Introduction to the Medication Error Reduction Workbook

Overview

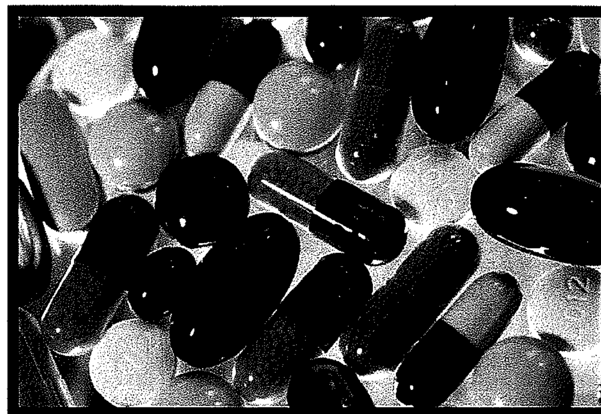
The Massachusetts Coalition for the Prevention of Medical Errors, MassPRO, the healthcare quality improvement organization for Massachusetts, and the Massachusetts Extended Care Federation have joined together to collaborate on reducing medication errors within long-term care. The primary aim of this collaborative effort is to develop the essential tools required by healthcare professionals working in the long-term care setting, which will lead to improved medication management systems and a reduction in the incidence of medication errors and resident harm. This work has been funded by the Betsy Lehman Center for Patient Safety and Medical Error Reduction and the Massachusetts Department of Public Health.

Summary

A systems approach to medication management in long-term care facilities is outlined in this workbook. This resource is designed to provide nursing home staff with a step-by-step guide through the key processes of a comprehensive medication management system and address areas that can lead to the reduction in medication errors. As the various processes affecting medication use are addressed in each tab of the workbook, focus will be given to key areas that contribute to medication errors. In addition, tools will be offered as strategies to reduce incidence and harm.

The workbook serves to:

- Guide nursing homes in their assessment of current medication practices
- Outline the key processes in the medication use system
- Assist nursing homes in identifying aspects of the medication use process that require improvement
- Specify how each step in the process can be improved
- Provide tools for monitoring the implementation of system changes and tracking accountability for medication errors



Adopting a systems approach to improving performance outcomes in nursing homes is the basis for the quality improvement work outlined in this workbook. Points to consider that relate to the successful adoption of a systems approach include the following:

- Failures in quality most commonly are the result not of faulty people but of faulty processes.
- All activities carried out in an organization can be described in terms of processes. Processes are a series or set of actions carried out to achieve a certain result (Schroeder, 1994). Processes then make up larger subsystems or systems.
- Healthcare organizations can be described as open systems made up of complex interconnecting elements such as subsystems and processes that are goal-directed, governed by feedback and have the ability to adapt (Gillies, 1982).
- Quality improvement concepts emphasize that improvement will happen when the assignment of blame is stopped and the process of studying and changing the way the system works begins (Schroeder, 1994).
- Improving the medication management system used in nursing homes by changing or redesigning care processes should lead to improved outcomes in medication errors and adverse drug events for residents in nursing homes.

Tools

- **Jumpstart Flow Diagram**