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# Medication Safety : Prevention of Medication Errors

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## Medication Safety: Prevention of Medication Errors

*Everyone Plays a Part in Preventing Medication Errors*

### What is a Medication Error?

“...any preventable event that may cause or lead to inappropriate medication use or patient harm, while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including: prescribing, order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.”

*-The National Coordinating Council for Medication Error and Prevention*

### 2006 National Patient Safety Goal: Reducing Medication Errors

Prevention of medication errors is one of our most important goals as we move toward becoming the safest hospital in Connecticut. To prevent possible errors, we will use a process called “medication reconciliation.” Medication reconciliation is the process of comparing the medications that the patient has been taking prior to the time of admission or entry to a new setting with the medications that the organization is about to provide. The purpose of the reconciliation is to avoid errors of transcription, omission, duplication of therapy, drug-drug and drug-disease interactions, etc. A medication, as defined in the Medication Management standards, includes any prescription medications; sample medications; herbal remedies; vitamins; nutraceuticals; over-the-counter drugs; vaccines; diagnostic and contrast agents used on or administered to persons.

### How do Medication Errors Happen?

Medication errors are often the result of sound-alike or look-alike drugs—an easy way to remember is: **SALAD**:

**S**ound-**A**like-**L**ook-**A**like-**D**rugs



There are several strategies to avoid medication errors that involve **SALAD** drugs:

- Use of TALL-man letters, for example:
- hydroOXYzine and hydrALZINE
- Avoid brand names
- Avoid storing **SALAD** drugs in close proximity to each other

Some examples of **SALAD** drugs are:

- Celebrex and Celexa
- Quinine and Quinidine
- Zantac and Zyrtec
- Lamictal and Lamisil
- Hesperin and Heparin

### How Common are Medication Errors and What is Their Impact?

- More than 7,000 deaths occur annually because of medication errors.<sup>1</sup>
- Medication-related errors for hospitalized patients cost \$4,700 per hospital stay or roughly \$2 billion dollars per year, nationally.<sup>2</sup>

1. Phillips, D.P. Lancet 1998  
2. Bates Institute of Medicine 1997

## Everyone Plays a Part in Preventing Medication Errors



Healthcare professionals and patients must work together to prevent medication errors—here are some ways we can educate patients.

- Remind patients that they should always take their medications and a list of their medications with them when they go to the hospital. The healthcare professionals there will need to know what they are taking.
- Encourage patients to educate themselves on the medications they take. They should ask their doctors the name of each medication prescribed for them and the reason they are taking it. Help them understand that it's really important to ask questions if anyone tells them something different.
- Just as we, as healthcare professionals, double check what medications we are giving, we should teach our patients to look at every medicine before they take it. If it does not look like what they usually take, they should ask why.
- Empower your patients. Tell them that they should not let anyone give them medications without first checking their hospital identification bracelet each time. This can prevent one patient getting another patient's medications.
- Let patients know that before any test or procedure, they should ask if it will require any dyes or medicines—this can help prevent allergic reactions.
- When patients are ready to go home, make sure they know that they can expect their doctor, nurse or pharmacist to discuss each medication with them. They should then update their medications list if any prescriptions change or if new medications are added.

### Healthcare Professionals, Remember: When you are delivering medication, make sure you have the:

- **Right Person**
- **Right Medicine**
- **Right Time**
- **Right Dose**
- **Right Route (oral, topical, nasal, etc.)**



## Where Can You Find More Information?

The following websites contain a wealth of information on the topic of medication safety:

**The Institute for Safe Medication Practices**  
[www.ismp.org](http://www.ismp.org)

**American Society of Health-System Pharmacists**  
[www.ashp.org](http://www.ashp.org)

**The Massachusetts Coalition for the Prevention of Medical Errors**  
[www.macoalition.org](http://www.macoalition.org)

**Institute for Healthcare Improvement**  
[www.ihl.org](http://www.ihl.org)

**Agency for Healthcare Research and Quality (AHRQ)**  
[www.ahrq.gov](http://www.ahrq.gov)

**National Patient Safety Foundation**  
[www.npsf.org](http://www.npsf.org)

## Medication Safety Quiz

1. Every time a patient moves from one area of care to another within our healthcare system, we need to review the list of medications they are currently taking and also check for any possibility of drug interactions.  
True or False?
2. Reducing medication errors is one of the ways we can become the safest hospital in Connecticut.  
True or False?
3. Everyone plays a role in medication safety, and this includes the patients themselves.  
True or False?

Answers to all of the above questions are TRUE.

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Chair, CAI Medication Safety Subgroup*

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- May—Pain: Alternative Treatments