ON ERROR

Broadcast These Strategies Loud and Clear to Prevent Medication Errors

By Brian Justice

Considering the pace of technology, the evolution of communication systems, and an ongoing emphasis on patient-centered care, people may assume that medication errors rarely occur. However, the entire system depends on professionals who—however highly trained or dedicated—can make mistakes. Health care providers, patients, and the systems that connect them are at risk for medication errors.

In March 2023, the Institute for Safe Medical Practices identified the top medication errors and hazards.[1] They applied some nuance to their choices. "Our selected top concerns are not solely based on the most frequently reported problems or those that have led to the most serious consequences for patients, although these factors were considered," the report states. "Rather, we focused on errors and hazards that continue to occur but can be avoided or minimized with system [and] practice changes."[1]

The Institute for Safe Medical Practices cites inaccurate patient medication lists as the cause of many medication errors.[1] In fact, inconsistent knowledge and poor communication of medical information are responsible for up to 50% of all medication errors, according to the Institute for Healthcare Improvement.[2]

"An error can occur at any time during the medication order, procurement, and administration process," says Joleen Sams, MSN, APRN, FNP-C, a health care content contributor and owner of Ad Astra Content Services. "In the ambulatory setting, drugs can easily be administered to the wrong patient because the patient is not wearing an armband or even because two doses [of something, like a vaccine] or medications with similar names are right next to each other."

"[Electronic health records] offer a lot of medication, doses, and frequency options," says April Jones, CMA (AAMA), who works with MetroPartners OBGYN in Woodbury, Minnesota. And yet, "some options may be chosen for ease rather than accuracy," she cautions.

TOO MUCH STATIC

Beyond the human aspect of the U.S. health care system, the information sources for medications are institutional and fragmented, says Frank Federico, RPh, an Institute for Healthcare Improvement director who focuses on patient safety.[2]

"The physician's [practice] has records, but they are difficult to keep current, especially if the patient has prescriptions from many specialists," he says. "The pharmacy has records, but only for the prescriptions filled there. The hospital medical record may be incomplete, considering that most care is administered in the ambulatory setting."[2]

Again, these institutions and organizations ultimately depend on people.

"The most common patient medication errors are administering [the] wrong medication, dosage, or route, as well as failing to identify drug interactions or allergies," says Brian Clark, BSN, MSNA, founder of United Medical Education, a Provo, Utah–based organization that offers online Advanced Cardiac Life Support, Pediatric Advanced Life Support, and Basic Life Support certifications. "They can also occur due to miscommunication, lack of knowledge or training, distractions, and even similar-looking packaging."

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NEWS FLASH

The consequences of medication errors are serious. Nearly 7,000 prescription medications and numerous over-the-counter drugs are available in the United States, in addition to thousands of supplements, herbs, and more.[3] As many as 9,000 people die yearly from medication errors, and hundreds of thousands of adverse reactions or complications go unreported.[3]

Medication errors are also expensive. Treating patients with medication-associated errors is estimated to cost more than $40 billion a year.[3] Other costs include patients' psychological and emotional suffering, decreased patient satisfaction, and a growing lack of trust in the health care system.[3]

Confusion can easily happen at almost any step, cautions Leann Buneta, AAS, BSS, CMA (AAMA), CMSS, with the Oklahoma Cancer Specialists and Research Institute Breast Clinic in Tulsa, Oklahoma. "Patients may not completely understand what medications they are taking because they do not ask questions or they have a lot of information given to them at one time," she says.

CROSSED WIRES

Pharmacies have also come under scrutiny for their practices amid declining drug reimbursement rates and cost pressures from prescription drug plan administrators. Consolidation has resulted in bigger but fewer sources for prescriptions. As of 2019, large chain drugstores distribute approximately 70% of prescriptions nationwide.[4]

Pharmacies may also request refills even when the drug was prescribed for only a single cycle.

"When you are bombarded with refill after refill, it's easy for things to fall through the cracks, despite your best efforts," said Mark Lopatin, MD, a rheumatologist in Pennsylvania.[4]

DEDICATED LISTENERS

"The best way to prevent errors is to take your time, read labels, and double-check yourself and patient charts," advises Sharonda Thomas, CMA (AAMA), about practice precautions. In the meantime, some more ambitious solutions are being developed locally.

Brattleboro Memorial Hospital in Brattleboro, Vermont, launched a community education program, which includes contributing articles to the local newspaper, their own newsletter, and other forums and offering access to blank copies of the hospital's admissions medication form. People are encouraged to fill in the medication form and keep a copy to take to the hospital or physician's practice.[2]

These kinds of efforts are working, observes Tim Lynch, PharmD, MS, of Franciscan Health System. "People are much more educated these days about how to help us help them," he says. "Patients often arrive with their medications or their list because they're aware of the importance." He notes that much of that education occurs in primary care settings, with practices encouraging patients to bring all their medications into every appointment for review.[2]

"A functional [electronic health record] that helps catch common mistakes is one of the best means of preventing errors," adds Sams. "As for human error, the best practice involves open discussion when [errors] occur, an environment that promotes patient safety, and management willing to listen and identify system failures."

At whatever point errors occur in the patient journey, health care professionals understand the commitment needed and the challenge.

"Organizations that are working on [embracing the challenge] don't do it just to meet national patient safety standards," says Federico. "They do it because it's the right thing to do for the patients. It is part of delivering good patient care, but that doesn't mean it's easy."[2] ✦

TUNE IN TO THESE TIPS

The Emergency Care Research Institute recently published a report[5] that cited medication errors as a top patient safety concern. The report includes recommendations for avoiding errors[5]:

- Standardizing medication reconciliation processes
- Identifying organizational factors contributing to inaccurate medication histories
- Encouraging patients to maintain a current medication list and bring it to every health care encounter
- Including the reason for the medication throughout all documentation systems for medication orders and care and discharge planning
- Using patient navigators to educate patients on using portals to double-check medication lists
- Creating a distraction-free environment for intake or admission processes
- Making staff feel safe reporting system issues that could lead to medication errors
- Developing a flowchart of processes to avoid unnecessary steps
- Defining roles and responsibilities
- Conducting multidisciplinary training sessions with medicatidn and reconciliation coaches for one-on-one training and assistance

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