NCPS
Nebraska Coalition for Patient Safety

NCPS Reporting Committee Summary
Quarter 4 - 2021

Could this happen in your organization?

Patient Safety Event

At the time of an inpatient's discharge from the hospital, the patient was given a bubble pack of medication that was in the hospital room's medication drawer. Several days later the patient's spouse returned to the hospital after having discovered the bubble pack meds were not for the spouse. Investigation found that the medication was the previous patient's home meds. The previous patient had been dismissed the day before this patient was admitted to the same hospital room.

Contributing factors:

- Failure to follow policies and protocols
- RN that dismissed the patient floated to the floor that day and was unfamiliar with patient dismissal process
- RN experienced distractions and interruptions as she completed the discharge process

Mitigating Risks Associated with Discharging a Patient with Incorrect Medications	Yes	No	What action is needed?
Does your organization have a policy for accepting a patient's home meds? Does it require: • the medication to be labeled with the patient's name? • the medication to be in its original packaging? • a Pharmacist from your facility to visually inspect the medication to confirm its identity and integrity? • the medication be securely stored while in the hospital?			
At the time of a patient's hospital admission is the patient/family member informed when the patient's own medication is not permitted? When possible are those medications sent home with the patient's family member/caregiver?			
Does your organization have a written medication reconciliation protocol for use at admission and discharge? Do you have a process to verify staff's competency in performing it? Are audits completed to ensure the process is completed without errors?			
What is your facility's orientation process for float staff?			
Is your facility's patient identification process the same in all departments?			
What is your organization's process for returning home medications to the patient at the patient's dismissal?			
What is your process for the patient medication drawer after dismissal? Who is responsible for emptying the medication drawer after dismissal?			
Does your organization have a written protocol for provision of patient education at their time of dismissal? Do you have a process to verify staff's competency in providing it? Are audits completed to ensure the process was completed?			
Does your organization have a method such as "Teach Back" to account for varying levels of health literacy and to ensure the patient understands their discharge instructions?			

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References

1. Joint Commission. National Patient Safety Goals 2022 for the Hospital Program. Available at: www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2022/npsg_chapter_hap_jan2022.pdf

2. Joint Commission. National Patient Safety Goals 2022 for the Critical Access Hospital Program. Available at: www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2022/npsg_chapter_cah_jan2022.pdf#:-:text=National%20Patient%20Safety%20Goals%C2%AE%20Effective%20January%202022%

3. Weber, R. 2010. Medication Reconciliation Pitfalls. Medication Reconciliation Pitfalls | PSNet (ahrq.gov)

4. Health Education England. Health Literacy Toolkit. Available at: Training and educational resources | Health Education England (hee.nhs.uk)

5. Agency for Health Research and Quality. Universal Precautions Health Literacy Toolkit. Available at: AHRQ Health Literacy Universal Precautions Toolkit | Agency for Healthcare Research and Quality

Additional Resources

- Grissinger, M. 2012. Pennsylvania Patient Safety Authority Advisory. Patients Taking Their Own Medications While in the Hospital. Available at Patients Taking Their Own Medications While in the Hospital | Advisory
- Lagasse, C. 2013. UFHealth. Patient's Own Medication in the Inpatient Setting. Available at Final-November-2013.pdf (ufhealth.org)

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