Medication Administration and Errors:

Ensuring Quality Care

caregivers

PREVENT *abuse/neglect* PROTECT *clients* PROMOTE *dignity*

FACILITATOR GUIDE

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Overview

Health or residential care providers licensed, certified, and regulated by the Wisconsin Department of Health Services (DHS), Division of Quality Assurance (DQA) are required by state and federal law to ensure staff are properly trained to provide specific services to the individuals served in their provider types. This includes training specific to medication administration, storage and documentation for residents or clients who require assistance with medication. These laws and rules are in place to ensure the safety of residents and clients who are cognitively or physically unable to manage their own medications.

Healthcare staff who dispense medication must comply with those state and federal requirements per their provider type. Staff that are improperly trained or who do not follow written facility policies and procedures are at increased risk of making medication errors, which puts the residents, clients, co-workers and themselves at risk. This course supports caregivers and providers by helping them:

- Prevent medication errors
- Avoid citations and other regulatory penalties
- Deliver a high standard of care
- Identify and utilize appropriate resources

[This training recognizes that facilitators and attendees may represent any DQA-regulated health or residential care provider and may use different terms to refer to their provider type; to the individuals receiving care, treatment, or services; and to the individuals providing care, treatment, or services. For this training, the term "provider" or "provider type" is used to refer to any DQA-regulated provider, entity, or facility. The terms "client" or "resident" are used to represent any person receiving care, treatment and/or services from any provider. Facilitators may wish to change the language to be appropriate to the setting in which they are presenting this information.

This training includes Administrative Quick Reference Charts and a Best Practice Checklist for you to reference when presenting this material to your participants. When you train this topic, have printed copies of the Quick Reference Charts specific to your provider type for your participants.]

Learning Points

Let's review the main learning points:

- Increase your understanding of medication administration.
- Recognize your role in adhering to rules and regulations.
- Identify best practices for preventing and reporting medication errors.
- Access relevant resources, including those related to substance use disorder (SUD) treatment.

Introduction to Medication Administration

In any DQA regulated health or residential provider type, there are most likely clients or residents who require assistance with medication administration. Medication administration is the process of giving prescribed or over-the-counter medications to another individual.

Medication administration is a critical component in providing healthcare to clients or residents in your provider setting. Medications are intended to help us but if taken or administered incorrectly, they can cause great harm. Administering medications correctly is the biggest factor in preventing medication errors. When assisting individuals with medication, it requires accuracy, following best practice protocols and above all, ensuring resident or client safety.

Regulatory Requirement Overview

Healthcare staff who assist individuals with medication administration must not only be aware of medication administration requirements, but also the requirements related to medication storage, documentation, reporting, and the development of best practice. These requirements vary depending upon the Administrative Code, and state and federal regulations specific to the provider type.

While there may be similar requirements across provider types related to medication administration, storage and documentation, there are rules and regulations specific to each provider type. For example, to provide medication assistance to residents in a nursing home, you must be a nurse aide who has completed a State approved medication aide training program, if you are not already licensed as a nurse. In a CBRF, staff who administer medications to residents must complete department approved training and be placed on the training registry prior to assuming medication administration job duties. Various provider types have specific requirements related to storage. In an AFH, prescription medications must be securely stored and remain in their original container from the pharmacy. Some provider types are required to store internal medications separately from external medications such as eye drops, creams or ointments.

There are also requirements specific to documentation. For example, if a home health aide is assisting a client with self-administration of medication, the HHA must maintain the medical record and it must include a list of the client's medications and documentation of the client's instructions. An ADCC shall have a written policy for medication management and shall designate which caregivers are authorized and trained to administer medications.

Knowing and adhering to the regulations and facility policies will help prevent medication errors and possible drug diversion. If drug diversion does occur in your provider setting, staff must be trained to immediately report to supervisors and managers who must follow reporting requirements to DQA and possibly law enforcement. If a medication error occurs, it is important for staff to know who to report the error to, and for designated staff to know if and how the error needs to be reported to the prescriber and/or DQA.

Medication Administration Summary

Regardless of the provider type you work in, it is imperative that all members of the care team responsible for any aspect of medication assistance to their clients or residents are properly trained per the regulations and facility policies and are competent in fulfilling this job duty. We know that serious consequences can occur when medication administration, storage, or documentation requirements are not followed; when medication errors occur; or if medication is diverted from clients or residents.

Information specific to administration, documentation, storage, errors, diversion and best practice will be discussed in more detail throughout this training.

Observing the Rules & Regulations

As we just reviewed, the Administrative Rules outline specific requirements for medication administration. Since the language of these rules can be a bit intimidating, the Quick Reference Charts found in the handout are designed to help you more easily navigate the related regulations and administrative requirements. The charts apply to the providers listed below:

- Adult Day Care Centers
- Adult Family Homes
- Community Based Residential Facilities
- Home Health Agencies
- Hospices
- Intermediate Care Facilities
- Nursing Homes
- Residential Care Apartment Complexes

Each chart cites the relevant administrative rule for the specific provider type and includes a description of the requirements and applicable expectations for direct care staff. Along with facility policies and procedures, these Administrative Rule Quick Reference Charts serve as a helpful tool to support compliance with medication administration requirements.

[Review the charts based on the relevant provider type(s). Please refer to the note at the bottom of each chart, which explains that these Quick Reference Charts focus specifically on administrative requirements related to medication administration. They are not intended to be an all-inclusive summary of provider responsibilities. Every effort has been made to ensure the accuracy of the information, based on the date noted in the footnote. If you have questions about the content, please consult the appropriate Administrative Rule directly or contact the relevant DQA office.]

Knowing Your Responsibilities

As a healthcare facility employee, you play a vital role in protecting the health and well-being of every resident. One of your most important responsibilities is ensuring medications are managed safely, correctly, and legally.

You are expected to:

- Always act with integrity.
- Follow facility policies and procedures.
- Respect the rights and dignity of each resident.
- Support a culture of safety and accountability.

Proper medication handling is not just a task, it's a critical part of resident care that directly impacts outcomes, comfort, and quality of life. Knowing your responsibilities means more than just following rules; it's about taking ownership of your role in resident care. By storing, administering, and disposing of medications properly, you help protect residents, support your team, and uphold the standards of the healthcare profession.

Preventing Medication Errors

Medication errors can lead to serious health problems and in some cases, even death. Preventing these errors is a critical responsibility shared by all healthcare staff. Whether you're storing, preparing, administering, or documenting medications, your attention to detail directly affects resident safety.

Medication errors are among the most common and most preventable issues in healthcare. These mistakes can result in:

- Harmful drug interactions
- Overdoses or underdoses
- Allergic reactions
- Delayed treatment
- Hospitalization or worse

In addition to the health consequences, errors can damage the trust between staff and residents or their families and affect the reputation and legal standing of your facility. Medication safety is a team effort. Whether you're a caregiver, medication aide, nurse, or administrator, you contribute to a safe and effective medication process.

Understanding where errors often happen can help prevent them. Common causes include:

- Similar-sounding medication names (e.g., metoprolol vs. metoclopramide)
- Poor handwriting or unclear MARs
- Rushing through medication rounds
- Interruptions during medication preparation
- Not confirming a resident's identity

[Preventing medication errors is not optional, it's a core responsibility for every staff member. By taking time to do things right, communicating effectively, and keeping safety top of mind, you help create a safer, more trusting, and more professional care environment. Your actions matter and the lives of your residents depend on them.]

Staff Training

Medication errors are preventable and ongoing staff training is one of the most powerful tools we can use to reduce risk and protect residents. In a fast-paced healthcare environment, staying current with procedures and best practices is essential to providing safe, high-quality care.

Staff training ensures that all team members are:

- Knowledgeable about current medication safety protocols.
- Confident in handling medications correctly and responding to errors.
- Prepared to identify and manage high-risk medications and situations.

Regular training improves awareness of common causes of errors—like distractions, look-alike medications, and improper documentation—and teaches staff how to prevent them before they happen.

[A strong medication safety training program includes the areas we will cover today:

- *The "Five Rights" of medication administration*
- *Documentation*
- *Safe storage, handling, and disposal procedures*
- *How and when to report errors or concerns]*

As a staff member, you are responsible for:

- Attending required training sessions

- Applying what you've learned to your daily work.
- Asking questions when unsure
- Staying informed about changes in medication policies or systems

Staff training plays a vital role in reducing medication errors. By staying informed, practicing carefully, and embracing ongoing education, you help protect residents, build trust, and maintain the highest standard of care in your facility.

The 5 Rights

Comprehensive training programs help staff understand the "five rights" of medication administration—right person, right drug, right dose, right route, and right time—and reinforce the importance of communication, documentation, and critical thinking. Each "right" represents a checkpoint in the process of delivering medication and serves as a reminder for healthcare professionals to be vigilant and thorough.

Here's an expanded explanation of each:

1. **Right Person**
   Verifying the correct person is essential to ensure that medications are not given to the wrong person. This includes checking at least two identifiers—such as the person's full name and date of birth or medical record number—and cross-referencing with the chart, wristband, and verbal confirmation whenever possible. Mistakes at this stage can have severe consequences, especially when people have similar names or are unable to communicate.

2. **Right Medication**
   Administering the correct medication involves carefully reviewing the medication label and comparing it with the medication order or prescription. This step helps avoid mix-ups between drugs with similar names or appearances, especially those classified as high-alert medications. It also includes verifying any known allergies or contraindications specific to the person.

3. **Right Dose**
   Ensuring the right dose means administering the exact amount of medication ordered, based on the person's condition, age, weight, and clinical parameters. Miscalculations, decimal point errors, or misinterpretation of units can lead to underdosing or overdosing, both of which can be harmful or even fatal.

4. **Right Route**
   The right route refers to giving the medication via the correct method, whether oral, intravenous (IV), intramuscular (IM), subcutaneous, topical, or other. Administering a drug through the wrong route can impact its effectiveness and safety. For example, giving an IV medication intramuscularly can cause severe tissue damage or fail to deliver the intended therapeutic effect.

5. **Right Time**
   Administering medication at the correct time is important to maintain therapeutic levels in the bloodstream and to coordinate with meals, procedures, or other medications. This includes recognizing when a medication needs to be given immediately, at regular intervals, or once daily. Delays or premature doses can reduce efficacy or increase the risk of adverse effects.

Together, the Five Rights form a safety checklist that healthcare providers should use consistently to prevent errors and ensure high-quality, person-centered care. Integrating these checks into daily practice reinforces a culture of safety and accountability throughout the facility.

Documentation

Accurate and timely documentation is a key defense against medication errors in healthcare settings. It ensures that all members of the care team have access to the same up-to-date information about a person's medications, dosages, and administration times.

Proper documentation helps prevent duplication, missed doses, and harmful drug interactions by creating a clear, traceable record of what has been given and when. It also supports effective communication during shift changes or handovers, reducing the risk of critical details being overlooked.

In the event of an error or adverse reaction, thorough documentation is essential for investigation and quality improvement. Ultimately, consistent, and precise documentation safeguards both residents and healthcare staff by promoting accountability and continuity of care.

Medication acronyms and abbreviations are frequently used in healthcare to save time, but they can lead to serious errors if misunderstood. Many organizations, including the Institute for Safe Medication Practices (ISMP) and The Joint Commission**,** recommend avoiding certain high-risk abbreviations.

Abbreviation	What It Means	Risk	Use Instead
U or u	Unit	Can be mistaken for 0 or 4	**"unit"**
IU	International Unit	Mistaken for IV or 10	**"international units"**
QD / Q.D.	Every day	Mistaken for QOD (every other day)	**"daily"**
QOD / Q.O.D.	Every other day	Mistaken for QD (daily)	**"every other day"**

Abbreviation	What It Means	Risk	Use Instead
MS	Morphine sulfate	Confused with magnesium sulfate	**"morphine sulfate"**
MSO4 / MgSO4	Morphine or magnesium sulfate	Easily confused with each other	**Write full drug name**
Trailing zero (e.g., 5.0 mg)	5 mg	Misread as 50 mg	**Do not use trailing zero (write "5 mg")**
Lack of leading zero (e.g., .5 mg)	0.5 mg	Misread as 5 mg	**Use leading zero ("0.5 mg")**

[Share and discuss facility policy regarding medication documentation here.]

Storage

Storing medication the right way helps keep it safe and effective. If medications are not stored correctly, several problems can happen:

- The medication might not work as it should.
- There's a higher chance of medication errors.
- Medications could be stolen or go missing.

Always follow the manufacturer's instructions. These usually include:

- **Temperature:** Some medications must be refrigerated and monitored with a thermometer.
- **Light and Humidity:** Some need to be kept away from light or moisture.
- **Security:** Controlled substances must be kept in a locked cabinet or medication cart. Only authorized staff should have access.

Make sure the medications are:

- Clearly labeled.
- Well organized.
- Easy to find when needed.

All staff must follow state and federal laws for storing and handling medications, especially controlled substances. Know your facility's policies and ask if you're unsure.

[Share and discuss facility policy regarding medication storage and handling here.]

Throwing medications in the trash or flushing them is often not safe or legal. There are rules about how to get rid of different types of medication waste. Medication waste usually falls into one of these groups:

- Hazardous waste – Can harm people or the environment.

- Infectious waste – May carry germs or diseases.
- Solid waste – Regular non-hazardous medication waste.

Always follow your facility's guidelines for disposal. If you're not sure, ask your supervisor.

[Share and discuss facility policy regarding medication disposal here.]

Increasing Awareness: Recognizing Red Flags

Recognizing red flags of potential medication errors is a critical component of maintaining safety in healthcare facilities. Concerns raised by residents or their family members should never be overlooked, as they are often the first to notice changes in behavior, new or worsening symptoms, or inconsistencies in care.

Repeated complaints about unresolved pain, confusion, drowsiness, or side effects may indicate incorrect dosing, missed medications, or adverse drug reactions. Similarly, if a resident's medical condition remains unaddressed despite treatment, it may be a sign that medications are not being administered as prescribed or are ineffective due to an error.

Staff behavior can also provide important clues to underlying medication issues, including possible diversion. Red flags may include inconsistent documentation, reluctance to have medication counts audited, missing or altered records, or defensive responses when questioned about medication administration. Sudden changes in a staff member's work performance, frequent absences, or an unusual level of interest in controlled substances can also be warning signs.

Medication diversion, the theft or misuse of medications intended for residents, is a serious concern that not only harms residents but also poses legal and ethical risks to the facility. Maintaining a high level of awareness, encouraging open communication, and acting promptly on concerns are key steps in identifying and addressing medication-related issues before they result in harm.

What Employees Can Do

If an employee suspects medication errors or diversion, it is their responsibility to act promptly and appropriately to protect residents and uphold the integrity of care. The first step is to document specific observations including dates, times, behaviors, and any inconsistencies in medication records or resident conditions without

making assumptions. Clear, factual documentation can help support a thorough investigation.

Next, the employee should report their concerns to the appropriate authority, such as a supervisor, nurse manager, or the facility's compliance or quality assurance team. Many facilities have anonymous reporting systems in place to protect staff from retaliation. If the concern involves a supervisor or goes unaddressed, it may be necessary to escalate the issue to higher leadership, human resources, or the facility's compliance hotline.

In cases where resident safety is at immediate risk, reporting must be urgent and direct. Employees should also be familiar with their facility's policies regarding medication handling, error reporting, and diversion, as well as any legal obligations to report misconduct. Acting in good faith to report concerns is not only supported by most employers, but also a legal and ethical duty to ensure the safety and well-being of those in care.

[Share and discuss facility policy regarding medication diversion here.]

What Employers Can Do

Managers and supervisors are first in line to ensure that clients and residents are safe and provided with appropriate care within their setting. As part of this responsibility, managers and supervisors must be confident that all employees are knowledgeable and competent in all aspects of medication management, including recognizing and reporting any signs of medication diversion.

One way for supervisors and managers to meet this responsibility is to be present during various times of the day or night:

- Observe staff responsible for medication administration job duties to ensure they are following the regulations specific to your provider type, that they are following facility policy and procedures, and that they are following the practices of the 5 R's.
- Provide regular in-services related to medication administration.
- Document staff training requirements and maintain documentation as required. Monitor MARs, medication counts, and storage on a regular basis.

As a supervisor or manager, it is also important to create a culture of openness within the facility. Create facility policies and procedures that encourage and require staff, regardless of their care responsibilities, to come forward with any concern they may have. Take these concerns seriously and follow through with the information reported.

Managers need to be knowledgeable about facility policies and procedures, as well as state regulations. When a drug diversion or impairment is discovered or suspected,

facility policy regarding investigation and reporting must be followed. SUD is a challenging and complex issue for healthcare professions, but with supportive and educated supervisors and colleagues, staff with this disease can receive the treatment they need.

The SAMHSA Behavioral Health Treatment Services Locator, found at https://findtreatment.samhsa.gov/, is a confidential and anonymous source of information for persons seeking treatment facilities for substance use/addiction and/or mental health problems.

Reporting Medication Errors

As stated earlier, medication administration requirements, including reporting medication errors vary per provider type based on the specific Administrative Code, state or federal regulation. The inclusion of the Quick Reference Charts in this training will help identify provider specific reporting requirements.

According to the National Coordinating Council for Medication Error Prevention and Analysis, a medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm.

Regardless of the regulations, facilities should have written policies and procedures specific to reporting medication errors. Medication error reporting should include:

- specific details of the error
- the type of error
- drug information
- when and how it was discovered
- the effect of the error on the resident or client
- and any contributing factors

Staff may not report a medication error for fear of possible disciplinary action. Managers and supervisors should consider all factors related to the error to determine what, if any, possible action should be taken. By providing a supportive and open reporting culture, it reduces the fear of reporting, creating a safer environment for clients and residents.

There are several reasons that highlight the importance of reporting medication errors:

- Identifying and addressing errors improves client or resident safety and prevents future harm.
- Reporting errors helps identify weaknesses in current systems and processes.
- Medication error reports lead to a better understanding of medication errors and best practices for prevention.

Reporting medication errors involves documenting and sharing details about preventable events that could lead to inappropriate medication use or client or resident harm. These reports are critical for improving resident safety by identifying systemic issues and preventing future errors

[Share and discuss facility policy regarding reporting medication errors here.]

Developing Best Practices

A best practice is a standard or set of guidelines that is known to produce good outcomes if followed. Facilities are encouraged to establish best practice guidelines to ensure compliance with the regulations and the protection of each individual being served by the provider setting. Think about some best practice guidelines that are in place in your facility or ones that could be included in the current practices.

[Ask your participants to volunteer best practices that may already be implemented in your facility or ones that can be added to current practices. Jot the responses on a flip chart. Consider adding responses from participants to your current best practices as appropriate. At this time, review your facility's best practices/policies with the participants to see how their responses compare to what your current practices/policies are.]

Activity: Applying Best Practices

Now that you've discussed and reviewed the best practices within your provider setting, let's identify the best practices that were not followed in this scenario.

Arlene is a 72-year-old woman who has been receiving care from your provider type for the past eight months. Overall, Arlene's health is stable, although she does have Type II diabetes and requires insulin injections two times per day. Arlene self-administers her injections. Arlene has reported to staff that her blood sugar levels have been unstable in the recent days. Staff have noted an increase in Arlene's fluid intake lately but have not reported it.

When caregiver Joanne checks in on Arlene, she sees Arlene's insulin on the bedside. Arlene reports she is not feeling well today and states she is very tired, and her vision is blurry. She asks caregiver Joanne to assist her with her injection since she cannot clearly see the marked measurements on the barrel of the syringe. Joanne has never administered an injection and has not been trained to do so, nor has she been delegated this task by an RN. Arlene tells her it's alright and she'll guide her in the process. Joanne agrees to give Arlene her injection. Due to Arlene's blurred vision, she miscalculates the units of insulin she needs and gives Joanne the wrong amount to draw.

Joanne does not review Arlene's medication orders to verify the amount and follows Arlene's verbal instructions. Joanne follows Arlene's instructions and completes the injection. An hour later, Joanne finds Arlene unconscious and slumped over in her chair.

[Ask participants to read the above scenario or read it aloud to the group. Using the Best Practice Handout, have participants place a check mark next to each best practice that was not followed in this scenario. If you have a larger group, you can break them into smaller groups for discussion. Have participants report out the best practices not followed. Suggested responses include:

- *Joanne was not assigned medication administration duties for Arlene*
- *Staff did not report Arlene's unstable blood sugars or increased fluid intake to management or her prescriber*
- *Joanne did not report to management that Arlene was not feeling well on this day*
- *Joanne was not trained or supervised by an RN to complete the delegated act of injections*
- *Joanne was unaware of proper storage requirements for insulin which had been sitting out on Arlene's bedside*
- *Joanne was not aware of the medication order and the specific amount of insulin that should have been administered by a qualified person*
- *Joanne was not aware of the side effects/consequences of administering the wrong dosage of insulin or the effects of administering the insulin when Arlene was experiencing other symptoms]*

Wrap-Up

This training highlights the important responsibility healthcare staff have when providing medication administration to clients or residents in their provider setting. Medication administration may likely be the most critical task a healthcare employee has when providing care to clients and residents.

Following the rules and regulations, facility policies and procedures, and best practices will help ensure safety, positive care outcome, comfort, and quality of life for the individuals you serve while reducing the potential of medication errors or medication diversion.

Review Learning Points

Let's review the learning points from today's training:

- Increase your understanding of medication administration.
- Recognize your role in adhering to rules and regulations.
- Identify best practices for preventing and reporting medication errors.
- Access relevant resources, including those related to substance use disorder (SUD) treatment.

[Ask participants to share what they learned during the training…did they learn something new, was it a good refresher, do they feel like they understand the facility policies, etc.]

Resources

The following resources are helpful for providers and staff:

Department of Health Services, Division of Quality Assurance

Assisted Living Medication Management
https://www.dhs.wisconsin.gov/regulations/assisted-living/mmi.htm

Assisted Living Medication and Administration
https://www.dhs.wisconsin.gov/regulations/assisted-living/mm-administration.htm

Medication Aides: Nursing Homes and Hospices
https://www.dhs.wisconsin.gov/regulations/nh/medaides-requirements.htm

Pharmacy Newscapsule
https://www.dhs.wisconsin.gov/dqa/memos/pharm-capsule.htm

Department of Health Services

Dose of Reality: Opioids in Wisconsin
https://www.dhs.wisconsin.gov/opioids/index.htm

Resilient Wisconsin
https://www.dhs.wisconsin.gov/resilient/index.htm

Substance Use Disorders
https://www.dhs.wisconsin.gov/aoda/index.htm

Institute for Safe Medication Practices
https://home.ecri.org/pages/ismp

National Council of State Boards of Nursing
https://www.ncsbn.org/substance-use-disorder.htm

NeedyMeds BeMedWise Patient Information and Education
https://www.bemedwise.org/

Safe Medication
https://www.safemedication.com/

Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov/

https://store.samhsa.gov/product/Creating-a-Healthier-Life/SMA16-4958

Training Materials Checklist

[For this training, you will need:

- *Laptop computer (recommended)*
- *MS PowerPoint (PPT Viewer can be downloaded for free at Microsoft.com)*
- *LCD Projector (recommended)*
- *Screen for viewing the PPT (recommended)*
- *Flip chart and markers*
- *Printed Participant Guides*
- *Printed relevant page(s) of Quick Reference Charts handout*
- *Printed Best Practices handout*
- *Pens or pencils*
- *Evaluation (optional)*
- *Certificate of completion (optional)]*