# Medication Administration Training Discussion - Common Medication Errors

- **Wrong Time:**
    - Many locations have bid medications (twice per day) at 7am & 7pm or 8am & 8pm. When documented correctly on the MAR, 7am on top and 7pm on bottom of the entry into the MAR… sometimes this is not done staff presume the top is am and the bottom is pm… need to pay attention to the times and how positioned on the MAR entry.
    - Highlighting each time with a different color (AM meds in pink, PM meds in blue) may help with this confusion.
    - Also, scheduling bid meds 12 hours apart can be confusing. Maybe doing 8 AM and 7 PM for example would help.

- **MAR Documentation Error:**
    - Examples and causes
        - This is often a forgotten initial on the front or back of the MAR, forgotten results on a PRN use or a forgotten signature in the bound book.
        - Hint for MH and ID: As folks are preparing each medication, placing a small dot in the box where your initial eventually goes, can be a safeguard to missing your initial that gets entered after the resident has successfully been administered the medications offered.

- **Pharmacy Error:**
    - Examples and causes
        - The pharmacy did not fulfill a requested prescription order
        - The pharmacy sent the wrong medication/dose/route, etc. or
        - Pharmacy sent an incomplete/wrongfully labeled medication packet.
    - Possible solutions
        - Physician should be notified that medication is unavailable.
        - Calling the pharmacy to confirm they received the order may help.

- **Refusal of Medications:**
    - There are times when a resident needs answers to questions about the medication, but the CRMA does not always ask the resident how they can help or why they are refusing. There can be a fine line between helping the resident and violating their right to refuse medication. The CRMA plays an important role in providing the resident with the information they need to make an informed choice.
    - Re-approaching the resident after 15 minutes or so may help.
    - Some residents may prefer their meds mixed with something other than what is being provided.

- **Missed dose:**
    - Examples and causes:
        - Meds are not ordered on time and therefore are unavailable at the facility
        - CRMA initials bubble pack prior to giving the med
        - Pre-popping pills rather than one at a time for each resident
        - CRMA does not stay to watch resident swallow the meds,
        - Med is scheduled at a time when other regularly scheduled medications are not being given (off-times),

        - Resident goes on an activity and meds aren't packed
    - Possible solutions
        - All medications must be given to one resident at a time
        - Set a timer for medications not administered during regular times
        - Designating a staff member to re-order medications once or twice weekly may help with this.
        - Medications should be ordered a week or so before running out. This has been an issue with the pharmacy at times. They may say it is too soon to order but then they do not have the med in stock and must order it themselves, thus delaying delivery.

- **Wrong dose:**
    - Examples and causes
        - pre-popping,
        - not doing 3 checks,
        - distractions in the med room
    - Possible solutions
        - Do not pre-pop, unless a resident refuses and staff are planning to re-approach. In this case, the med cup should be labeled with the resident's initials.
        - Eliminate distractions from team members

- **Transcription errors:**
    - Examples and causes
        - Meds are transcribed correctly but the start date in EMAR is not correct (AL only),
        - Meds are not co-noted in EMAR prior to the pharmacy order cut off time (AL only),
        - Co-noter does not catch an error
    - Possible solutions
        - The physician's order should be faxed to the pharmacy right away. The noting and co-noting should happen after the order is faxed.
        - Check the eMar date after transcribing (AL only)