Communicating with hospitalised children and families in managing medications – examining possibilities for engagement

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LEARNER OBJECTIVES

- To define what is meant by child and family engagement.
- To analyse medication communication encounters to determine how child and family engagement occurs.
- To identify strategies to facilitate medication communication with children and families.
AIMS OF PRESENTATION

To examine how children and families are involved in managing medications in hospital.

To identify possible opportunities for child and family engagement with managing medications.
GO PUBLIC | Parents find son's lifeless body after pharmacy switches sleep medication for toxic dose of another drug

Boy's mother wants legislation that would force pharmacies to make prescription errors public


Second Infant Dies After Heparin Overdose

July 11, 2008 05:46 PM
by Denis Cummings

Medications mistakes common among young children

Seattle Children’s: overdose error led to death

By The Associated Press  |  June 9, 2013, 4:32 a.m.

St. Luke’s: Nurse’s Medication Error Resulted in Child Fatality

JULY 3, 2016

FATAL HOSPITAL ERROR CAUSES PATIENT’S DEATH BY GIVING HIM WRONG MEDICATION

Boy, 8, Dies After Pharmacy Allegedly Gave Medication Dosage 1,000 Times Higher Than Prescribed

by Inside Edition  |  11:06 AM EDT, June 20, 2016

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CHILD AND FAMILY ENGAGEMENT

• Enabling children and families to participate in treatment decisions that reflect their preferences.¹

• Parents and children assist in managing medications.² ³

• Direct link between medication errors and ineffective communication. ³ ⁴

• Few studies have focused on experiences within the hospital context.


METHODS

Interviews, Focus Groups, Observations
Hospitalised children, families, doctors, nurses and pharmacists.
Diverse wards – surgical, medical and adolescent and rehabilitation.
Thematic analysis.

Clinical Audit
Retrospective review of medication errors submitted to an online voluntary reporting system over five year period.
Descriptive statistical analysis with IBM SPSS.
THEMES

Sociocultural and environmental influences

Actual communication encounters

Outcomes of communication
Patient: They don’t really say anything about side effects until it actually happens...and I would like to know... I’m on vancomycin and gentamycin for the central line infection...I know my Losec [omeprazole] is for indigestion. My Nilstat [nystatin] is so I don’t get a fungal infection in my stomach...Warfarin is to stop my line from blocking...[Int-Pat-Neuro-BT-33]
Dr: So are there any bad effects you have to be careful with, for your medicines?

Patient: No.

Mum: What about the purple one [asthma preventer], what do you have to do after you have the purple one?

Patient: I rinse my mouth out with water. [Int-Pt-Surg-So-1]
ENVIROMENTAL INFLUENCES

• Miscommunications following children’s transfers of care between diverse hospital settings.
  - Emergency → general wards → operating room → specialty wards.

• Miscommunications involving interactions with health care staff of different specialties.
  - Health professional responsibilities across wards.
ACTUAL COMMUNICATION ENCOUNTERS

Encounters with children and health professionals
- Short in length.
- One-on-one encounters.
- Administering medications or checking supply.
- Initiated by health professional usually.

Encounters with parents, children and health professionals
- Variable in length.
- Health care team encounters.
- Information seeking and giving, decision making about medications.
- Initiated by health professionals, parents and child.
ACTUAL COMMUNICATION ENCOUNTERS – CONVERSATION INITIATED BY CHILD

Nurse: So, I’ve held off on your Endone [oxycodone]. You know, the tablets we gave you yesterday, because that’s what the pain team have asked us to do...but if it’s getting unbearable you can have that. So just let me know.

Patient: So when should I ask for it, when it’s unbearable?

Dad: When it hurts.

Patient: Like do you mean, if that clonidine doesn’t help in an hour and the pain’s still pretty bad, can I let you know and you’ll give me the stronger stuff? [OBS-NUR-Neuro-EH-36-1(1+2)]
Nurse: Now I’ve got the medication here.
Mother: The Infatabs [phenytoin]? 
Nurse: Yes, I started crushing them and people were like “you can’t”, and so I didn’t, but then the other nurse just told me you can.
Mother: I’m sure you can because ((consultant)) said crush it and I put it in yoghurt. And you chew them.
Nurse: How else was she having them?
Mother: ...She was on the oral liquid before but it’s got Sunset Yellow in it, which is one of the banned food colours around the world. And I said to the consultant to take her off it. [OBS- NUR-Neuro-EM-37-1(1+2)]
Nurse: Alright. Well we need to fight the monster pain. So you need to have this medicine.

Patient: I can’t fight it.

Nurse: You can if you have this!

Patient: No. The medicine doesn’t have powers.

Nurse: This one does.

Dad: Yeah. Sometimes. Magical powers.

Patient: Oh, but I don’t think so.

Nurse: Let’s try. Are you ticking me again? [Patient giggles as he strokes the nurse’s elbow.]

Patient: [small voice] I can try.

Nurse: I have a nice bit of sugar. Open up. [Silence as nurse administers the oral Panadol.]

Student: Let’s see what happens. You got your powers yet?

Patient: No. [Obs-Nurs-Surg-CC-12]
OUTCOMES OF COMMUNICATION

Total number of medication errors reported, N=3,340.

Individual responsible for the medication error
- Family member, n = 50 cases (1.5%).
- Child, n = 27 cases (0.8%).

Involvement of child or family member in identifying a medication error
- n = 515 cases (15.4%).
Acknowledged hospitalised children and family members play an important role.

Increase opportunities for engagement between health professionals and children.

Facilitate improved participation at formal and informal communication encounters.