Communication Of Medication Side Effects In An Acute Care Hospital

Deb Bachand
Maine Medical Center

Rachel Caiola
Maine Medical Center

R6 Neurology Med-Surg Unit

Haley Pelletier
Maine Medical Center

Brendan Lilley
Maine Medical Center

See next page for additional authors

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Authors
Deb Bachand, Rachel Caiola, R6 Neurology Med-Surg Unit, Haley Pelletier, Brendan Lilley, Suneela Nayak, Ruth Hanselman, and Stephen Tyzik

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Prior to this KPI, patients were not effectively taught the side effects of medications prescribed to them, creating a safety and risk issue. Previous attempts at educating patients had been ineffective and the nursing staff was looking for a better solution to this problem.

**Problem/Impact Statement:**

Prior to this KPI, patients were not effectively taught the side effects of medications prescribed to them, creating a safety and risk issue. Previous attempts at educating patients had been ineffective and the nursing staff was looking for a better solution to this problem.

**Scope:**

In scope: All clinical staff working within the R6 unit at MMC
Out of scope: All clinical staff at MMC

**Goal/Objective:**

KPI 1: Educate patients about the medications prescribed to them
KPI 2: Have two new medications written on the patient whiteboard every day

Overall Goal: Ensure that patients report that they understand the side effects of their medications when asked, higher than the national average.

**Baseline Metrics/Current State:**

![R6 - Communication About Medications HCAHPS Score](chart1.png)

**Figure 1:** Baseline data for HCAHPS question regarding communication about medications

**Root Cause Analysis:**

<table>
<thead>
<tr>
<th>Reasons New Medications Not On Patient Whiteboard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Too Sick</td>
</tr>
<tr>
<td>Patient Refused</td>
</tr>
<tr>
<td>Patient Confused</td>
</tr>
<tr>
<td>Sleeping</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
<tr>
<td>Seizure Activity</td>
</tr>
<tr>
<td>New Admit</td>
</tr>
</tbody>
</table>

![Chart 2: Reasons Patients did not receive two new medications on their whiteboards](chart2.png)

**Countermeasures**

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Due Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse gives an overview of medications to patient</td>
<td>R6 Nurses</td>
<td>March 2017</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Improvement Plan #1 – Team up with pharmacists, who will discuss the medications with at least two patients a day</td>
<td>Culture Safety Group</td>
<td>March 2017</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Improvement Plan #2 – R6 will no longer report out on confused and nonverbal reasons for goal not met</td>
<td>Culture Safety Group</td>
<td>April 2017</td>
<td>Completed</td>
</tr>
<tr>
<td>Improvement Plan #3 – Write explanation/overview of two new prescribed medicines each day on the patient whiteboard</td>
<td>Culture Safety Group</td>
<td>April 2017</td>
<td>On-going</td>
</tr>
<tr>
<td>Improvement Plan #4 – R6 will no longer report out on confused and nonverbal reasons for goal not met</td>
<td>Culture Safety Group</td>
<td>April 2017</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Improvement Plan #5 – Send out page to remind RNs to ensure medications are written on whiteboard at 9am and 9pm</td>
<td>Culture Safety Group</td>
<td>May 2017</td>
<td>On-going</td>
</tr>
</tbody>
</table>

**Outcomes**

![R6 - Communication About Medications HCAHPS Score](chart3.png)

**Figure 3:** Post-KPI data for HCAHPS question regarding communication about medications

**Next Steps**

Next steps involve hard-wiring and spreading these developed ideas:
- Instituting these procedures in orientation
- Partner with the doctors in the process (doctors can change the board when they change meds)