temporarily closed after Superstorm Sandy.
- Goals of the Service
  - Provide expertise and serve as a resource and support to nurses working with patients on constant observation and demonstrating challenging behaviors.
  - Collaborate with floor RNs, transdisciplinary treatment team, patient and family members in the creation of a treatment plan.
  - Created Educational Series presented to RNs, PCTs, PUAs, CM and SW.
  - Initiated daily rounds on all patients on constant observations.
  - Available to see patients experiencing emotional distress and/or with psychiatric histories.

Delirium Risk factors

Psychiatric RNs Liaison Service:
- Perform chart review of medication regimen
- Identify any potential causal factors for delirium
- Utilize Beers Criteria for potentially inappropriate medication use
- Identify opportunities to collaborate with Psych MDs on consult service to evaluate appropriateness of meds.

Questions . . . .

Thank you!