



# CHAPTER 15

## Medication Safety

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### LEARNING OUTCOMES

**After completing this chapter, you will be able to**

- List 10 different types or categories of medication errors.
- Identify causes or factors that contribute to medication errors.
- List five high-alert medications.
- Describe 10 medication error prevention strategies.
- Define culture of safety.
- Describe the possible consequences of actual medication errors.
- Explain the steps to be taken when an error has been identified.
- Identify the four steps in the PDSA cycle.

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## KEY TERMS

<b>Compliance error</b>	An error occurring when patients do not follow their dosing regimen.
<b>Culture of safety</b>	An environment or philosophy that encourages reporting of errors without the fear of punishment.
<b>Deteriorated drug error</b>	Use of an expired medication or one whose properties have been compromised.
<b>Failure mode and effects analysis (FMEA)</b>	A process that evaluates where errors might occur and estimates their potential impact.
<b>High-alert medications</b>	Medications that have a high risk of causing patient harm when used in error.
<b>Improper dose error</b>	A dose that is greater than or less than the prescriber's order.
<b>Medication error</b>	An error occurring during the medication-use process.
<b>Medication misadventure</b>	A general term to describe drug-related incidents.
<b>Medication safety</b>	Freedom from accidental or preventable injury related to the medication-use process.
<b>Monitoring error</b>	Failure to review a medication order or associated clinical laboratory values.
<b>Omission error</b>	A scheduled dose that is omitted entirely.
<b>Patient safety</b>	Freedom from accidental or preventable injury produced by medical care.
<b>Plan, do, study, act (PDSA)</b>	A method of testing small changes quickly, studying the outcomes, and making adjustments to improve a process.
<b>Prescribing error</b>	Error occurring during the prescribing process.
<b>Root cause analysis (RCA)</b>	A process for retrospectively analyzing an error.
<b>Stop, think, act, review (STAR)</b>	A safety strategy to refocus attention to detail.
<b>Unauthorized drug error</b>	An error occurring when a drug given to or taken by a patient was not ordered by an authorized prescriber.
<b>Wrong administration technique error</b>	An error occurring when a medication is given or taken by the wrong route or the use of an improper procedure.
<b>Wrong dosage form error</b>	Use of the incorrect medication dosage form.
<b>Wrong time error</b>	Administration of a medication dose outside of an established scheduled time.