Strengthening Med Safety in Long-Term Care

ISMP CANADA

Med Safety Signal

Risks in medication safety reported by LTC Homes in Ontario

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Wrong Resident Medication Error

Reported Incident (details are modified to ensure confidentiality of the home and reporter)

A medication with potential for significant toxicity and risk of harm was prescribed for a resident. Unfortunately, the resident's roommate accidentally received a dose of the medication. The error was discovered when the roommate's clinical condition deteriorated, necessitating transfer to the emergency department. The roommate needed a prolonged hospital stay to recover.

After reviewing their resident identification policies and procedures, the long-term care home (LTCH) introduced specialized processes for residents receiving medicines with significant risk of toxicity.

In a recent ISMP Canada review of medication incidents in LTCHs*, administration to the wrong resident was one of the most common factors contributing to resident harm.

Disclaimer: ISMP Canada staff determined the following key contributing factors and considerations for improvement. It is the responsibility of medication safety leaders in long-term care to determine what, if any, actions for improvement are needed in their medication management processes.

Key Contributing Factors:

- Unlike patients in an acute care facility, long-term care residents often do not wear wristbands or other forms of identification. Confirmation of identity must therefore rely on less effective methods, such as memory or potentially outdated photographs.
- New or temporary staff may be unfamiliar with residents and may not be able to identify them solely by visual recognition.
- Residents often receive their medications while congregated in the dining area, making location (e.g., room number) an unreliable method of identification.

Considerations for Improvement:

- Ensure that the LTCH has a reliable method of identifying residents, using at least two different identifiers, before medication administration.
- If resident photographs are used for identification, update them every 6 months or whenever a person's appearance changes.
- Consider, with input from families and residents, using biometric and technological solutions to improve identification processes, especially for medications with a high risk of harm.
- If possible, tell the resident what medications they are about to receive and why, and confirm they are receiving what they expect.

Resource:
*Reporting and Learning in Ontario Long-Term Care Homes: A Multi-Incident Analysis of Medication Incidents
https://ismpcanada.ca/bulletin/reporting-and-learning-in-ontario-long-term-care-homes-a-multi-incident-analysis-of-medication-incidents

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