Medication Error Defined

- Any error that occurs in medication administration process, whether or not it reaches the client. May be applied to:
  - Misinterpretations
  - Miscalculations
  - Misadministration
  - Handwriting misinterpretation
  - Misunderstanding of verbal or phone orders

Factors That Contribute to Medication Errors by the Health-Care Provider

- Omitting one of the five rights
- Failing to perform an agency system check
- Failing to take into account client variables such as age, body size, and renal or hepatic function

Factors That Contribute to Medication Errors by the Client

- Taking drugs prescribed by several practitioners
- Getting prescriptions filled at more than one pharmacy
- Not filling or refilling prescriptions
Factors That Contribute to Medication Errors by the Client

• Taking medications incorrectly
• Taking medications that may be left over from a previous illness
• Taking medications prescribed for something else

Nurse-Practice Act

• Designed to protect the public
• Defines the legal scope of practice
• Enforced by state boards of nursing or state nursing examiners
• Should be reviewed periodically, as they are routinely updated

Standards of Care

• Defined as skills and learning of a specific profession (e.g., nursing)
• Defined by the nurse-practice act and what is a reasonable and prudent action
• Established by policies and procedures of hospital for any activity, including medication administration

Examples of Common Errors

• Giving an incorrect dose
• Not giving an ordered dose
• Giving an unordered drug
• Pharmacists and nurses must collaborate on checking accuracy of medication orders
• Not reviewing recent client laboratory data
• Not reviewing other pertinent information from chart

Examples of Common Errors (continued)

• Not getting written order from health-care provider
• Verbal and telephone orders not written by prescriber
• Lack of clarifying questions regarding correct drug, dosage, or routes of administration

Examples of Common Errors (continued)

• Not clarifying with physician if order is incomplete or illegible
• Using unapproved abbreviations
• Administering unfamiliar medications—consult reference
• Refer to Table 9.1 for additional recommendations
Examples of Common Errors (continued)

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>i.v.</td>
<td>Intravenous infusion</td>
</tr>
<tr>
<td>i.m.</td>
<td>Intramuscular injection</td>
</tr>
<tr>
<td>q.d.</td>
<td>Every day</td>
</tr>
<tr>
<td>q.4h</td>
<td>Every 4 hours</td>
</tr>
<tr>
<td>q.12h</td>
<td>Every 12 hours</td>
</tr>
</tbody>
</table>

Severities

- One-half of fatal medication errors occurred in clients older than 60 years of age
- Children are another vulnerable population due to smaller dosages

Impact of Medication Errors

- Common cause of morbidity and preventable death in hospitals
- Emotionally devastating to nurse and client
- Increased cost to patient and facility, as it may extend client’s stay
- Poor reputation for unit or facility, caused by high incidence of errors
- Penalizing of administrative staff because of errors

Frequent Types of Drug Errors

- Administering improper dose
- Giving wrong drug
- Using wrong route of administration

Rules, Policies, and Procedures

- Understand and follow policies and procedures governing medication administration for organization in which nurse practices
- Policies and procedures establish standards of care
- Standards of care and agency’s policy manual help reduce medication errors and maintain client safety

Reporting and Documenting Medication Errors

- Documentation should occur in a factual manner
- Documentation in medical record must include specific nursing interventions that were implemented following error in order to protect client
- Document all individuals who were notified of error
- Medication-administration record is a source detailing what medication was given or omitted
**Reporting with an Incident Report**

- Details recorded in factual and objective manner
- Allows nurse to identify factors that contributed to the error
- Is not part of client’s hospital record

**Legality and Reducing Errors**

- Accurate documentation verifies client’s safety
- Used as tool to improve drug administration processes
- Reduction of medication errors can be created from written data

**Reduction of Medication Errors and Incidents—Assessment**

- Assess food or medication allergies
- Assess current health concerns
- Assess use of OTCs and herbal supplements
- Review recent laboratory tests
- Review recent physical-assessment findings
- Identify need for education of medication regimen

**Reduction of Medication Errors and Incidents—Planning**

- Avoid using abbreviations that can be misunderstood
- Question unclear orders
- Do not accept verbal orders

**Reduction of Medication Errors and Incidents—Implementation**

- Follow specific facility policies and procedures related to medication administration
- Ask to client to participate by restating the right time and dose of medication
- Be aware of potential distractions during medication administration
- Remove distractions, if possible
- Focus on task of administering medications
- Practice five rights of medication administration
Reduction of Medication Errors and Incidents—Evaluation

- Assess client for expected outcomes
- Determine if any adverse effects have occurred

Educate Client with

- Written, age-appropriate handouts
- Audiovisual teaching aids
- Contact information

Additional Client Education

- Know names of all medications
- Know what side effects may occur
- Use appropriate administration devices
- Read label prior to each drug administration
- Carry list of all medications, including OTC and herbals
- Ask questions

Three Agencies That Collect and Report on Medication Errors

- FDA’s MedWatch
- Institute of Safe Medication Practices (ISMP)
- MEDMARX

Methods to Reduce Number of Medication Errors

- Automated, computerized, locked cabinets for medication storage on client-care units
- Risk-management departments to examine risks and minimize the number of medication errors
- Collaboration with nursing to modify policies and procedures
Figure 9.2: NCC MERP Index for Categorizing Errors. Source: © 2001 National Coordinating Council for Medication Error Reporting and Prevention. All rights reserved.