Addressing self-medication safety in a rehabilitation facility - a multi-disciplinary approach to minimising risk and improving patient outcomes across the continuum

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“Place under your tongue and swallow. Then spit it out when no one’s looking.”
Self Medication History at HRC

- Protocol and compliance checklist developed in late 80’s
- Contract between client, pharmacy and medical staff – nurses as supervisors only
- A revised document signed by the pharmacist in 1993 states:
  “The self-administration program forms part of the on-going rehabilitation process at Hampstead Centre.”

Nursing role unchanged. Nominal mention of Multi-D team
Self Medication History at HRC

- Vague criteria for participation in the program
- Each unit interprets criteria and develops own compliance monitoring processes
Self Medication History at HRC

- Nurses become instigators, educators and evaluators of self medication
- In 1997, a Medication Incident Working Party was established by the Nursing Department after concerns of increased medication errors which also included self medication
- Interdisciplinary Working Party recommended by MIWP and convened.
Medication Management/ Safety Committee

- Formed in 2006 (at urging of nursing staff), 7 years after recommendations of Interdisciplinary WP had been made to management!
Committee Objectives

- Quality Activities related to medication management
- Improve medication safety
- Reduce risk associated with medications
HRC Self-Medication Sub-Committee

- Clinical Service Coordinators x2
- Pharmacist
- Medical Officer
Self-Medication Issues at HRC

- Multiple medication charts in use (pre-NIMC).
- Change of Medical Officers and lack of orientation concerning self medication.
- Potential of “double dosing”
Self-Medication Issues at HRC

- Potential for omission of medication.
- Potential of client forgetting medication – lack of supervision.
- Decision on medications to be included or not in dosettes.
What had to change?

- Self Medication storage – individual supply.
- Investigation of other forms of dispensing other than dosette.
- “Progress” clients onto bottles and boxes instead of using dosettes.
- Appropriate selection of clients for self administration.
- Establish appropriate policies, e.g. RAH Drug Formulary is acute-specific.
What had to change?

- A need for common documentation

- A need for common assessment sheet for suitability to self medicate that can be included in medical records.

- Need to safely meet rehabilitation goal of independence.
By the way, we also changed:

- Cold chain storage and monitoring
- Nurse-initiated medication orders (response to lack of after-hours MO coverage)
Hello Pharmacy? Ya! I ordered that medication three times and I haven't seen it yet!

Three times? You didn't even order it once!

If I told the truth, they would have thought it was my fault it didn't come!

Oh... I see.
Sub-Committee’s Objectives

• Developed a self-medication policy, processes and documents based on Best Practice and rehabilitation principles
• Encouraged further Allied Health involvement (unit-specific)
• Oversee introduction of new medication trolleys/ IPS
• Investigate dispensing systems
• Evaluate trials and revise policies as necessary
• Computerised physician ordering
• IPS
• Pharmacists to double check and consult
• Dedicated nurse for administration
• Double checking by nurses may reduce errors
• Medication Safety Committees can reduce errors
There is evidence that the use of “multi-compartment medication compliance aids” may represent a simple method of improving medication adherence.
The common thread to interventions at improving adherence with medications is increased frequency of interaction with patients.
Guiding Principles

- Selection of suitable people
- Choice and provision of medication
- Medication storage
- Legal and procedural documentation
- Resources
The Self-Medication Stamp
Reasons for Self-Medication

- Client lives alone and will be solely responsible for medications
- Client has social support but who are unwilling to assist
- Uncertainty regarding discharge destination
- Discharge to low level residential care
- Client takes frequent leave
- Client/family requests self medications
- Client needs to direct carers to administer
- Any other reasons determined by clinical team
Potential barriers

- Client has significant deficits, e.g. visual, dexterity, memory, communication
- Concerns re adherence
- Client unable to demonstrate understanding of condition/s and medications
- Unstable medication regime
- Client does not understand responsibilities
- Unable to open containers or direct carers
- Client does not consent

Problem solving strategies provided
**Assessment of the Client for Suitability to Self-medicate**

**PART ONE — Client is suitable to trial self medications:** Document the reason for commencing trial.
- e.g.: Client will be independently living on discharge and medication safety must be assessed prior to discharge; there is a need to assess the client's ability to direct care's to administer medications.
- If client is not suitable for self medication trial, write "Not applicable" and proceed to Part Two.

**PART TWO — Client is unsuitable/unwilling to self medicate:** Document the reason for not proceeding with trial below (Refer to problem solving section of HRC).
- Self Medication Guidelines for alternative strategies:
- e.g.: Client will not be responsible for medication administration on discharge: client is not able to safely administer or direct administration of medications.
- If client is suitable for trial, write "not applicable".

Mode of medication management (circle): Dosette Bottles / Boxes

Assessment completed and discussed with patient by:

(Sign) ____________________________ (Name / Designation)

(Sign) ____________________________ (Name / Designation)

Next Review (if applicable):

Date of assessment:

Fax copy of completed form to Pharmacy with initial self-medication order.

Date / /
### Inpatient Progress Notes

**Assessment of Self-medication Compliance**

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Trial Process

- Four stages, accompanied by team evaluation, in consultation with client, documentation and further education as required. Each stage is a minimum of one week (if appropriate to length of stay)
- Education by Pharmacist a key component
- Record of adherence
Guidelines implemented March 2008 following education in all clinical units (and trial in 2 units)

Source: unknown
Audit 6 months post-implementation

- 84% of clients who are self medicating have documented assessment
- 89% have mode of administration pre-assessed
- 89% have adherence documentation implemented
Number of Self-Medication Incidents (April - September)

- 2005: 10
- 2006: 12
- 2007: 8
- 2008: 1
Number of Occupied Bed Days per Incident (April - September)
Problems

- Still a Nurse/Pharmacist responsibility
- Need for further education re guidelines
- Poor documentation of compliance after initial stage
- Strange decision-making re client independence
Learning from mistakes

- Keep
- It
- Simple
- Stupid
THANK YOU

Any questions?