Chapter 55
Sun Country Regional Health Authority—Managing Medications

1.0 Main Points

This chapter reports the results of our first follow up of recommendations we made in 2013 relating to Sun Country Regional Health Authority's (Sun Country) processes to manage and administer medications in its district hospitals. By September 30, 2015, Sun Country made significant improvements; it had implemented four of the five recommendations.

Sun Country revised its policies on obtaining medications after regular pharmacy hours and disposing of medications, and took steps so that nursing staff understood the new policies. It created and began using a Medication Management Continuous Quality Improvement team. This team is responsible for analyzing reasons for medication errors and recommending changes to prevent similar errors in the future. While its staff consistently used the approved form to create patient medication histories, they did not consistently document patients' weight on patient medication profiles as expected. A patient's weight plays an important role in determining the dose of medication for the patient.

2.0 Introduction

Under *The Regional Health Services Act*, regional health authorities (RHAs) are responsible for the operation of hospitals and the services provided in those hospitals. Medications play a vital role in patient care and the operation of any hospital. Effectively managing and administering medications in hospitals reduces the risk that patients could be adversely affected by medication errors.

In our *2013 Report – Volume 2*, Chapter 31, we concluded that Sun Country had effective processes to manage and administer medications in its two district hospitals except that it needed to:

- Follow its established policies to gain access to the pharmacy after regular hours and properly dispose of medication
- Use its approved form to document patient medication history and weight
- Analyze medication errors and the contributing factors, and use that analysis to develop action plans to address the issues

We made five recommendations.

To conduct this review engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook – Assurance*. To evaluate Sun Country's progress towards meeting our recommendations, we used the relevant criteria

from the original audit. Sun Country's management agreed with the criteria in the original audit.

In this follow-up, we examined Sun Country's policies and procedures related to medication management, minutes, and other relevant documents. We reviewed a sample of medication profiles.[1] We also interviewed members of Sun Country's senior management and other key staff.

3.0 Key Findings and Recommendations

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at September 30, 2015, and Sun Country's actions up to that date.

By September 2015, Sun Country has implemented four recommendations and has made limited progress on addressing the remaining one recommendation.

3.1 Policy on After-Hours Pharmacy Access Followed

We recommended that Sun Country Regional Health Authority monitor that staff consistently follow its policy of obtaining proper authorization and documenting the pharmacist consulted before entering the pharmacy after regular hours. (2013 Report – Volume 2; Public Accounts Committee agreement January 15, 2015)

Status – Implemented

In November 2014, Sun Country revised its policy on obtaining medications after regular pharmacy hours. Staff continued to complete forms that document the date, time, drug required, dosage form, patient's room number, and quantity of pills taken. At one district hospital, staff also consults the pharmacist noting it on the form. At the other district hospital, the hospital's pharmacy department assigns alarm codes (i.e., access codes) to designated nursing supervisors; these supervisors use the alarm codes to gain entry into the hospital pharmacy.

During our review, we found that one district hospital consistently filled out forms noting the pharmacist consulted. At the other district hospital, designated nursing supervisors used individual alarm codes. The pharmacy manager at this location performed monthly audits that consisted of reviewing records of who accessed the pharmacy after hours to determine if the access was reasonable.

[1] A medication profile is the documented information on a patient's medication history.

3.2 Training and Monitoring Compliance with Wasted Medication Policy Provided

We recommended that Sun Country Regional Health Authority train its staff to follow its policy to dispose of wasted medication properly and monitor compliance with the policy. (2013 Report – Volume 2; Public Accounts Committee agreement January 15, 2015)

Status – Implemented

Sun Country provided its nursing staff with a copy of the revised medication disposal policy, and required them to sign off that they had read and understood the policy changes. The region requires nursing staff to sign off each time a policy update takes place.

Nursing supervisors monitor compliance with the revised medication disposal policy as part of their day-to-day duties. Any issues noted with the policy by these supervisors are brought to the attention of the region's pharmacy staff. In addition, management indicated nursing staff bring forward to their nursing supervisor or pharmacy staff any questions related to the application of the revised policy.

3.3 Approved Form Used to Create Patient Medication Histories

We recommended that Sun Country Regional Health Authority require all its hospitals to use the approved form generated from the province-wide pharmaceutical system to create accurate patient medication histories. (2013 Report – Volume 2; Public Accounts Committee agreement January 15, 2015)

Status – Implemented

During our review, we found that all of Sun Country's district hospitals used the approved form from the province-wide pharmaceutical system to create patient medication histories.

3.4 Complete Patient Medication Profiles Needed

We recommended that Sun Country Regional Health Authority consistently complete patient medication profiles by documenting patients' weight. (2013 Report – Volume 2; Public Accounts Committee agreement January 15, 2015)

Status – Not Implemented

Patient medication profiles document key information on a patient's medication history. A patient's weight plays an important role in determining the dose of medication for the patient. Sun Country recognizes the importance of documenting patient weight in a consistent place; its policy requires nursing staff to record the patient's weight when completing patient medication profiles.

For patient files we reviewed, 50% of the medication profiles did not document patients' weight. As part of monitoring, Sun Country performs monthly audits of medication reconciliations. As a part of these audits, management reviews patient medication profiles for documentation of patient weight. Sun Country's audits for April to June 2015 also found staff did not always record weight in patient files.

Not following established processes to document the patient's weight in conjunction with the completion of patient medication profiles increases the risk of prescribing and administering improper doses to a patient, resulting in harm.

3.5 Medication Errors Analyzed

We recommended that Sun Country Regional Health Authority analyze the medication errors and the contributing factors, and use that analysis to develop action plans to address the reasons for serious and reoccurring errors. (2013 Report – Volume 2; Public Accounts Committee agreement January 15, 2015)

Status – Implemented

Management collects information on the number of medication errors through its patient safety database. The information is provided to staff every two months as part of continuous quality reports. These reports provide staff with information on items such as patient safety incidents, critical incidents, and lessons learned.

Sun Country created a Medication Management Continuous Quality Improvement (CQI) team in December 2013. The region's Pharmacy Director receives copies of all medication-related patient safety reports for review and forwards any issues or trends identified during this review to the CQI team. In addition, staff forward all serious medication management related issues (e.g., adverse drug reactions, medication errors) to the CQI team for its review and action. We noted that upon a notification of serious medication errors, the CQI team performs a root-cause analysis[2], and recommends changes to prevent similar errors in the future.

[2] Root-cause analysis includes identifying the causes for the problem.