Sample of Medication Errors experienced by TF at Fircrest Residential Habilitation Center from 2011 through 2015

The charts below only reflect 4 of the 9 medications which I had questions about concerning administration as prescribed. I was assured that the medications were being administered since they were charted as given. In reviewing the records of the Medication Administration Records and the Pharmacy Dispensed Records, I discovered extremely large discrepancies in the amount of medication dispensed and that which was documented as given.

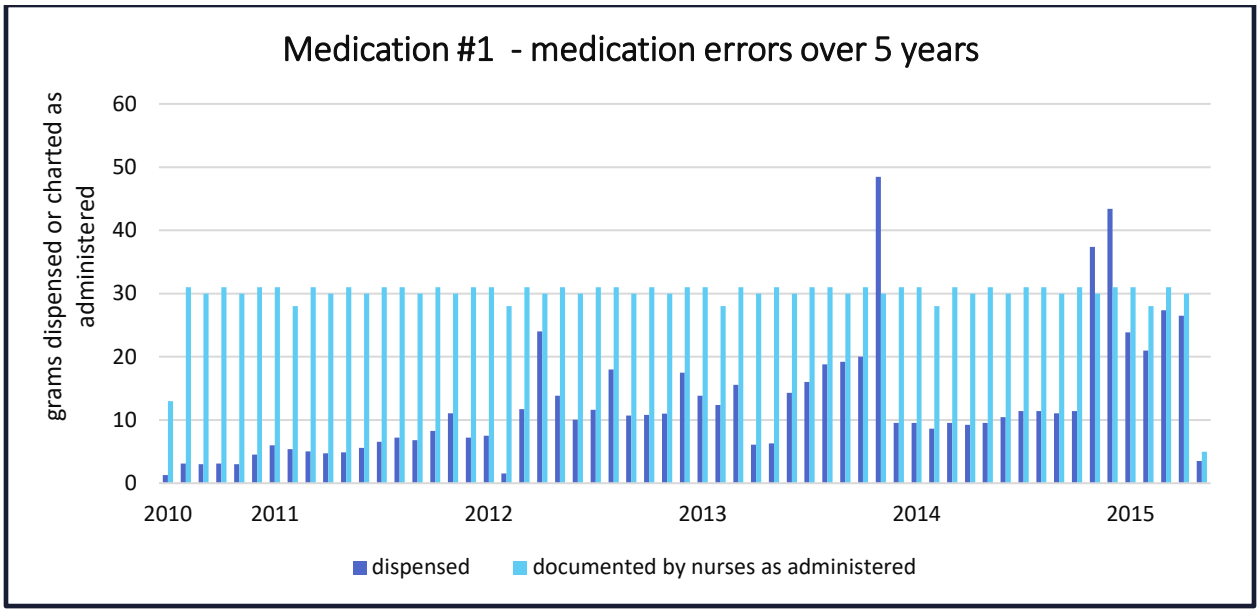
The magnitude of the medication errors also explained the lack of response that my son was getting from the prescribed medications. Since they were not being administered as prescribed, stronger medications and treatments were needed in attempts to control symptoms. These were also not successful due to non-compliance of administration of prescribed medications or refusal to take TF to his medical treatments.

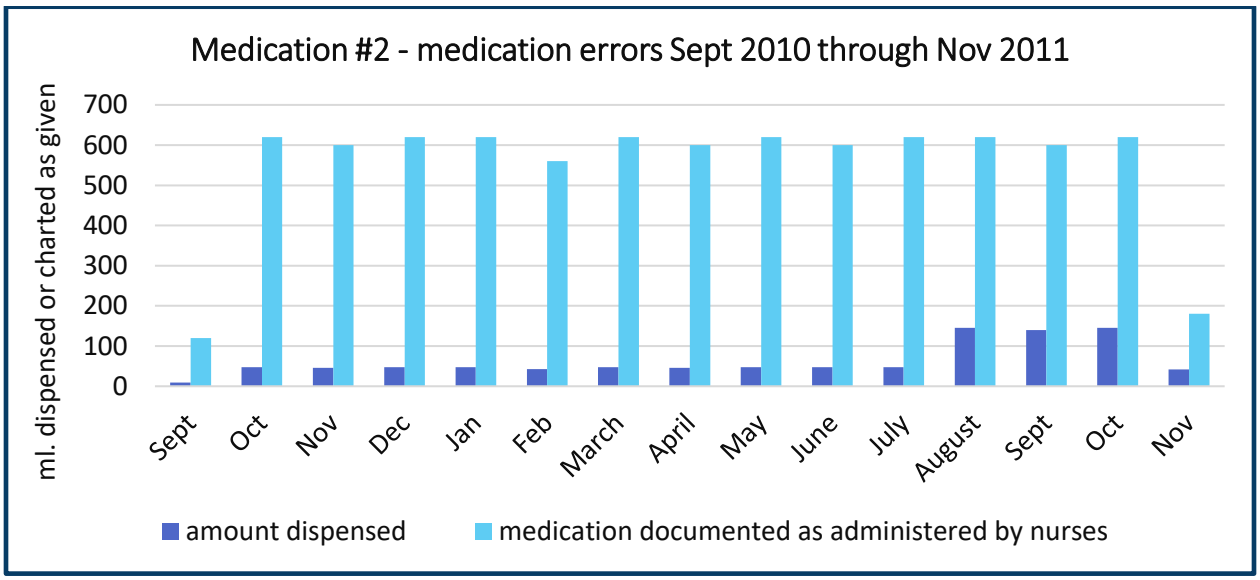
My concerns about medications not being administered as prescribed were also validated after my son moved from Fircrest. In his new home, the medications were administered as prescribed. Within 2 months my son had the first relief from a chronic health condition that he had been suffering from for over 4 years.

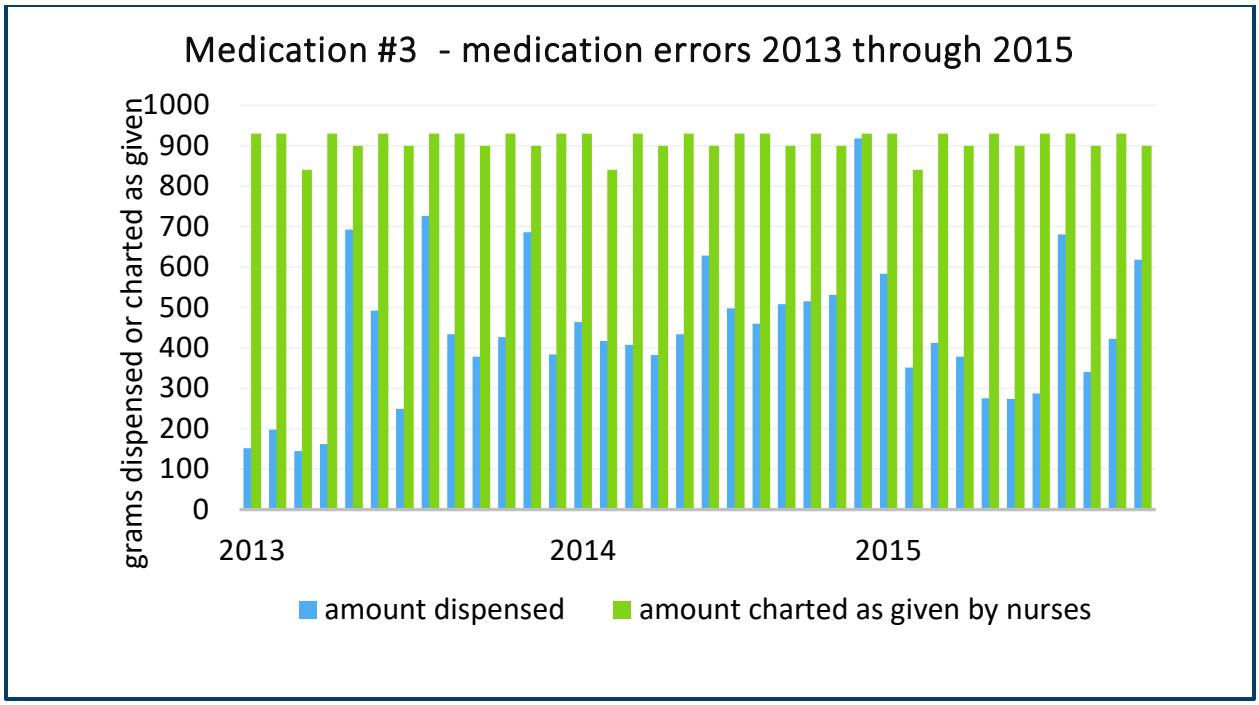
This is a major systemic problem for patient safety.

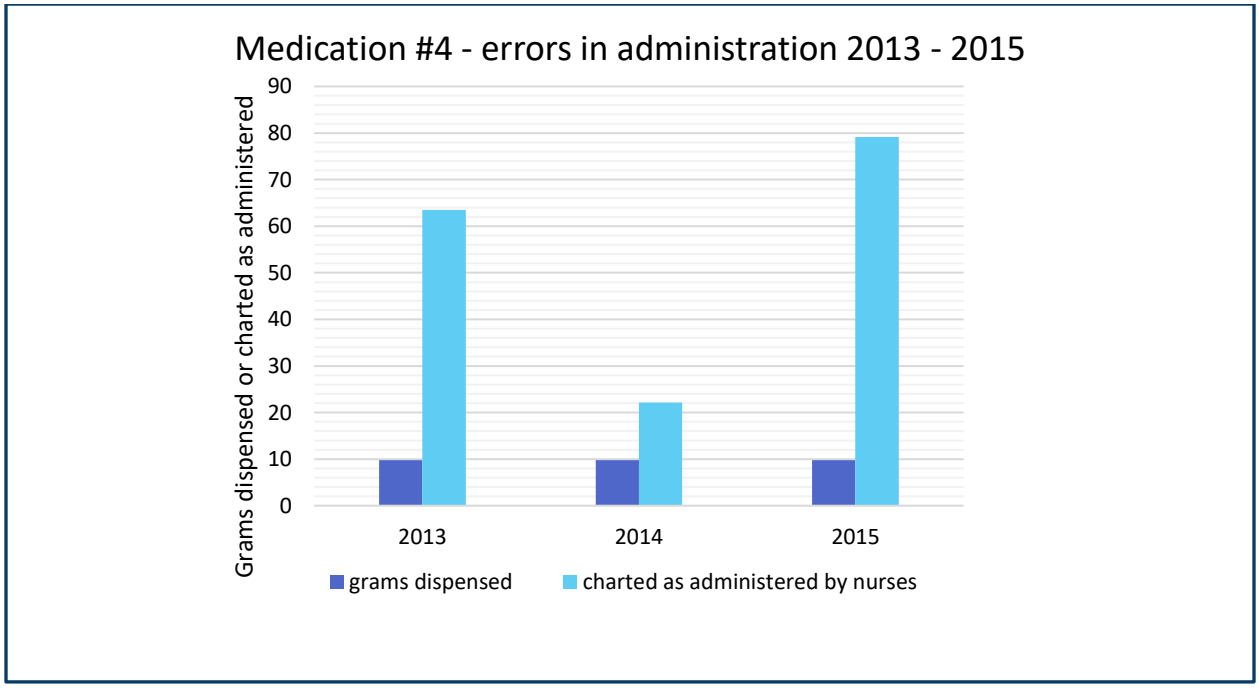
Nurses are to administer medications as prescribed or give a reason why the medication was not administered. False documentation of medication administration went on for several years with the nurses documenting medications which they clearly did not administer.

This violates the Washington State Nurse Practice Law (RCA 18.79) and violates Federal requirements as outlined in the State Operations Manual – Appendix J - Intermediate Care Facilities for Individuals with Intellectual Disabilities.


Medication #1 - medication errors over 5 years
grams dispensed or charted as administered
60
50
40
30
20
10
0
2010
2011
2012
2013
2014
2015
dispensed
documented by nurses as administered


Medication #2 - medication errors Sept 2010 through Nov 2011
ml. dispensed or charted as given
700
600
500
400
300
200
100
0
Sept
Oct
Nov
Dec
Jan
Feb
March
April
May
June
July
August
Sept
Oct
Nov
amount dispensed
medication documented as administered by nurses


Medication #3 - medication errors 2013 through 2015
grams dispensed or charted as given
1000
900
800
700
600
500
400
300
200
100
0
2013
2014
2015
amount dispensed
amount charted as given by nurses


Medication #4 - errors in administration 2013 - 2015
Grams dispensed or charted as administered
90
80
70
60
50
40
30
20
10
0
2013
2014
2015
grams dispensed
charted as administered by nurses

These errors are indicative of major patient safety risk factors and need to be addressed by the agencies responsible for licensing these facilities and providers.

The Department of Social and Health Services licenses Fircrest and the other Residential Habilitation Centers. At this point in time, DSHS has continued to state that the allegations for medication errors and other issues of alleged neglect are unfounded.

Look at the facts – the medication errors are clear. There needs to be an overhaul at Fircrest in medication management – from the MD who prescribes, to the pharmacy which dispenses, to the pharmacist who makes the reviews and to the nurse who administers and evaluates response.

List of Violations in SOM – Appendix J

W331 (Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.460(c)

The facility must provide clients with nursing services in accordance with their needs.

- Guidance §483.460(c) The nurse responds in a timely manner to all medical concerns reported, conducts assessments as indicated, effects timely and appropriate interventions, communicates with the client's physicians and other health care professionals as indicated, provides treatments as ordered, monitors client progress following illness or injury and provides training to clients and/or staff as indicated.

W339 (Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.460(c)(4

Other nursing care as prescribed by the physician or as identified by client needs

- Guidance §483.460(c)(4) Nursing interventions are implemented as indicated by the needs of the client and consistent with either standard nursing practice principles or orders from the attending physician.

W344 (Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.460(d)(2)

The facility must employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans.

- Guidance §483.460(d)(2) The facility provides for nursing services based on the health needs and conditions of clients residing there.

W345 (Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.460(d)(3)

The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.

- Guidance §483.460(d)(3) Refer to the applicable State Nurse Practice Act.

W362 (Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.460(j)(1)

A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.

W363 (Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.460(j)(2)

The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

- Guidance §483.460(j)(2) The physician and IDT members must discuss, document and take necessary follow-up action for any irregularities noted.

W367 (Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.460(k)

The facility must have an organized system for drug administration that identifies each drug up to the point of administration. §483.460(k)

W368 (Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.460(k)(1)

All drugs are administered in compliance with the physician's orders;

- Guidance §483.460(k)(1) Administration errors identified in previous medication administration records qualify as noncompliance with physician’s orders.

W369 (Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.460(k)(2)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_j_intermcare.pdf