Family Participation with Home Health Care in High Alert Medication Safety

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Overview

According to HHCS Data of medications errors in 2018, Administration Errors represent 54%of all medication's errors. All administration errors were done by the caregivers for the patient at home. By analysis of administration errors, the most common type is wrong dose was given to the patient. The medication with most common administration error is warfarin tablet which represent more than 30%between other medications.

So after using fishbone diagram ,the most common cause of administration error of warfarin is the communication of the dose between Home Health Care (HHCS)Staff and the caregiver at home although using read back technique .HHCS team with Family members of Patient Family Advisory Committee (PFAC) started creating simple warfarin template including pictures of different warfarin tablet strengths within table with the week days to mark under warfarin tablet strength in each day of week and sending photo of warfarin template for the responsible family member /caregiver to make sure the dose is clear even for caregivers with low health literacy level after informing the caregiver by telephone call and using read back technique.
After starting using warfarin template in District three patients from March 2019 till August 2019 ,there was significant decrease in administration errors of warfarin .

Learning Objectives

1-Decrease in administration errors of warfarin by using simple warfarin template.
2-Family members engagement in safety of high alert medication and creating warfarin template .
3-Improve the safety of High Alert Medication.
4-Decrease the number of adverse outcomes may result from wrong dose administration.
4-Improve patient/family member satisfaction about HHCS service .

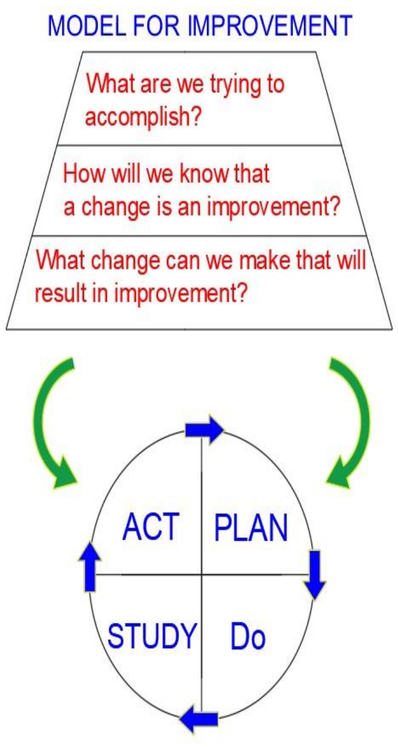
Methodology

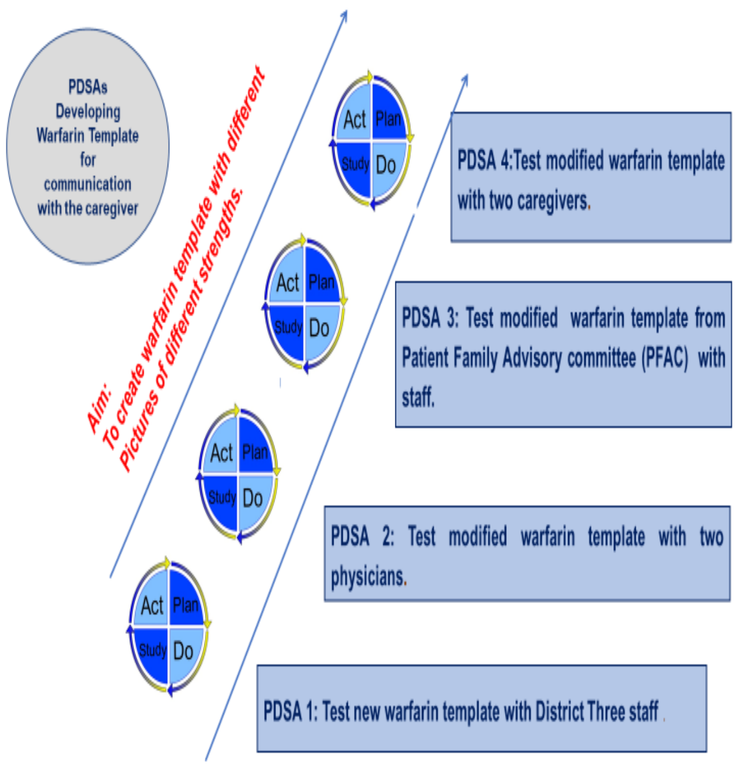
Home Health Care(HHCS) Multidisciplinary team with family members started first PDSA cycle of testing warfarin template (including pictures of different strength colors of warfarin tablet in table with weekdays in Arabic and English Languages) followed by three PDSA cycles of modified warfarin template based on staff, physicians and family members comments.

District three staff started in March2019 using warfarin template in communication about the dose of warfarin with the caregivers /family members by sending photos of warfarin template after writing the dose under the strength in every day of the week based on the prescription by HHCS Physicians and informing the dose by phone call also.

By comparing percentage of administration errors of warfarin to total administration errors for other medications in the last six months before starting using warfarin template to the next six months after implementing warfarin template ,there was significant decrease as shown in Graph(1).

Under district three ,there are four cases with repeated administration errors of warfarin (2-7times) in previous six months before using warfarin template ,these cases became able to take warfarin doses correctly without any error (Graph2) .





Warfarin Template

خدمات الرعاية الصحية المنزلية
Home Healthcare Services

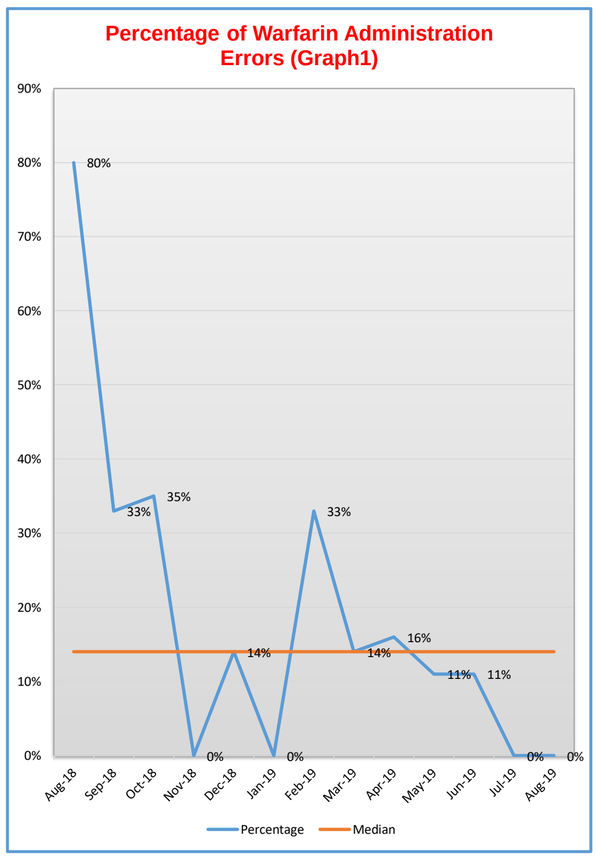
Patient HC: _____ Physician Name: _____ Start Date تاريخ البدايه _____
Staff Name: _____ End Date:نهايه العقد _____

Week Days أيام الأسبوع	Warfarin 1 mg وارفارين 1 مجم 	Warfarin 2 mg وارفارين 2 مجم 	Warfarin 3 mg وارفارين 3 مجم 	Warfarin 5 mg وارفارين 5 مجم 
Sunday الأحد				
Monday الأثنين				
Tuesday الثلاثاء				
Wednesday الأربعاء				
Thursday الخميس				
Friday الجمعه				
Saturday السبت				
Sunday الأحد				
Monday الأثنين				
Tuesday الثلاثاء				
Wednesday الأربعاء				
Thursday الخميس				
Friday الجمعه				
Saturday السبت				

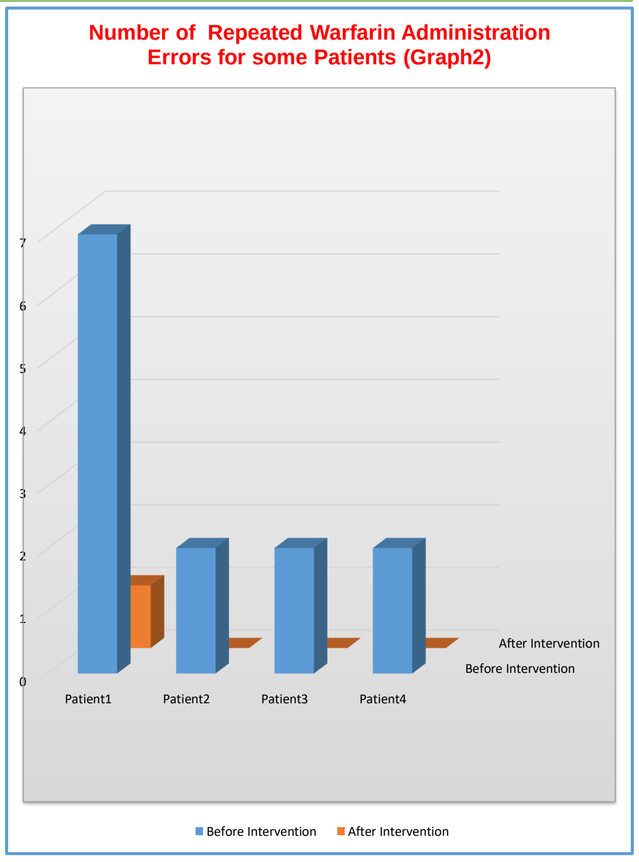
*Check the history in order information about the dispensed strength before calling family.

Results

Percentage of Warfarin Administration Errors (Graph1)



Number of Repeated Warfarin Administration Errors for some Patients (Graph2)



Conclusions

The Safety of High Alert medication is one of The Joint Commission(JCI) International Patient Safety Goals (IPSG3)so HHCS started effective action to decrease administration errors of warfarin doses and the complications that may result from wrong dose administration.

HHCS will spread using Warfarin template to all district staff to decrease administration errors between all HHCS patients.

First active involvement of (PFAC) Members in quality improvement project of safety of high alert medications and looking forward for more projects with the family members.

References

1-Warcel D, Johnson D, Shah N et al. Service improvement system to enhance the safety of patients admitted on long-term warfarin. BMJ Qual Improv Report 2014;3(1)
2-Federico F. Preventing harm from high-alert medications. Jt Comm J Qual Patient Saf 2007;33:537–42

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