Medication Errors—8th Top Reported Sentinel Event

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“Medications are the most common intervention in healthcare but are also most commonly associated with adverse events in hospitalized patients.”i A medication error may occur at any point along the ‘medication use process’ continuum, namely during prescribing, compounding, dispensing, drug administration, and monitoring process which is carried out after the provider makes a decision regarding the treatment for the patient.ii

Frequency of Medication Errors

Medication errors were noted as the sixth chief medical factor in a cumulative analysis of malpractice claims for the time frame of January 1, 2003-December 31, 2012, according to the PIAA (Physician’s Insurers Association of America). Of the 4,965 malpractice claims that involved medication errors as the chief medical factor, 19.50% involved an indemnity payment in order to close the claim. iii

A number of agencies track medication errors including the Food and Drug Administration, Institute for Safe Medication Practices, U.S. Pharmacopeia, The Joint Commission and MedMARX. The Food and Drug Administration has received nearly 30,000 reports of medication errors since 1992.iv “Medication Error” is the eight most common sentinel event reported to The Joint Commission (TJC). During the time period of 2004-June 2013, approximately 400 medication-related sentinel events were reported to TJC. v Based on the statistics, there is a clear understanding that too many medication errors are occurring and impacting the safety of patients.

High-Alert Medications and Population

The scope of reducing medication errors can be overwhelming, so prioritization is a must. Harm related to the use of high alert medications is more likely to be more serious, and they “have the highest risk of causing injury even when used correctly.”vi High-alert medications responsible for the majority of adverse medication events include insulin, anti-coagulants, narcotics and sedatives.
Patient populations that are vulnerable to medication errors include the elderly and pediatric patients. Medications and processes should be reviewed to ensure appropriate precautions are taken to prevent adverse events from occurring.

**Risk Reduction Strategies**

Numerous safe medication principles and error-reduction strategies are available to assist facilities with promoting patient safety. Strategies include standardization, checklists, double checks, automation, computerization, forcing functions, prevention of interruptions and distractions, unit dosing, removal of medications from certain settings, and precaution with storage of lookalike-soundalike medications.vii

The Institute for Safe Medication Practices (ISMP) has released the 2014-2015 Targeted Medication Safety Best Practices for Hospitals. The targeted best practices are based on specific medication safety issues that continue to cause fatal and harmful errors in patients, despite repeated warnings in ISMP publications.viii

The Joint Commission ("TJC") has published the following patient safety goals applicable to medication safetyix:

- NPSG.01.01.01: Improve the accuracy of patient identification
- NPSG.01.03.01: Eliminate transfusion errors related to patient misidentification.
- NPSG.02.03.01: Report critical results of tests and diagnostic procedures to the right person in a timely manner.
- NPSG.03.04.01: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.
- NPSG.03.05.01: Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.
- NPSG.03.06.01: Maintain and communicate accurate patient medication information.

Several types of medication-related Sentinel Event Alerts (Alerts) have been published by TJC. The Alerts are based upon sentinel events and/or trends and include evidence based actions to help avoid adverse events. Sentinel Event Alert topics include: safe use of opioids in hospitals, safely implementing health information and converging technologies, preventing errors relating to commonly used anticoagulants, preventing medication errors, using medication reconciliation to prevent errors, preventing vincristine administration errors, patient-controlled analgesia by proxy, and medication errors related to potentially dangerous abbreviations. x
Conclusion

Medication errors cause harm to patients daily.

In an effort to improve medication safety, healthcare organizations are encouraged to focus on processes occurring along the entire continuum of the medication treatment process. This means that an organization proactively reviews potential risks, institutes reduction strategies, responds to incidences, tracks the root causes, and implements strategies to prevent reoccurrence.

Dr. Lucian Leape of Harvard School of Public Health said it well, “Incompetent people are, at most, 1% of the problem. The other 99% are good people trying to do a good job who make very simple mistakes, and it’s the processes that set them up to make these mistakes.”

MAG Mutual Risk Management and Patient Safety Consultants invite our policyholders’ questions. If you wish to discuss information presented in this article, or have other questions please call us at 1-800-282-4882 and ask for Risk Management.

Published May 2014

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