Procedures Pose a Barrier to Reporting Medication Errors

BY DOUG BRUNK
San Diego Bureau

SALT LAKE CITY — It's a bad thing when a medication error occurs in a nursing facility. It's a good thing when that error is reported and the result is improved procedures. But it's a common thing for a wrong medication or dose to go unreported because the facility doesn't have a readily available reporting system or form.

That's the key message from results of a novel study that set out to identify barriers to medication error reporting in nursing homes.

'Efforts to improve medication error reporting frequency should focus on organizational ... interventions.'

DR. HANDLER

"Efforts to improve medication error reporting frequency should focus on organizational rather than on individual-level interventions," Dr. Steven M. Handler suggested at the annual symposium of the American Medical Directors Association.

Medication errors, as defined by the Centers for Medicare and Medicaid Services under F-tag 332, include preparation or administration of drugs not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards. Reporting of such errors is important so facilities can understand the causes of errors, make responsible parties aware of correctable problems, and improve patient care, Dr. Handler said.

In 2005, Dr. Handler of the division of geriatric medicine at the University of Pittsburgh and his associates created a survey by first asking physicians, pharmacists, nurses, and other advanced practitioners, "From the perspective of your profession, what are the reasons for not reporting medication errors in the nursing home?"

The researchers also asked participants to say whether the obstacles to error reporting were "organizational" (involving the process of reporting medication errors) or "individual" (involving the preferences, abilities, or characteristics of people responsible for reporting errors).

From these preliminary answers, the team created a 20-item survey and administered it to 145 of the health professionals at four nursing homes in Pennsylvania.

The respondents used a five-point scale to score factors in terms of their likelihood of posing a barrier ("very likely" to "very unlikely") and their potential to be corrected ("not modifiable" to "very modifiable"). The survey's response rate was 68%, Dr. Handler said.

Four of the top five barriers that the respondents considered to be the most modifiable were organizational processes: a lack of a readily available medication-reporting system or forms, a lack of information on how to spot a medication error, a lack of feedback to the reporter or to the rest of the facility on reported medication errors, and a time-consuming error-reporting system or form.

Dr. Handler called the lack of feedback "particularly important. If the expectation is that all medication errors should be reported, then staff should have an equal expectation that all reported medication errors will be reviewed and analyzed, and that some form of action will be taken to prevent the same or similar events from occurring in the future."

Only one individual obstacle made the list of five most-modifiable barriers to error reporting: Ranked fourth was lack of knowledge of which medication errors should be reported.

"The study results provide a broad-based perspective of the barriers to medication error reporting in the nursing home setting," Dr. Handler said. "To the best of our knowledge, this represents the first study that's focused on this outcome in the nursing home setting."

He acknowledged certain limitations of the study, which was published last year (J. Am. Med. Dir. Assoc. 2007;8:568-74). These include the fact that the sample, for convenience, involved only a few nursing homes. In addition, the study excluded the perspective of medication technicians, since the state of Pennsylvania doesn't allow them to administer medications.

The study was supported in part by an AMDA/Pfizer Quality Improvement Award, by a Merck/American Federation for Aging Research Junior Investigator Award in Geriatric Clinical Pharmacology, and by grants from the National Institutes of Health.

Medicare Expands Coverage for INR Testing

The Centers for Medicare and Medicaid Services has expanded coverage of home prothrombin time (or International Normalized Ratio, INR) testing to include patients who are taking anticoagulation therapy for chronic atrial fibrillation and venous thromboembolism.

Patients must meet certain other criteria, and the home tests can't be used more than once a week, according to the final decision issued by the CMS.

Medicare has covered home prothrombin time testing since 2002, but only for patients with mechanical heart valves. The request for expanded coverage was made in June 2007 by the three main manufacturers of home testing devices—Roche Diagnostics, International Technidyne Corp., and HemoSense Inc. The companies said that there was plenty of new evidence to support home testing for the two other conditions. The CMS agreed.

"Medicare's coverage extension of home blood testing of prothrombin time International Normalized Ratio is based on current evidence for these two conditions," CMS Acting Administrator Kerry Weems said in a statement. Currently, prothrombin testing is conducted about every 4-6 weeks, primarily in physicians' offices, according to the CMS. Fewer than 5% of patients on anticoagulation therapy monitor prothrombin at home.

"Those Medicare beneficiaries and their physicians managing conditions related to chronic atrial fibrillation or venous thromboembolism will benefit greatly through the use of the home test," Mr. Weems said.

Roche estimated that Medicare beneficiaries would pay $35 for training in use of at-home devices, and about $30 a month for test strips. Patients who have supplemental Medicare insurance might not have any out-of-pocket costs, the company said in a statement.

—Alicia Ault

Senate Bill Would Encourage Practitioners To Care for the Elderly

BY JANE ANDERSON
Contributing Writer

Sen. Barbara Boxer (D-Calif.) has introduced legislation aimed at addressing the potential crisis in providing care for elderly Americans. The bill offers a combination of educational-loan forgiveness and career-advancement opportunities for health care professionals choosing practice in nursing homes.

The Caring for an Aging America Act, S. 2708, would have the federal government provide $130 million over 5 years to benefit physicians, physician assistants, advance practice nurses, psychologists, and social workers choosing geriatrics and gerontology. Aid would come primarily through educational loan repayments for these professionals. The bill already has been endorsed by the American Geriatrics Society, the National Council on Aging, the National Association of Geriatric Education, the Alzheimer's Association, and the National Association of Social Workers.

'The medical and health community is already struggling to meet the demand for geriatric health care and support services, and the need ... is only growing.'

The American Medical Directors Association (AMDA), which represents nursing facility practitioners, has approved the bill's concepts in principle. "I'm very positive on the bill," said Dr. Paul Katz, AMDA vice president and chief of geriatrics at the University of Rochester, N.Y. "I think overall, this really is a big step forward."

To benefit from the loan repayment provisions, health care professionals would not only need to complete specialty training in geriatrics or gerontology but also agree to provide full-time clinical practice and service to older adults for a minimum of 2 years. In addition, the bill would expand eligibility for the Nursing Education Loan Repayment Program to include registered nurses who complete specialty training and provide nursing services to older adults in long-term care settings. The proposed law also would expand midcareer specialty training in long-term care services through an existing training-grant program.

Sen. Boxer also proposes creation of a Health and Long-Term Care Workforce Advisory Panel for an Aging America, which would advise federal policy makers on workforce issues related to long-term care for the country's aging population.

"The medical and health community is already struggling to meet the demand for geriatric health care and support services, and the need for trained professionals is only growing," said Sen. Boxer in a statement. "This legislation will provide incentives to help encourage qualified practitioners to join the geriatrics and gerontology fields."

AMDA's director of government affairs Kathleen M. Wilson said that the association supports the concepts included in the legislation, based on a draft that Sen. Boxer's staff provided last year. At press time, AMDA's Public Policy Committee was reviewing the actual legislation, which Ms. Wilson said is made up of initiatives closely similar to the concepts endorsed last year.

The loan guarantees in the legislation could be worth up to $150,000 for a professional who provides full-time health care to older adults for 4 years. "That's fairly substantial, and it has to be substantial to get peoples' attention," said Dr. Katz. "That's something I've been preaching for awhile."

However, Dr. Katz also warned that the bill needs to better define the term "geriatric providers" for the purposes of the legislation's financial aid, especially nonphysician providers. "Right now, for physicians there's a formal process of being trained in geriatrics, so it's not an issue. But for social workers and therapists, there aren't always specialty courses."

And, he added, the bill needs to specify what kinds of courses would qualify.

Dr. Katz also noted that the bill isn't specific to long-term care. "It's focusing on geriatricians," he said. "What about people who want to practice in long-term care?"

Overall, though, Dr. Katz said he supports S. 2708.