

Back the MACC: **M**edication **A**dministration **C**ross **C**heck

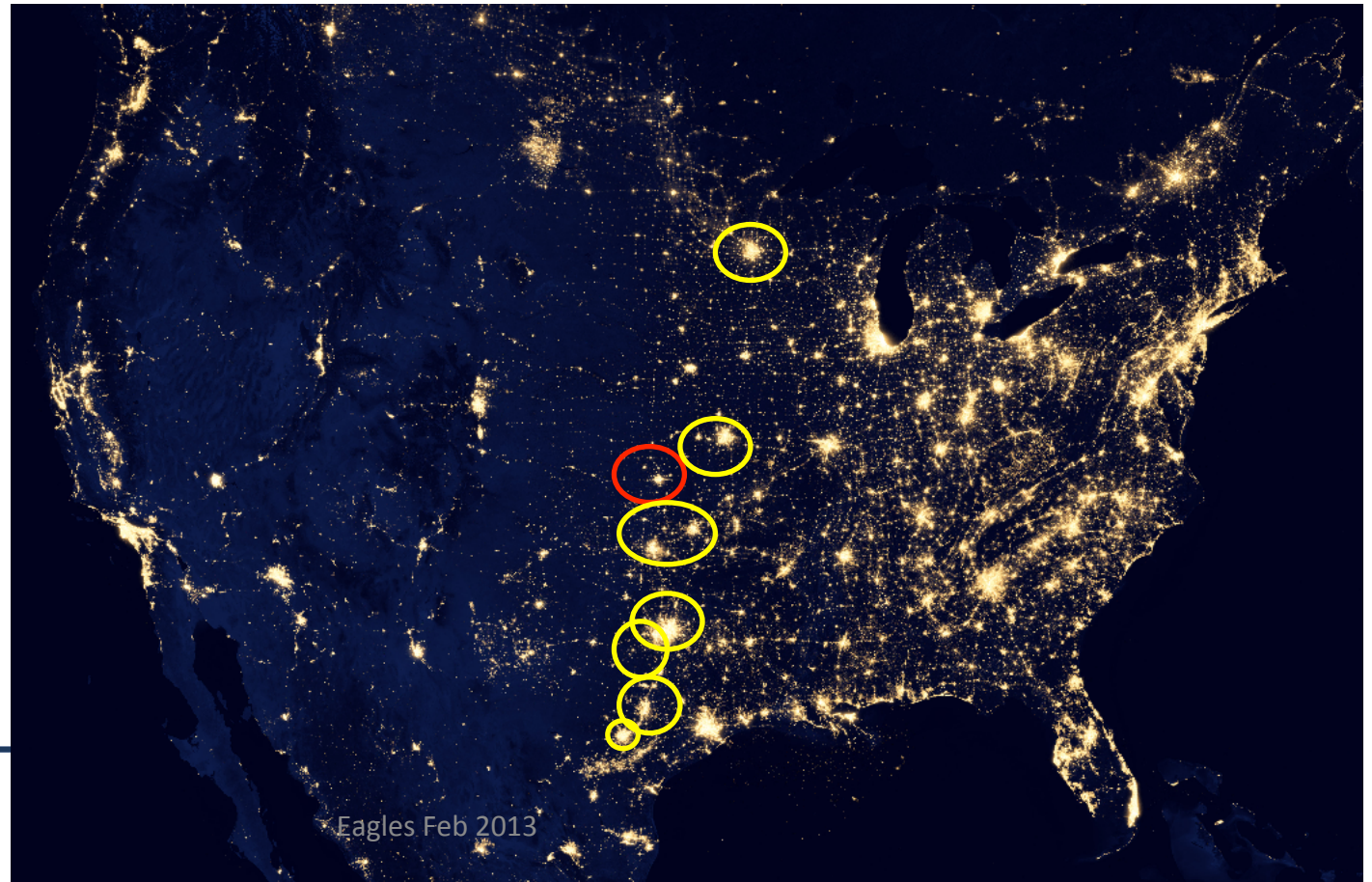
Sabina Braithwaite, MD, MPH



Conflict of Interest Disclosures:

Sabina Braithwaite, MD, MPH, FACEP

Consultant for Masimo: October, 2012



Objectives

- Highlight EMS environment characteristics that create risk of medication errors
- Discuss a taxonomy of medication errors for quality monitoring purposes
- Introduce a cross-check tool for medication administration



Medication Error Definition

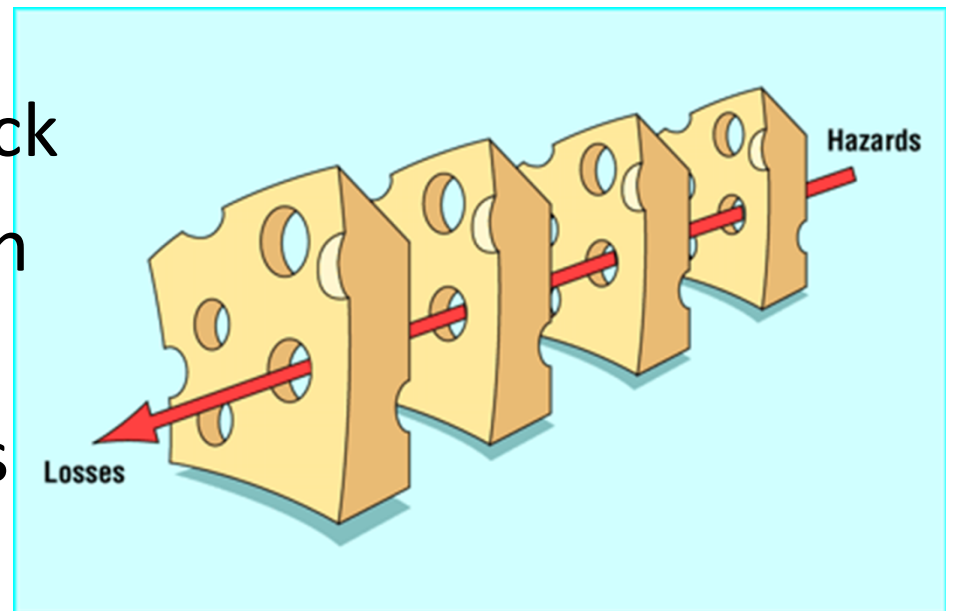
"A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use."



AHRQ Medication Safety http://www.ahrq.gov/qual/nursesfdbk/docs/hughesr_mas.pdf
IOM Preventing Medication Errors: http://www.nap.edu/catalog.php?record_id=11623

EMS Environmental Risks

- Emergency situation
- No written order
- No external crosscheck
- No electronic decision support
- High-risk medications
- Drug shortage issues and substitutions



IOM Testimony to Congress 5-3-2001:

http://www7.nationalacademies.org/cgi/2001/testimony/Patient_Safety_and_Medication_Errors.asp

Reason, James. Human error: models and management. British Medical Journal 2000; 320:768-770.

Change to a Culture of Safety

- acknowledge the **high-risk** nature of an organization's activities
- determine to achieve **consistently safe** operations
- a **blame-free** environment to report errors or near misses
- encourage **collaboration** to seek solutions to patient safety problems
- commit organizational **resources** to address safety concerns

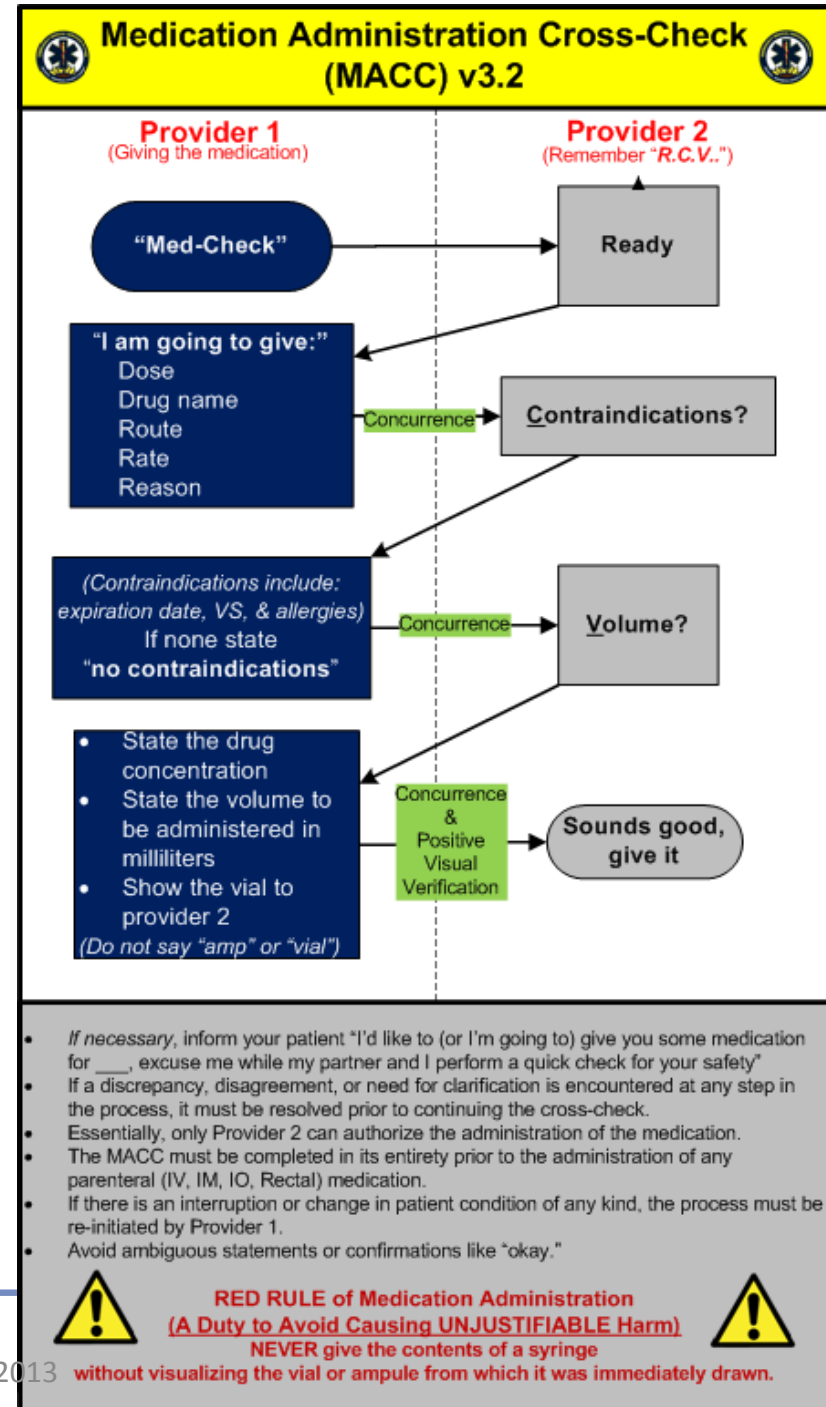


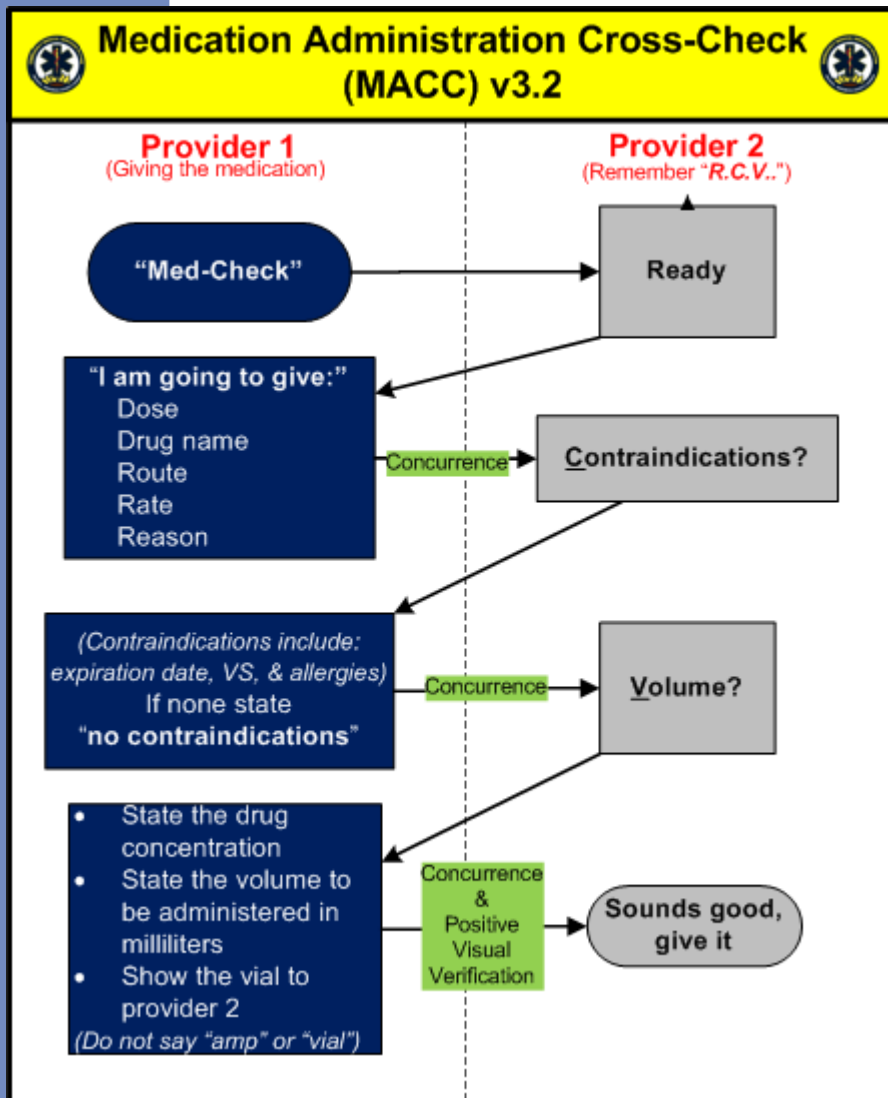
What is most important:
Deliver medication quickly?
Deliver medication correctly?



Medication Administration Cross-Check (MACC):

Standardized method for medication administration, every time, every med





- 2 person verbal procedure
- Contains error traps
- Fast, simple
- Only the 2nd provider 'authorizes' the med administration
- barrier to error reaching the patient
- Creates a pause point



MACC Demonstration

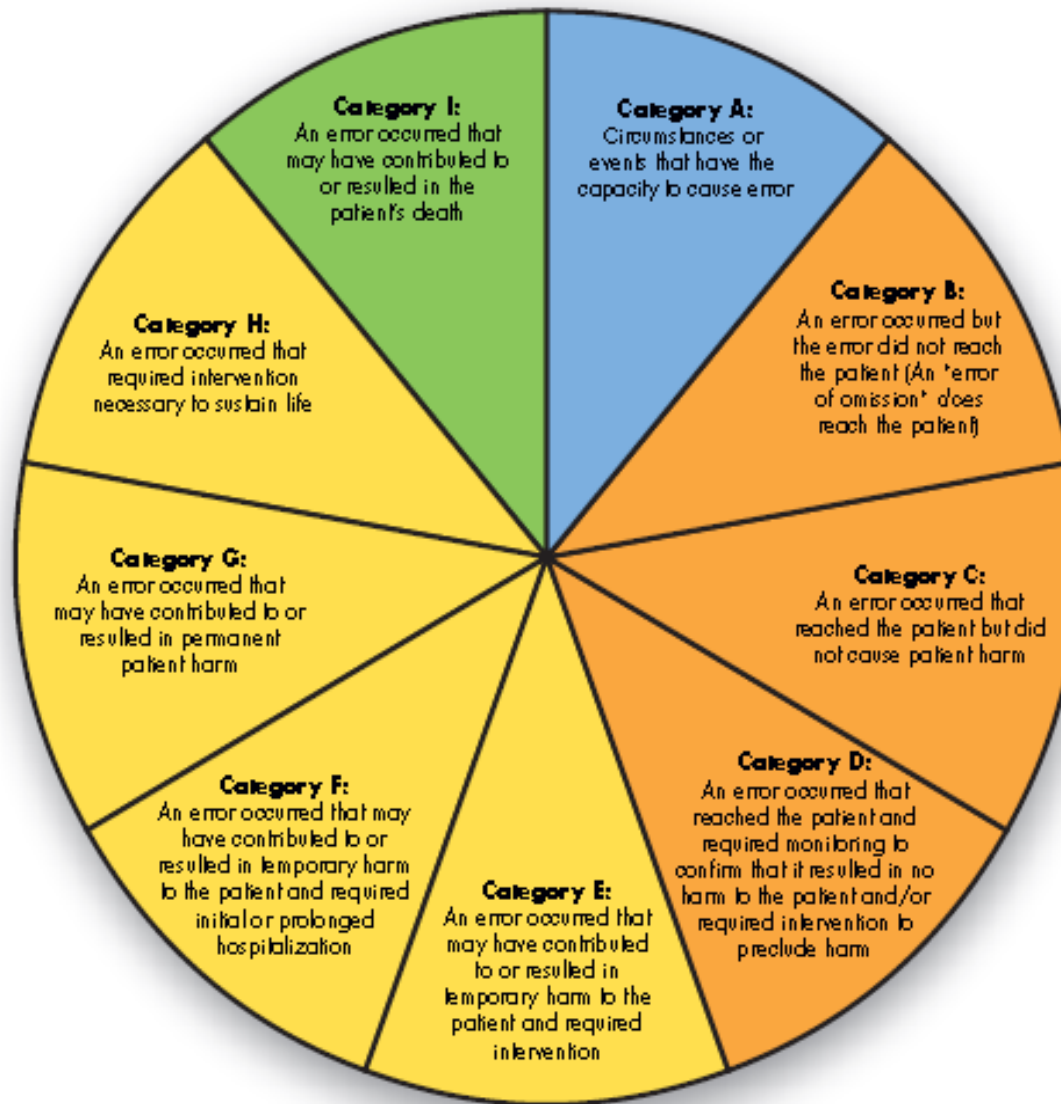
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No error video: <http://vimeo.com/wscomd/review/40680029/9b7a58c827>
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NCC MERP Index for Categorizing Medication Errors



Definitions

Harm

Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

Monitoring

To observe or record relevant physiological or psychological signs.

Intervention

May include change in therapy or active medical/surgical treatment.

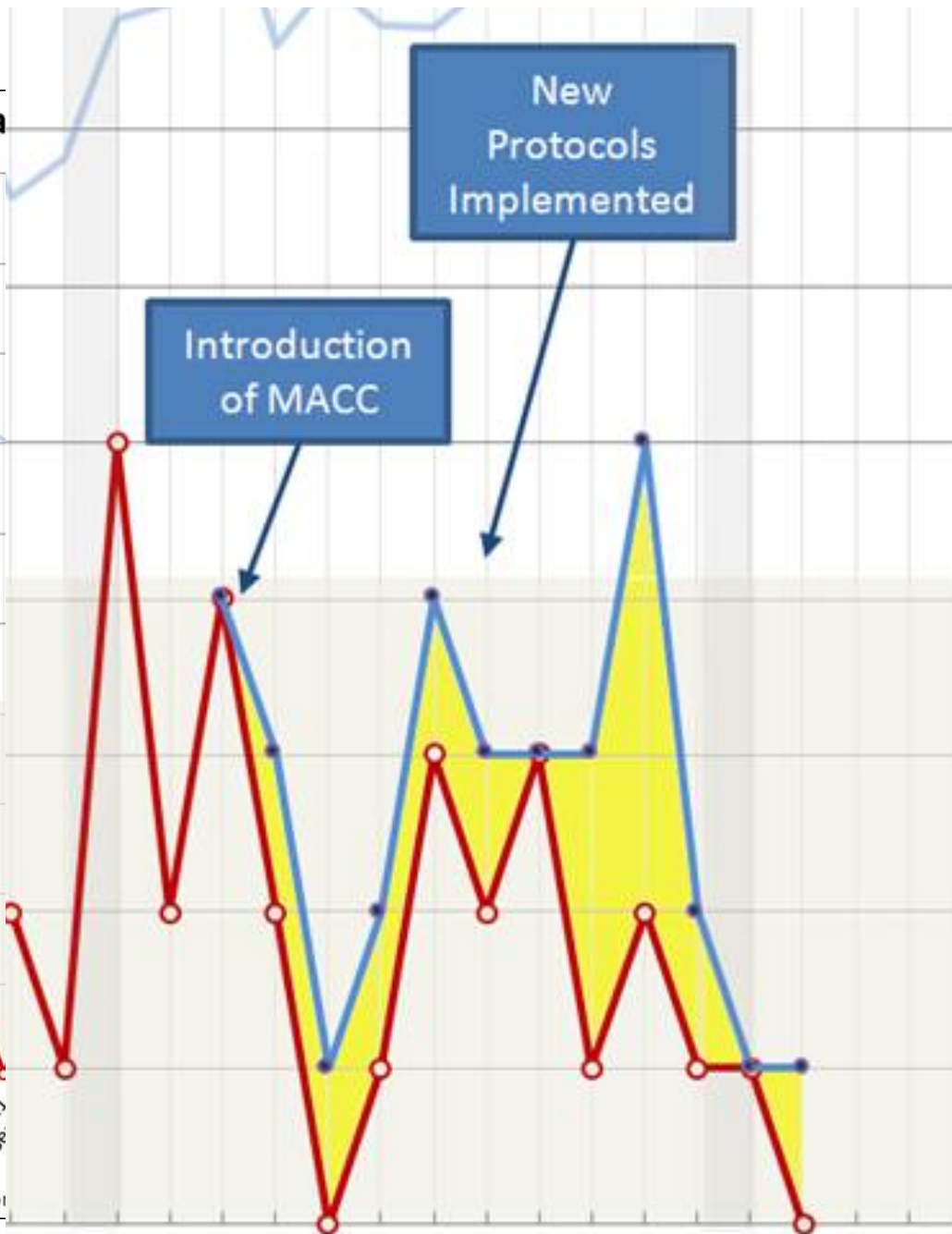
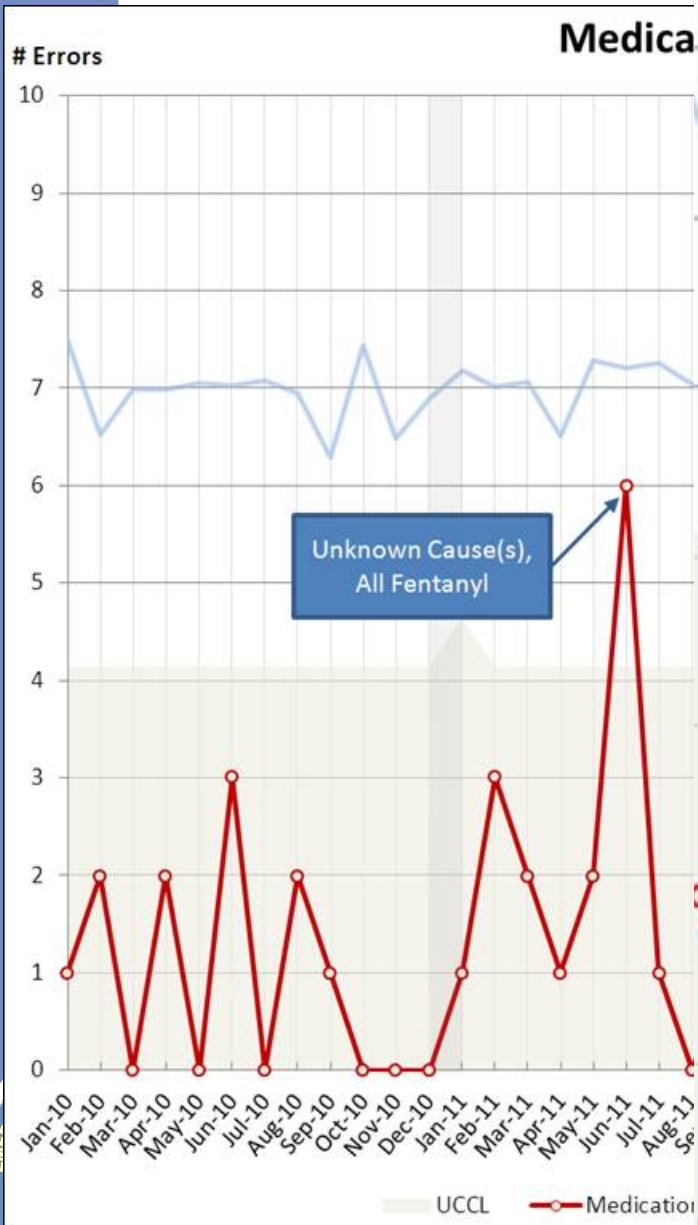
Intervention Necessary to Sustain Life

Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubation, etc.)

- No Error
- Error, No Harm
- Error, Harm
- Error, Death

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Take-Home Points

- Medication errors are happening, whether recognized or not
- Find system opportunities to limit medication error
- Promote a culture of reporting and thoughtful analysis of incidents



Thank You

Sabina Braithwaite, MD, MPH, FACEP

Sabina.Braithwaite@gmail.com

Paul Misasi, MS, NREMTP

pmisasi@sedgwick.gov

Jon Friesen, MSOD, NREMTP

jfriesen@sedgwick.gov

