

2nd Training School

BetterCare Notebook



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The QR code directs you to **Eurocarers** and gives you the opportunity to get an overview of different European countries.

WHO DO YOU CONSIDER AS INFORMAL CAREGIVERS IN YOUR COUNTRY?

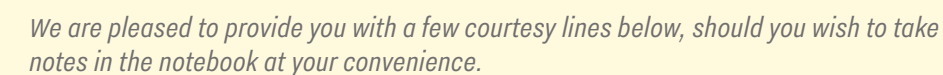
IS THERE A LEGAL DEFINITION THAT YOU KNOW OF?

WHAT DO YOU BELIEVE ARE THE MAIN STRUGGLES OF INFORMAL CAREGIVERS REGARDING PATIENT SAFETY?

ARE THERE ANY PROTECTIVE PROGRAMS RUNNING IN YOUR COUNTRY?

1. Social Activities

Room for notes

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1. Social Activities

1.1 Informal Caregivers - A special situation

Informal caregivers are individuals who provide care at home to patients with chronic illnesses, disabilities, or other long-term health or care needs, without having formal qualifications or academic training as healthcare professionals. These caregivers can be family members or close friends offering support within the context of a personal relationship, but they can also include individuals who are not personally related to the care recipients. This kind of care can be either paid or unpaid.

Inclusion Criteria:

Family members or other persons close to the patient who provide care in a home setting without formal education as healthcare professionals.

- Family members with formal education as healthcare professionals but lacking specific knowledge and appropriate medical equipment and support.
- Personnel from non-profit volunteer associations.
- Family members or non-family members officially recognized by the responsible authority—usually social security—meeting required conditions to receive a subsidy.
- Individuals without academic qualifications as healthcare professionals who provide care either independently as self-employed or as part of services offered by care sector companies.

Exclusion Criteria:

- Caregivers who provide professional medical care at home, such as visiting nurses, physiotherapists, social workers, psychologists, or other institutional workers who perform medical procedures at home. Adverse events occur frequently in the health care

setting. When these events occur, not only the care receivers or patients and their relatives are harmed as first victims of the adverse event, but also the health care workers as second victims (and even the institutions as third victims)

[1]. The EU-cost-action ERNST (European Researchers' Network Working on Second Victims) published a new, evidence- and consensus-based definition.

[2]. Second victims are now referred to as:

“Any health care worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury and who becomes victimized in the sense that they are also negatively impacted”

Informal caregivers are in the unique position of not only being the relatives of the care recipients, but also their caregivers. Therefore, they might experience adverse events from both perspectives: The relative as first victim and the caregiver as second victim

[3]. So, it should be questioned, if family caregivers are to be considered as first, second or even double victims.

The next few chapters of this manual will dive into possible errors informal caregivers can face and therefore make them prone to emotional harm, possibly leading to them becoming first, second or double victims.

2. Patient Safety Incidents in the Home Care Setting

2.1 Medication Errors

The following chapter will provide you with a brief overview of possible errors occurring in the home care setting and summaries of some studies on the topic. The main focus of this Training School are medication errors.

2.1 Medication Errors

Patients mostly take their medications at home and yet there is a research gap on medication safety in the home care setting since most studies focus on the hospital setting.

A scoping review hints that the most common adverse event within the home care setting is due to medication error [4]. Medication errors are unintended failures during the drug treatment process that can possibly lead to harming the patients [5].

Factors that might play a role in any type of medication error are shown in figure 1. [6-8]:

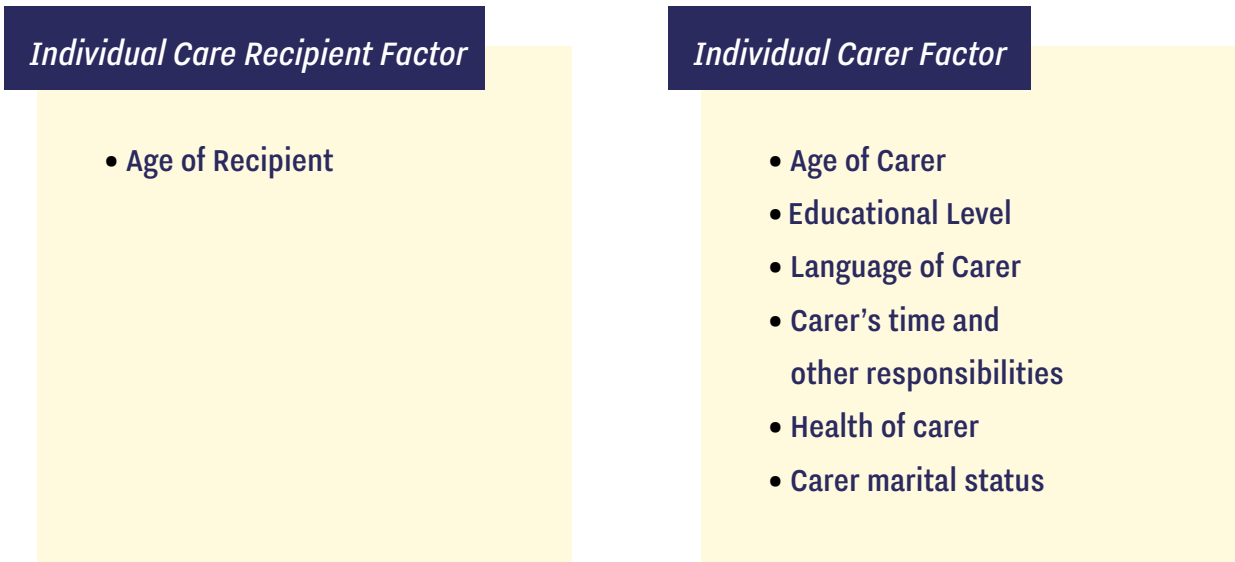
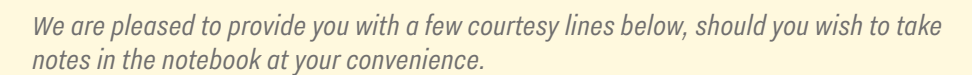


Figure 1. Factors influencing medication errors [6-8].

2.1 Medication Errors

Another possibility for medication error is administering the medication at the wrong time or in the wrong application form [7].

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Working Group 1 - Session 1

Medication Errors in the Home Care Setting



You have 90 minutes to prepare your scenarios in your Working Groups. For the presentation, you will have 20 minutes in total (including the following group discussion!). Please keep the time limits in mind when preparing your presentation!

General objectives

- To gain a deeper understanding about contributing factors regarding medication errors in the home care setting
- To develop some cases to teach others about medication errors in the home care setting

- Working Group 1 -

This Working Group will focus on individual carer and care recipient factors that may contribute to medication errors. Some examples of individual carer factors are:

Working Group 1 objectives

- Develop a realistic case about a medication error of your choice including at least three contributing factors (individual carer and care recipient factors)
- Your setting is: Amanda Smith (62) cares for her husband, Harry Smith (82) with dementia. Amanda works part time in an office and can adjust her working hours accor-

ding to her husbands' caring needs. Harry needs help with preparing his medication and reminding him of the correct time to take it but is capable of taking his medication himself

- Use your imagination to develop your case – you can decide yourself, what exact job Amanda works and which medication(s) Harry needs to take. Please keep in mind to make the case as realistic as possible
- Your case needs to be clear enough for the rest of the group to identify your chosen contributing factors



Use your imagination: Think about different influencing factors of the case – what's the general family situation, to they receive help from formal carers, do they receive any government aid, what's the living situation?

Working Group 2 - Session 1

Medication Errors in the Home Care Setting



You have 90 minutes to prepare your scenarios in your Working Groups. For the presentation, you will have 20 minutes in total (including the following group discussion!). Please keep the time limits in mind when preparing your presentation!

General objectives

- To gain a deeper understanding about contributing factors regarding medication errors in the home care setting
- To develop some cases to teach others about medication errors in the home care setting

- Working Group 2 -

This Working Group will focus on medication factors that may contribute to medication errors. Some examples of individual carer factors are:

Working Group 2 objectives

- Develop a realistic case about a medication error of your choice including at least three contributing factors (medication)
- Your setting is: Lisa Young (36) is the mother of Jake (7). Jake suffers from a chronic condition and his mother has to assist him with his medication. Lisa assists her son full

time while her husband Fred (37) generates the family's income.

- Use your imagination to develop your case – you can decide yourself, what Lisa exactly does for Jake and how which error(s) occur. Please keep in mind to make the case as realistic as possible.
- Your case needs to be clear enough for the rest of the group to identify your chosen contributing factors.



Use your imagination: Think about different influencing factors of the case – what's the general family situation, to they receive help from formal carers, do they receive any government aid, what's the living situation?

Working Group 3 - Session 1

Medication Errors in the Home Care Setting



You have 90 minutes to prepare your scenarios in your Working Groups. For the presentation, you will have 20 minutes in total (including the following group discussion!). Please keep the time limits in mind when preparing your presentation!

General objectives

- To gain a deeper understanding about contributing factors regarding medication errors in the home care setting
- To develop some cases to teach others about medication errors in the home care setting

- Working Group 3 -

This Working Group will focus on prescription communication factors that may contribute to medication errors. Some examples of individual carer factors are:

Working Group 3 objectives

- Develop a realistic case about a medication error of your choice including at least three contributing factors (prescription communication)
- Your setting is: Gordon Hughes (76) cares for his wife Jane (74) who has Multiple Sclerosis. She recently got back home from hospital after an exacerbation of her disease.

- Use your imagination to develop your case – you can decide yourself, what Gordon exactly does for Jane and how which error(s) occur. Please keep in mind to make the case as realistic as possible.
- Your case needs to be clear enough for the rest of the group to identify your chosen contributing factors.



Use your imagination: Think about different influencing factors of the case – what's the general family situation, do they receive help from formal carers, do they receive any government aid, what's the living situation?

Working Group 4 - Session 1

Medication Errors in the Home Care Setting



You have 90 minutes to prepare your scenarios in your Working Groups. For the presentation, you will have 20 minutes in total (including the following group discussion!). Please keep the time limits in mind when preparing your presentation!

General objectives

- To gain a deeper understanding about contributing factors regarding medication errors in the home care setting
- To develop some cases to teach others about medication errors in the home care setting

- Working Group 4 -

This Working Group will focus on psychosocial factors that may contribute to medication errors. Some examples of individual carer factors are:

Working Group 4 objectives

- Develop a realistic case about a medication error of your choice including at least three contributing factors (psychosocial factors)
- Your setting is: Marge and Homer Simpson (both in their early 50s) care for Homer's father Abraham (82) with dementia. Abraham has several health conditions and needs

to see his physician regularly for check-ups.

- Use your imagination to develop your case – you can decide yourself, what Marge and Homer have to do for Abraham and how which error(s) occur. Please keep in mind to make the case as realistic as possible.
- Your case needs to be clear enough for the rest of the group to identify your chosen contributing factors.



Use your imagination: Think about different influencing factors of the case – what's the general family situation, to they receive help from formal carers, do they receive any government aid, what's the living situation?

Working Group 5 - Session 1

Medication Errors in the Home Care Setting



You have 90 minutes to prepare your scenarios in your Working Groups. For the presentation, you will have 20 minutes in total (including the following group discussion!). Please keep the time limits in mind when preparing your presentation!

General objectives

- To gain a deeper understanding about contributing factors regarding medication errors in the home care setting
- To develop some cases to teach others about medication errors in the home care setting

- Working Group 5 -

This Working Group will focus on a mix of factors that may contribute to medication errors. Some examples of individual carer factors are:

Working Group 5 objectives

- Develop a realistic case about a medication error of your choice including at least three contributing factors (mixed approach)
- Your setting is: Jeff and Linda Davis care for their disabled daughter Bonny (4). Bonny has epileptic seizures and autism. She needs help with many daily tasks as well as

the preparation and administration of medication (including her emergency medication when she has a seizure).

- Use your imagination to develop your case – you can decide yourself, what Jeff and Linda exactly do for Bonny and how which error(s) occur. Please keep in mind to make the case as realistic as possible.
- Your case needs to be clear enough for the rest of the group to identify your chosen contributing factors.



Use your imagination: Think about different influencing factors of the case – what's the general family situation, to they receive help from formal carers, do they receive any government aid, what's the living situation?

3. Medication Safety in the Home Care Setting

3.1 Prescription Errors

According to the WHO policy brief “Medication without harm”, errors can occur during the entire medication use process, starting with the prescription of medication and ending with the monitoring of the patient’s response to and appropriateness of the medication [12] . The following paragraphs will explore possible errors during the medication use process.

3.1 Prescription Errors

Prescription errors are errors made by the prescribers during the process of the prescription of medication, for example while writing the prescription (including the failure to prescribe a necessary drug) or while making therapeutic decisions [13]. Most errors occur during this phase [14]. Most prominent contributing factors are poor legibility, incompleteness or errors in information about the patient and the medications [15,16]. Further risk factors contributing to prescription errors are shown in figure 2.

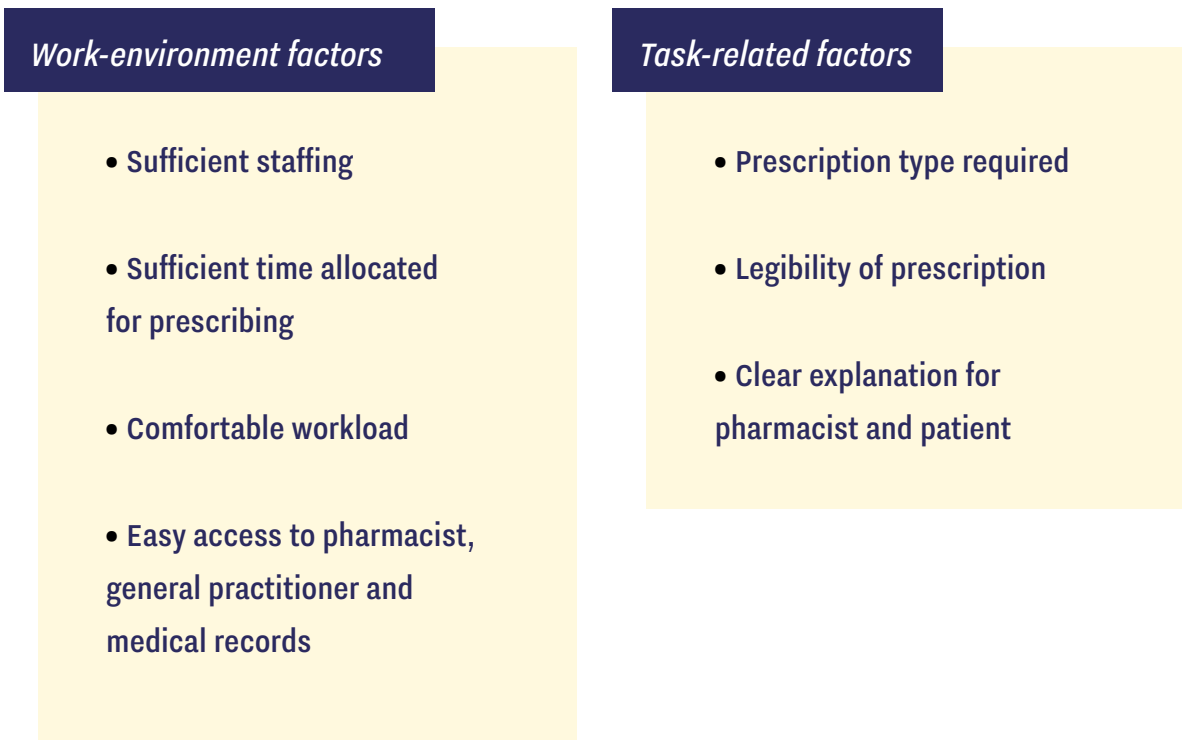
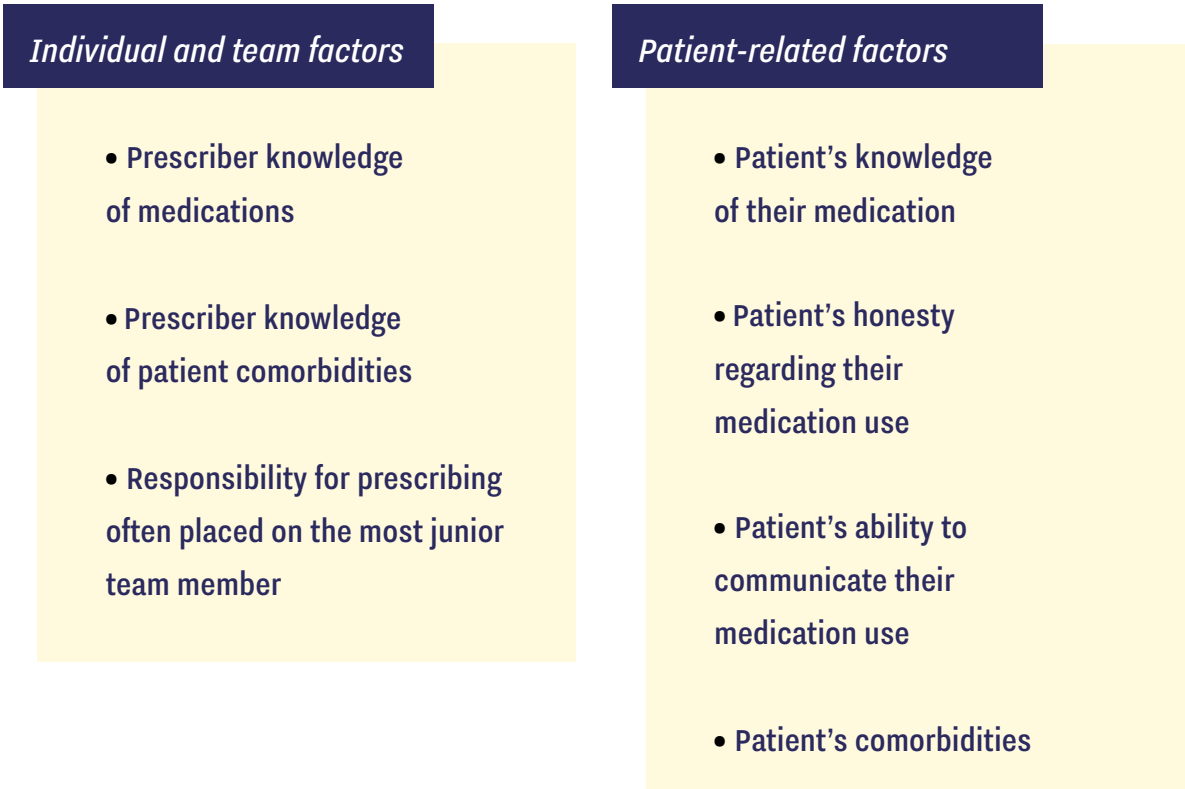


Figure 2. Risk factors contributing to medication errors [17]

In some cases, informal caregivers have to be the ones to communicate to the prescriber about the patient-related factors and to make sure, the prescription is legible and any information needed (i.e. dosage, time of application, ...) is given to them by the prescriber.

3. Medication Safety in the Home Care Setting

3.1 Prescription Errors



We are pleased to provide you with a few courtesy lines below, should you wish to take notes in the notebook at your convenience.

[illegible]

We are pleased to provide you with a few courtesy lines below, should you wish to take notes in the notebook at your convenience.

[illegible]

3. Medication Safety in the Home Care Setting

3.2 Transcription Errors - 3.3 Dispensing Errors

3.2 Transcription Errors

Transcription errors are defined as any discrepancy between the medication order and the actual written medication order in any document (i.e., medical record, medication chart, medication request sheet, discharge medication chart, ...) [18].

A study examined the root causes of transcription errors further [19]. Regarding errors in strength and dosage of the medication, four primary causes were identified:

1. Handwritten prescriptions
2. Traps (i.e., due to complexity or potential of misreading, look-alike, sound-alike)
3. Lack of effective control of prescription, label and medicine
4. Lack of concentration caused by interruptions

3.3 Dispensing Errors

Dispensing errors are any deviation from the prescription made by the pharmacy when distributing the medications [13].

Most common contributing factors are high workload, low staffing, mix-ups (due to look-alike, sound-alike), lack of knowledge or experience, distractions or interruptions, and communication problems [20].



We are pleased to provide you with a few courtesy lines below, should you wish to take notes in the notebook at your convenience.

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4. Group Session 2

Designing Informational Materials for Informal Caregivers

BetterCare's aim is to support and empower informal caregivers to provide safe care at home. Our Training School is also fully dedicated to this. Therefore, you will prepare informational materials for informal caregivers.

The type of material you choose to make is up to you! You can make a video, podcast, or whatever you think is suitable for informal caregivers. While designing your materials keep the factors influencing safe medication at home in mind. Also, you can use the WHO's 5 moments of medication safety to structure your materials (Figure 4). The following subchapters will provide you with the specific tasks of each group.



Each group will have 15 minutes to record their materials. There will be a presentation of these materials tomorrow and time for plenary discussions.

Figure 4. The 5 moments of medication safety [12].

4.1 - Group 1

- We've prepared some information on how to structure and make digital materials and sent them to you before the Training School.



4.2 - Group 2

- We've prepared some information on how to structure and make digital materials and sent them to you before the Training School.



4.3 - Group 3

- We've prepared some information on how to structure and make digital materials and sent them to you before the Training School.



4.4 - Group 4

- We've prepared some information on how to structure and make digital materials and sent them to you before the Training School.



4.5 - Group 5

- We've prepared some information on how to structure and make digital materials and sent them to you before the Training School.



References

Roundtables

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Roundtables

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Acknowledge

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