# Institute for Safe Medication Practices

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## Nurses Identify Barriers to Teaching Patients about Their Medications

**HUNTINGDON VALLEY, Pa.**—According to newly released survey data from the Institute for Safe Medication Practices (ISMP), lack of adequate written information and time constraints may hinder nurses' efforts to educate patients about how to take their medications after discharge from the hospital. The survey, which was mailed with the June 2003 issue of ISMP's newsletter for nurses, received more than 250 responses and uncovered areas where other health care providers can offer support for medication teaching.

**Lack of Adequate Materials**. Almost all nurses surveyed (more than 80%) consistently provide verbal information to patients about their medications, but only 28% always or frequently offer written information, which is known to aid memory retention. One in four nurses cited lack of written materials about medications as a frequent problem; one in three felt there was a lack of materials available in the patient's native language; and one in four said that available materials were not suitable for the patient's health literacy or reading level. Only half of nurses surveyed were using videos, television, or intranet sites to teach patients about medications or medication safety.

Pharmacists and physicians should work with nurses to make suitable written materials more readily available. If computer terminals and a printer reside in patient care units, electronic databases may provide one solution, since a few systems offer patient leaflets at different reading levels as well as in several languages. If electronic databases are not feasible, the pharmacy should provide annually updated paper leaflets for the most commonly used medications.

**Need for Medication Error Information**. Half of the nurses who responded to the survey reported that they have little or no information at all to provide to patients about medication error prevention, despite the fact that publications and web-based resources can be obtained through ISMP (www.ismp.org/pages/psb.htm) and the Agency for Healthcare Research and Quality (www.ahrq.gov).

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Hospital pharmacists can also assist by providing error prevention materials for specific therapeutic categories of drugs or drug administration devices that are error prone, such as low molecular weight heparin and metered dose inhalers. Pharmacists and physicians can also help determine if new formulary drugs under consideration require special patient education, and develop any necessary patient materials before those products are added.

**Time Pressure**. Insufficient time/staffing was also a frequent barrier to medication teaching for almost half of all nurses surveyed, even more so in the inpatient (47%) than outpatient (29%) settings. Targeted consultations with a pharmacist for patients discharged on numerous prescription medications may prove to be the most effective educational support. Physicians can help by identifying patients who need in-depth education and listing the medications anticipated upon discharge in the progress notes so nurses can begin the educational process before the day of discharge.

The survey uncovered successes as well as barriers to medication teaching—for example, more than two thirds (68%) of nurses indicated that they require all patients to repeat back instructions or demonstrate their proficiency in drug administration techniques, such as injections, that have been taught to them. Most nurses (79%) also reported that patients were provided with a way to contact them with questions about their medications after discharge.

For additional survey results, visit www.ismp.org/NursingSurvey.asp. For tips on educating patients about their medications, see the attached fact sheet.

**About ISMP:** The Institute for Safe Medication Practices (ISMP) is a 501c(3) nonprofit organization that works closely with healthcare practitioners and institutions, regulatory agencies, and professional organizations to provide education about medication errors and their prevention. Over the past 25 years, ISMP has become the premier international resource in all matters pertaining to safe medication practices in health care organizations. For more information on ISMP, or its medication safety alert newsletters for health care professionals and consumers, visit www.ismp.org

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# Patient Medication Teaching Tips

- **Install a computerized drug information system** (e.g., Micromedex, Lexi-Pals) that offers patient leaflets in different languages and appropriate reading levels.

- **Always provide patients with written drug information** if they are taking medications prone to errors (e.g., metered-dose inhalants) or high-alert medications (e.g., warfarin, heparin, insulin, opiates, chemotherapy).

- **Include the family or caregivers** during patient education when appropriate so that they can provide additional support and reminders.

- **Do not wait until discharge** to begin education about complex drug regimens. Physicians can help by identifying patients who require in-depth education and listing the medications that are anticipated upon discharge in progress notes.

- **Clearly explain the directions** for using each medication, including obvious information, since patients may misinterpret instructions. For example, some teenage girls have spread contraceptive jelly on their toast and eaten it as a means of birth control.

- **Always require repeat demonstrations** or explanations about medications that will be taken at home. Have the patient repeat back the information provided or show that they have mastered drug administration techniques such as measuring liquid medications.

- **Use the time you already spend with patients** during assessments and daily care to evaluate their level of understanding about their medications.

- **Develop standing orders for pharmacy consults** to educate patients who are being discharged on five or more medications and therefore more prone to medication errors.

- **Identify patients at risk for non-adherence** with medication regimens. Consider a referral to home care services and alert a pharmacist to design a drug administration schedule that minimizes the number of times per day medications must be taken or administered.

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