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Medication errors and patient safety resources

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Medication Errors and Patient Safety Resources

—For more information, see our Continuing Education program, "Medication Error Prevention," available at www.pharmacistsletter.com—

There is an increase in news reporting about medication errors and the sometimes devastating consequences associated with them. Medical malpractice claims are on the rise. Most claims involve physicians, but it is not uncommon for a pharmacist to be named in a medication error claim.

Most legal claims against pharmacists involve high-risk prescriptions such as warfarin (*Coumadin*), digoxin (*Lanoxin*), diabetes medications, levothyroxine (*Synthroid*, etc), and amitriptyline. A majority of the legal claims against pharmacists involve dispensing errors. About 50% of dispensing error claims involve dispensing the wrong drug, 27% are due to dispensing the right drug in the wrong strength, and 8% are due to incorrect labeling. Other reasons that a claim may be filed against the pharmacist include failure to review drug regimen (e.g., missed allergies, drug interactions) (7%) and failure to counsel or warn of potential adverse drug reactions (2%).[1] Failure to counsel or warn of potential adverse drug reactions is the fastest growing segment of claims against pharmacists. Drugs that are commonly involved in medication errors include insulin, morphine, heparin, fentanyl (*Duragesic*, etc), hydromorphone (*Dilaudid*), warfarin (*Coumadin*), potassium, vancomycin (*Vancocin*), enoxaparin (*Lovenox*), metoprolol, furosemide (*Lasix*), methylprednisolone, and meperidine (*Demerol*).[3] Most of the medication errors can be avoided if preventive measures are in place. Some prevention measures include avoiding use of dangerous abbreviations; checking for allergies; reading back phone orders; providing proper patient counseling; and verifying the indication, dosage, etc.[2]

Most states allow a pharmacist to refuse to fill a prescription if there is a potential for patient harm (e.g., severe drug interactions, dosage error, medication abuse) or if the prescription is believed to have been forged. However, five states (Delaware, New York, North Carolina, Oregon, and Texas) have policies that prohibit the pharmacist from refusing to fill medications or interfere with patient access to medications.[3] Some of these laws are poorly written and can be interpreted as requiring pharmacists to fill prescriptions even if the prescriptions can cause harm to the patient (e.g., wrong dose, drug interactions, allergies, etc).[4] Many of these laws stemmed from pharmacists refusing to fill the morning after pill (e.g., *Plan B*, etc). The intent of these laws is to prohibit pharmacists from refusing to fill prescriptions due to personal moral beliefs. As an obligation, pharmacists still need to ensure patient safety and consult the physician if it is believed that the prescription can pose harm to the patient.

If a medication error does occur, it is important to act quickly and professionally. Of course, the first step should be to minimize any potential ill effects for the patient. Accept the responsibility to resolve the problem and don't be afraid to offer a sincere apology. It's usually O.K. to say "I'm sorry this happened" without accepting liability by admitting you made a mistake or caused harm to the patient. You should, however, be familiar with your medical malpractice policy. Most policies contain a "cooperation clause" requiring the insured to cooperate with the insurance company's efforts to defend the insured against a claim. The clause commonly forbids the insured from admitting liability to an injured or harmed party.[5] As part of the movement to encourage healthcare professionals to promptly and fully inform patients of an error and to apologize, some states in the U.S. have passed laws to allow physicians to apologize to the patient and family members without worrying the apology will be used against them in court.[6] Apology laws vary by state; check with your local state board for law specifics.

—Please proceed to the next page for a listing of helpful medication error and patient safety resources—

More. . .

Pharmacist's Letter/Prescriber's Letter Detail-Documents	
170201	Medical Errors
170601	How To Respond to Medication Errors
170615	Know Your Medications Patient Handout
191115	*Darvocet A500* (Propoxyphene Napsylate and Acetaminophen) (Discusses problems with confusing names, similar products)
191116	Dispensing Error Alerts
191215	Dangerous Abbreviations
201201	Joint Commission Required Medication Profile Reconciliation
210401	A Different Drug, a Different Country, but the Same Brand Name?
220513	Medication Reconciliation
220714	Safe Use of Acetaminophen (*Tylenol*)
221211	Emergency Department Visits Due to Adverse Drug Events
230113	Medication Errors Due to Medication Delivery Devices
230276	Look-alike, Sound-alike Medication Errors
230301	New Developments for Electronic Prescribing
230311	OTC Brand Name Extensions
Comprehensive References	
Medication Errors (Cohen, M. ed.)	A comprehensive, authoritative resource for healthcare professionals that focuses on causes, prevention, and risk management of medication errors. $46.95 (soft-cover). http://www.ismp.org
Major Internet Resources	
Institute for Safe Medication Practices (ISMP)	A nonprofit healthcare organization dedicated to learning about medication errors; understanding their system-based causes; and disseminating practical recommendations that can help healthcare providers, consumers, and the pharmaceutical industry prevent errors. ISMP offers a wide variety of free educational materials and services on patient safety and prevention of medication errors. It offers a confidential medication error-reporting program for healthcare professionals and monthly safety bulletins. http://www.ismp.org **ISMP Canada**: http://www.ismp-canada.org/
U.S. Pharmacopeia (USP)	USP is an independent, science-based, nonprofit public health organization. USP provides a medication errors reporting program for healthcare professionals to directly report medication errors along with the MEDMARX medication error and adverse drug reaction reporting program. USP supports the healthcare community in the research and development of patient safety initiatives. http://www.usp.org/hqi/patientSafety/
Institute of Medicine of the National Academies (IOM)	The IOM provided the foundation report, *To Err is Human* (2000), that called for establishing patient safety reporting systems and systems for quality improvement. The IOM also recommended that steps be taken to develop standards for data collection, analysis, and error prevention. http://www.iom.edu/ http://www.iom.edu/subpage.asp?id=6659

More. . .

Major Internet Resources Con't	
Quality Interagency Coordination Task Force (QuIC)	The Quality Interagency Coordination Task Force (QuIC) was established to ensure that all federal agencies involved in purchasing, providing, studying, or regulating health care services were working in a coordinated manner toward the common goal of improving quality care. QuIC provided the presidential report, "Doing What Counts for Patient Safety" designed to reduce medication errors and their impact. http://www.quic.gov/index.htm http://www.quic.gov/report/toc.htm
Agency for Healthcare Research and Quality (AHRQ)	AHRQ was established to improve the quality, safety, efficiency, and effectiveness of health care. AHRQ was also responsible for an analysis of state-based patient safety reporting systems and to integrate data collection on medical errors and adverse events, coordinate research and analysis efforts, and promote collaboration on reducing the occurrence of injuries that result from medical errors. http://www.ahrq.gov/qual/ http://www.ahrq.gov/qual/errorsix.htm
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	JCAHO establishes national and international standards of performance for healthcare organizations to continuously improve the safety and quality of care provided to the public. They have ongoing national patient safety goals which must be met by all organizations that they accredit. http://www.jointcommission.org/
National Coordination Council for Medication Error Reporting and Prevention (NCC MERP)	NCC MERP is an independent body comprised of 23 national organizations that meet, collaborate, and cooperate to address the interdisciplinary causes of errors and to promote the safe use of medications. http://www.nccmerp.org/
Institute for Healthcare Improvement (IHI)	IHI is a not-for-profit organization driving the improvement of health by advancing the culture, quality, and value of international health care. http://www.ihi.org/IHI/ http://www.ihi.org/IHI/Topics/PatientSafety/
Topic-specific Resources	
Bar Coding	Neuenschwander M, Cohen MR, Vaida AJ, et al. Practical guide to bar coding for patient medication safety. *Am J Health Syst Pharm* 2003;60:768-79. Anon. Implementing a bar coded patient medication safety program: pharmacist's toolkit. ASHP Foundation 2004. http://www.ashpfoundation.org/BarCoded.pdf. Anon. National Coordinating Council for Medication Error Reporting and Prevention. Council recommendations, promoting and standardizing bar coding on medication packaging: reducing errors and improving care. June 27, 2001. http://www.nccmerp.org/council/council2001-06-27.html. Pathways for Medication Safety. Assessing bedside bar-coding readiness (2002). http://www.ismp.org/PDF/PathwaySection3.pdf.

More. . .

Topic-specific Resources Con't	
Classification of Errors	http://www.nccmerp.org/medErrorCatIndex.html http://www.nccmerp.org/medErrorTaxonomy.html
Computerized Physician Order Entry	http://www.leapfroggroup.org/media/file/Leapfrog-Computer_Physician_Order_Entry_Fact_Sheet.pdf http://ccbh.ehealthinitiative.org/communities/community.aspx?Section=105&Category=236&Document=478
Confused Drug Names	http://www.ismp.org/tools/confuseddrugnames.pdf
Continuous Quality Improvement	http://www.patientsafety.gov/rca.html http://www.isixsigma.com/library/content/c050516a.asp http://www.isixsigma.com/library/downloads/RootCauseTemplate.xls
Culture for Prevention	http://www.outcome-eng.com/index.html http://www.justculture.org
Dangerous Abbreviations	http://www.nccmerp.org/dangerousAbbrev.html http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/abbr_tips.htm http://www.jointcommission.org/NR/rdonlyres/2329F8F5-6EC5-4E21-B932-54B2B7D53F00/0/06_dnu_list.pdf http://www.ismp.org/PDF/ErrorProne.pdf
Definitions	http://www.nccmerp.org/aboutMedErrors.html **For Canada:** http://www.ismp-canada.org/definitions.htm
Disclosure and Apology	http://www.sorryworks.net/media54.phtml
Effective Communication	http://www.nccmerp.org/council/council2001-02-20.html http://www.nccmerp.org/council/council1996-09-04.html

More. . .

Topic-specific Resources Con't	
Electronic Prescribing	http://www.ehealthinitiative.org/initiatives/erx/ http://www.ismp.org/MSAarticles/improve.htm
High-alert and Problem-prone Medications	http://www.ismp.org/Tools/highalertmedications.pdf http://www.usp.org/patientSafety/resources/top50DrugErrors.html
Look-alike, Sound-alike Drugs	http://www.usp.org/patientSafety/newsletters/qualityReview/qr792004-04-01.html http://www.fda.gov/cder/drug/MedErrors/nameDiff.htm http://www.jointcommission.org/NR/rdonlyres/C92AAB3F-A9BD-431C-8628-11DD2D1D53CC/0/LASA.pdf **For Canada:** http://www.hc-sc.gc.ca/dhp-mps/brgtherap/activit/fs-fi/lasa-pspcs_factsheet-faitsaillant_e.html http://www.hc-sc.gc.ca/dhp-mps/brgtherap/proj/alike-semblable/lasa_comm_rep-noms_conson_sembl_comm_rep_e.html http://www.hc-sc.gc.ca/dhp-mps/brgtherap/proj/alike-semblable/lasa-pspcs_ias-ra_e.html
Patient Safety Goals	http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/
Physician-specific Resources	http://www.ama-assn.org/ama1/pub/upload/mm/370/stridesinsafety.pdf **For Canada:** http://www.cma.ca/multimedia/staticContent/HTML/N0/l2/safemedication/ResourceBook.pdf
Prevention	http://www.jointcommission.org/NR/rdonlyres/C5403CAB-21B6-4CD4-A636-98822CE81C7A/0/pharm_med_station_1.pdf http://www.jointcommission.org/NR/rdonlyres/2E48C6E5-F4B1-4685-BBCE-23C52879F99C/0/pharm_med_station_2.pdf http://www.medpathways.info/medpathways/index.jsp http://www.fda.gov/FDAC/features/2003/303_meds.html http://www.mederrors.com/ **For Canada:** http://www.patientsafetyinstitute.ca/index.html http://www.saferhealthcarenow.ca/Default.aspx?folderId=82&contentld=124

More. . .

Topic-specific Resources Con't	
Products Associated with Medication Errors	http://www.usp.org/patientSafety/newsletters/qualityReview/qr792004-04-01.html http://www.ismp.org/tools/confuseddrugnames.pdf http://www.usp.org/hqi/patientSafety/resources/top50DrugErrors.html http://www.fda.gov/cder/drug/MedErrors/#drug http://www.drugtopics.com/drugtopics/article/articleDetail.jsp?id=111202
Reporting Adverse Drug Events	http://www.fda.gov/cder/aers/default.htm https://www.accessdata.fda.gov/scripts/medwatch/medwatch_online.cfm **For Canada:** http://www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/index_e.html
Reporting Errors	http://www.usp.org/patientSafety/mer http://www.usp.org/pdf/EN/patientSafety/medform.pdf http://www.fda.gov/medwatch/index.html https://www.ismp.org/orderforms/reporterrortoismp.asp **For Canada:** https://www.ismp-canada.org/err_report.htm
Statistics	http://www.iom.edu/report.asp?id=5575 http://www.usp.org/products/medMarx/

Users of this document are cautioned to use their own professional judgment and consult any other necessary or appropriate sources prior to making clinical judgments based on the content of this document. Our editors have researched the information with input from experts, government agencies, and national organizations. Information and Internet links in this article were current as of the date of publication.

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References

1. Personal communication. Kenneth R. Baker, RPh., J.D. April 12, 2007.
2. Grissinger M, Horn D. Top 10 adverse drug reactions and medication errors. Presented at APhA 2007 Annual Meeting and Exposition. Atlanta, Georgia. March 16-19, 2007. http://www.aphameeting.org/Images/Documents/EVENT_577_1015.pdf. (Accessed March 29, 2007).
3. Morrison J, Borchelt G. Don't take "no" for an answer. A guide to pharmacy refusal laws, policies and practices. National Women's Law Center. January 2007 Updates. http://www.nwlc.org/pdf/DontTakeNo2007.pdf. (Accessed April 12, 2007).
4. Cada DJ. Declining to dispense. *Hosp Pharm* 2005;40:746.
5. Banja JD. Does medical error disclosure violate the medical malpractice insurance cooperation clause? http://www.ahrq.gov/downloads/pub/advances/vol3/Banja.pdf . (Accessed April 10, 2007).
6. Anon. 'I'm sorry,' hard for doctors to say. CNN.com. April 11, 2007. http://www.cnn.com/2007/LAW/04/11/sorry.doctors.ap/index.html. (Accessed April 12, 2007).

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