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## **Kathy Ferrell: Medical-Legal Consulting Newsletter April 2006**

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### **Greetings!**

I hope you find my newsletters useful and informative. As always, I welcome your suggestions for future monthly newsletters, including topics you would like for me to address. Also, I would appreciate your forwarding my newsletter to other attorneys who may need assistance in medical malpractice, personal injury or product liability cases. I look forward to being of service to you.

## **MEDICATION ERRORS – WHAT CAN BE DONE?**

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Medication errors are listed by the Joint Commission on Accreditation of Healthcare Organizations as the third most common error (12.2%) occurring in general hospitals. This percentage is likely higher than reported because studies have shown medication errors which fail to cause injuries may not be reported for fear of retribution.

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

The types of medication errors are too numerous to list, but the top 5 types of errors include:

- Wrong drug (22%)
- Overdosage (17%)
- Wrong route of administration (8%)
- Monitoring error (7%)
- Wrong strength/concentration (7%)

Medications that have the highest risk of causing injury when misused are known as high-alert medications. The top five high-alert medications are insulin; opiates and narcotics; injectable potassium chloride; intravenous anticoagulants (heparin); and

sodium chloride solutions above 0.9 percent.

The most common causes of medication errors are:

- Communication – Written miscommunication; misinterpretation of the order; poor handwriting of the ordering physician and nurse failure to verify the order; misunderstanding of a verbal order due to sound-alike drug names; and using drug abbreviations
- Human factors – Lack of orientation and training resulting in knowledge deficit; performance deficit, miscalculation of dosage or infusion rate, drug preparation error, transcription error, stress or fatigue
- Procedural compliance – The five "right's" of medication administration: right patient, right drug, right time, right dose and right route of administration
- Labeling – Most medications are not provided to the patient or consumer in the original package from the manufacturer but have been repackaged into individual doses. Repackaging of medication provides opportunities for mislabeling according to drug name, dosage, etc.
- Name confusion - With tens of thousands of brand names and generic drugs currently on the market, the potential for error due to confusing drug names is significant. Similar drug names, either written or spoken, account for approximately 15% of all reports to the USP Medication Error Reporting Program. In March 2001, the U.S. Pharmacopeia released "Use Caution, Avoid Confusion," an updated list highlighting hundreds of confusing drug name set and identifying more than 750 unique drug names that have been reported to the Medication Error Reporting Program. [www.ismp.org](http://www.ismp.org); [www.usp.org](http://www.usp.org) and [www.fda.org](http://www.fda.org)

The Institute for Safe Medication Practices, USP and the FDA collect and track medication errors and make information available to health care providers and the public. This has led to the change of several commonly confused drugs. In fact, the FDA rejects approximately one-third of all proposed new drug names because of their potential for confusion.

Other risk reduction strategies include:

- Do not store problem medications alphabetically, but in an alternate location
- Provide or ask for both the generic and brand names of drugs for medication orders
- Write the purpose of the medication on the prescription order
- Develop a policy for taking verbal or telephone orders including the request for the correct spelling of the medication
- Avoid abbreviations in writing medication orders such as "U" for units and "µg" for "micrograms"
- Avoid the use of trailing zeros (e.g., 2.0 vs. 2) or use of leading decimal point without a leading zero (e.g., .2 instead of 0.2)
- Label all medications with generic and brand names
- Stock and use standardized dosages and premixed medications if at all possible
- Reconcile all medications to ensure the medication order, medication label, and nursing administration record are all the same.

**Ways in which the Legal Nurse Consultant can assist attorneys with cases involving medication errors:**

- Review medical records to establish injury as the result of a medication error
- Review medical records for reconciliation of all medication orders and administration
- Review medical records for nursing standards of care in administration of medications
- Review the medical records for nursing standards in documentation guidelines following medication administration
- Review medical records for nursing standards of care in the monitoring of appropriate medications
- Review the medical records for patient assessments which indicate adverse drug reactions
- Review all admission orders, post-operative orders, discharge instructions, transfers and other "interfaces of care" to ensure reconciliation of medications
- Request and review the list of unacceptable abbreviations established by the health care facility or provider
- Request and review policies and procedures to ensure that the medical staff refer to the list and comply with the list of unacceptable abbreviations
- Request and review the policy that if an unacceptable abbreviation is used, the prescription order is verified with the prescriber prior to its being filled
- Request and review all staff orientation and education concerning the use of patient controlled anesthesia pumps and other intravenous or intrathecal medication administration pumps

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