RECOMMENDED PATIENT SAFETY PRACTICES – MEDICATION ERRORS

Best Practices adopted by Tennessee Improving Patient Safety (TIPS) on March 1, 2002

15 WAYS TO LOWER YOUR DOSE OF MEDICATION ERRORS

A study from the **University of Chicago Medical Center** places the incidence of medication errors between 1.7 and 59.1 percent. According to the **Joint Commission on Accreditation of Healthcare Organizations**, 15 percent of reported medication errors are due to confusion between drug names. Thousands more are due to confusing or misunderstood abbreviations.

According to the **Food and Drug Administration** and the authors of the **University of Chicago** study, the following guidelines can greatly reduce the number of medication errors:

1. Clearly write all orders with a ballpoint pen so that copies are legible.
2. Avoid the use of abbreviations and unnecessary symbols on drug orders.
3. Include the indication for the medication in each order, i.e. "for blood pressure."
4. Never guess about a medication order, but contact the physician if there are any questions about drug, dose, route, indication or instructions.
5. Avoid the use of verbal or telephone orders. When absolutely necessary, make sure the recipient repeats the order back to the physician.
6. Keep only necessary and authorized medications available to nursing staff and return other medications to pharmacy.
7. Always read the drug packaging label three times during the preparation of a dose.
8. Incorporate the "five rights" of drug administration into daily practice - right patient, right drug, right dose, right route, right time.
9. Try to avoid the use of a patient's own medication in a facility setting.
10. Never use trailing zeros when prescribing medications.
11. Always use a zero to precede a decimal point when prescribing less than one dose.
12. Physically separate dangerous medications and label them as such.
13. Keep the prescription and the label together and incorporate multiple checkpoints in the dispensing process.
14. Make the patient counseling session a final checkpoint in the drug dispensing process.
15. Provide brand and generic name on all medication labels.

Resource:

www.JCAHO.org