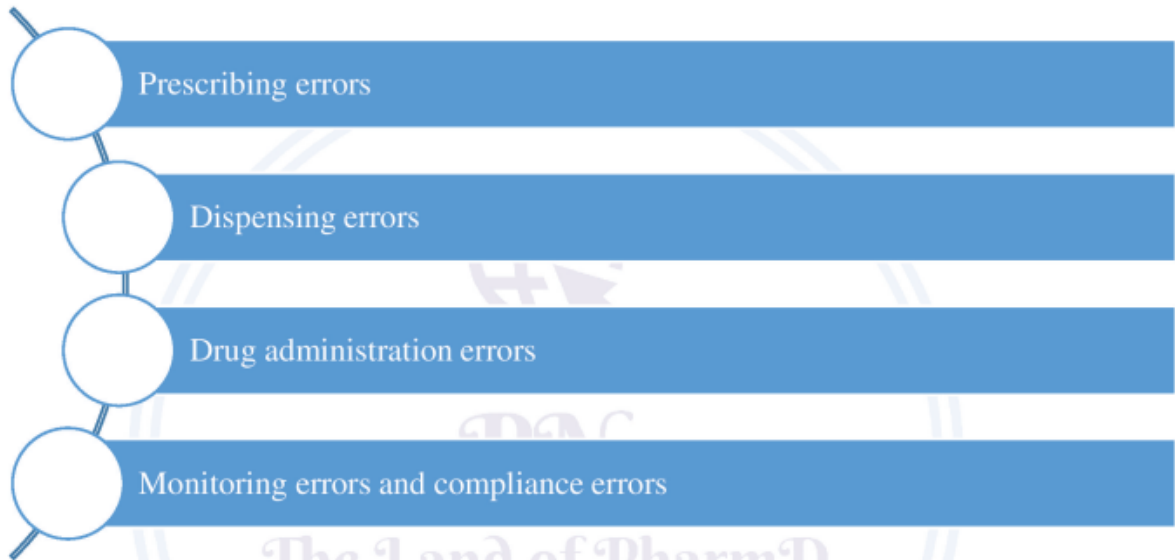


Medication Error

Definition-

A medication error is any preventable event that may cause or lead to inappropriate medication use or client harm while the medication is in control of health care professional client or consumers.

Types:



Medication Error	Contributing Factors	Methods to minimize error
<p>Prescription error</p> <p>Most common type of medication error.</p> <p>Account for 80% of all medication mistakes.</p>	<p>Inadequate knowledge</p> <p>Calculation errors and different drug formulations available</p> <p>Uncommon dosage regimen frequencies</p> <p>Complicated dosage regimens</p> <p>Poor patient history taking use of multiple dosage forms per dose</p> <p>Use of abbreviations mental slips</p> <p>lack of adequate resources</p> <p>Drug name confusion (look alike sound alike)</p>	<p>Ensuring up-to-date reference sources</p> <p>Use of computerized physician order entry</p> <p>Ensuring knowledge of a drug before prescribing</p> <p>Ensuring an accurate drug history is taken</p> <p>Printing the drug name and patient details clearly on the prescription</p> <p>Including all details of drug therapy i.e name of drug, dose, directions, duration of therapy.</p> <p>Being aware of look alike and sound alike products</p> <p>Avoiding the use of abbreviations.</p>

<p>Dispensing Errors</p> <p>This error occur at any stage</p>	<p>Confusing the name of one drug with another.</p>	<p>Ensuring a safe dispensing procedure.</p>
--	---	--

<p>during the dispensing process. Research estimates that 5% of all prescriptions are dispensed improperly. Confusion occurs primarily with drugs that have a similar name or appearance</p>	<p>Two or more drugs have a similar appearance or similar name. Lack of knowledge on new medicines. Use of outdated or incorrect references. Poor dispensing procedures with inadequate checking. Unreasonable workloads. Poor housekeeping standards. Distractions and interruptions Dispensing unfamiliar products Dispensing before seeing a written order The use of computerized labelling transposition and typing errors.</p>	<p>Using different brands or separating look alike and sound alike products. Focusing on the task in hand Keeping interruptions to a minimum Maintaining workload at a safe and manageable level Being aware of high risk drugs Introducing good housekeeping practices.</p>
<p>Administration Errors Extra dose error Wrong dose error Wrong route error Wrong rate error Wrong dosage form Wrong time error Wrong administration technique Administration of expired drugs Administration of wrong preparation Omission error (eg: lack of stock)</p>	<p>Failure to check the patients identity prior to administration. Storage of look a like preparaitons side by side in the drug trolley Environmental factors such as noise, interruptions and poor lighting while undertaking the drug round. Calculation to determine the correct dose where more than one dose is required.</p>	<p>Checking patients identity. Having dosage calucations checked independently by another healthcare professional before the drug is administered. Having the prescription, the drug and the patient in the same place so they can be checked against one another. Ensuring that medication is given at the correct time. Minimizing interruptions during drug rounds.</p>
<p>Monitoring and compliance errors</p>	<ol style="list-style-type: none"> 1. Monitoring Errors: Are errors caused by- Failure to review a prescribed regimen for appropriateness or Failure to use appropriate clinical or laboratory data to assess the patients response to prescribed therapy 2. Compliance Errors: Caused by Inappropriate patient behavior regarding adherence to a 	<p>Regular follow up Medication history interview.</p>

	<p>prescribed medication regimen.</p>	
--	---------------------------------------	--

Strategies to prevent Medication Errors

<p>Ensure the five rights of medication administration</p>	<p>Nurses must ensure that institutional policies related to medication transcription are followed. It isn't adequate to transcribe the medication as prescribed, but to ensure the correct medication is prescribed for a correct patient, in the correct dosage, via the correct route and timed correctly.</p>
--	---

Follow proper medication reconciliation procedures	Institutions must have mechanisms in place for medication reconciliation when transferring a patient from one institution to the next or from one unit to the next in the same institution.
Double check or even triple check procedures	This is a process whereby another medical staff on the same shift or an incoming shift reviews all new orders to ensure each patients order is noted and transcribed correctly on the physicians order and the medication administration record or the treatment administration record.
Have the prescriber read it back	This is a process whereby a medical staff reads back an order to the prescribing physician to ensure the ordered medication is transcribed correctly.
Consider using a name alert	Some institutions use name alerts to prevent similar sounding patient names from potential medication mix up. Names such as johnson and Johnston can lead to easy confusion on the part of nursing staff
Place a zero in front of the decimal point	A dosage of 0.25 mg can easily be constructed as 25 mg without the zero in front of the decimal point, and this can result in an adverse outcome for a patient
Records and documentation	This includes proper medication labelling, legible documentation or proper recording of administered medication
Ensure proper storage of medications for proper efficacy	Medications that should be refrigerated must be kept refrigerated to maintain efficacy and similarly medications that should be kept at room temperature should be stored accordingly.