

HEROIN



Medication Errors

Nithushi Rajitha Samaranayake

Medication Errors

Medication Errors Michael Richard Cohen, 2007 In the second expanded edition of the acclaimed Medication Errors 1999 Michael R Cohen brings together some 30 experts from pharmacy medicine nursing and risk management to provide the best most current thinking about medication errors Their contributions make this the most comprehensive authoritative examination in print of the causes of medication errors and strategies to prevent them Medication Errors provides the health care community acute care long term care ambulatory care the pharmaceutical industry regulatory affairs and academia with practical guidance to make patients who take or receive medications safer Key Features Numerous insights into the causes of medication errors including drug names drug packaging and labeling and error prone abbreviations and dose expressions In depth analyses of prescribing errors dispensing errors drug administration errors and errors related to drug delivery devices using examples of actual errors for illustration Detailed discussions of specialty areas fraught with risk cancer chemotherapy pediatric and neonatal patients and immunologic drugs A comprehensive chapter on high alert medications those drugs most frequently involved in harmful events with precautions that should be taken to avoid such mishaps Dozens of tables and figures throughout plus a color plate section capturing key information concisely

Medication Errors

Robert Naylor, 2024-08-23 Adverse events in patients caused by medical management are a serious and grossly underreported public health problem One patient in ten entering hospital will suffer an adverse event of impairment disability or death This book is a major comprehensive examination of the incidence and causes of adverse events Using data obtained from hospitals within the United Kingdom United States and other developed countries it examines the risk factors leading to errors the human and financial costs and the scope to reduce errors In particular it focuses on the need for a critical reappraisal of undergraduate teaching and clinical tuition All healthcare professionals throughout primary and secondary care including clinicians managers and policy makers and patient and carer groups can benefit from reading this book It identifies possible solutions and how adverse events and medication errors can be reduced resulting in improved patient care

Preventing

Medication Errors Institute of Medicine, Board on Health Care Services, Committee on Identifying and Preventing Medication Errors, 2006-12-11 In 1996 the Institute of Medicine launched the Quality Chasm Series a series of reports focused on assessing and improving the nation's quality of health care Preventing Medication Errors is the newest volume in the series Responding to the key messages in earlier volumes of the series To Err Is Human 2000 Crossing the Quality Chasm 2001 and Patient Safety 2004 this book sets forth an agenda for improving the safety of medication use It begins by providing an overview of the system for drug development regulation distribution and use Preventing Medication Errors also examines the peer reviewed literature on the incidence and the cost of medication errors and the effectiveness of error prevention strategies Presenting data that will foster the reduction of medication errors the book provides action agendas detailing the measures needed to improve the safety of medication use in both the short and long term Patients primary health care

providers health care organizations purchasers of group health care legislators and those affiliated with providing medications and medication related products and services will benefit from this guide to reducing medication errors

Medication Errors Neil M. Davis, Michael Richard Cohen, 1981 Medication Error: Use of Warfarin Patrick Kimuyu, 2017-11-20 Scientific Essay from the year 2016 in the subject Health Public Health grade 1 Egerton University language English abstract Medication errors remain life threatening mistakes affecting the delivery of health care Medical errors are considered as a global problem capable of increasing the length of hospital stay mortality rate and other related costs Though medication errors can be caused by any healthcare professional a high percentage of such mistakes are made by nurses especially during drug administration The current research indicates that thousands of Americans die on an annual basis owing to medication errors Nurses commit majority of errors during intravenous injection of drugs while poor hand writing witnessed among primary care givers often results to dosing errors Other primary care givers use abbreviations during prescriptions making it hard for pharmacists to interpret hence rising the risk of medication errors Medication errors can also be attributed to inadequate pharmacological knowledge and lack of awareness of the route of the administration Further Medication errors are also attributed to complexities within the healthcare environment particularly multiple processes involved in the medication process ranging from packaging to the actual administration of the drug Health Services Support Agency 2012 This research paper discusses medication error with warfarin and its consequences

Medication Errors Zane Robinson Wolf, 1994 This book features accounts of nurses experiences with medication errors practical approaches and advice regarding errors and suggestions for risk reduction as well as possible solutions to problems PRODUCT NOW DESIGNATED AS A KIP KEEP IN PRINT EDITION AS OF 9 20 00 WILL BE REPRINTED BASED UPON CUSTOMER NEED DEMAND **Safety in Medication Use** Mary Patricia Tully, Bryony Dean Franklin, 2015-08-18 An estimated 1 in 20 patients are admitted to the hospital due to problems with their medication and 1 in 100 hospitalized patients are harmed due to medication errors during their stay The prescribing of medications is the most common health care intervention and medication safety is relevant to all health care professionals and patients in all

Preventing Medication Errors and Improving Drug Therapy Outcomes Charles D. Hepler, Richard Segal, 2003-02-25 Read this book in order to learn Why medicines often fail to produce the desired result and how such failures can be avoided How to think about drug product safety and effectiveness How the main participants in a medications use system can improve outcomes and how professional and personal values attitudes and ethical reasoning fit into **Medication Error Rates** Felicia Dunbar, AI, 2025-02-21 Medication Error Rates investigates the pressing issue of medication errors within hospitals highlighting their frequency causes and impact on patient safety and healthcare outcomes These errors which can occur during prescribing dispensing or administration not only endanger patients but also impose a substantial financial burden on healthcare systems The book emphasizes the necessity of understanding the factors that contribute to these errors from

workload and communication breakdowns to inadequate training and technology related issues to implement effective prevention strategies. The book uniquely integrates diverse data sources providing a comprehensive view of medication error trends in clinical settings. It connects concepts from pharmacology, healthcare administration and human factors engineering to address systemic inadequacies and design safer systems. By analyzing specific error types such as wrong dose administrations and drug drug interaction oversights, the book pinpoints high risk medications and patient groups. For instance, errors related to high alert medications like insulin and anticoagulants can have particularly severe consequences. Structured to systematically address medication safety, the book begins with fundamental concepts and error classification. It progresses through the root causes and specific error types, culminating in evidence based prevention and mitigation strategies. These strategies include technological solutions, policy enhancements and staff training programs all aimed at improving medication management and reducing preventable medication errors.

Medication Safety in Hospitals Nithushi Rajitha Samaranayake, 2017-01-26. This dissertation, *Medication Safety in Hospitals: Medication Errors and Interventions to Improve the Medication Use Process* by Nithushi Rajitha Samaranayake, was obtained from The University of Hong Kong Pokfulam Hong Kong and is being sold pursuant to Creative Commons Attribution 3.0 Hong Kong License. The content of this dissertation has not been altered in any way. We have altered the formatting in order to facilitate the ease of printing and reading of the dissertation. All rights not granted by the above license are retained by the author.

Abstract: Medication errors are an unnecessary threat to patient safety. The aim of this study was to assess the epidemiology of medication errors and to assess the effectiveness of interventions intended to avoid medication errors in a tertiary care hospital in Hong Kong. The epidemiology of medication errors included the study of the pattern of interception of medication errors and the study of technology related medication errors using medication incidents reported during years 2006-2010. 34.1% of all medication errors that were reported in the study hospital were not intercepted and 92.4% of all drug administration errors reached the patient. 17.1% of all reported medication errors were technology related and most were due to human interaction with technology. The effects of a bar code assisted medication administration (BCMA) system when used without the support of computerised prescribing stand alone on its users and the dispensing process was studied using direct observations, questionnaires, Likert scale and interviews. It was found that this system increased the number of dispensing steps from 5 to 8 and dispensing time by 1.9 times. Potential dispensing errors also increased. Avoiding the use of inappropriate abbreviations in prescriptions will help to reduce medication errors. Therefore the effectiveness of a Do Not Use list, a list of error prone abbreviations used in the study hospital and attitudes of health care professionals on using abbreviations in prescriptions was studied using prescription review and questionnaires respectively. The use of abbreviations included in the Do Not Use list decreased significantly. The use of abbreviations in prescriptions and attitudes of pharmacists in the study hospital was compared with a different medical system to determine the appropriateness of developing a universal error prone

abbreviation list It was found that the types and frequencies of using inappropriate abbreviations vary among different medical systems In conclusion additional interventions such as technological interventions are needed to minimise drug administration errors but proper planning and careful monitoring are needed to avoid unintended errors when using technologies Implementing a stand alone BCMA system aimed at reducing drug administration errors may affect the dispensing process Therefore effects of a technology on all related processes need to be considered before implementation and monitored after implementation The introduction of a Do Not Use list is effective in reducing inappropriate abbreviations in prescriptions and most health care professionals agree that avoiding inappropriate abbreviations may help to reduce medication errors However formul **200 Medication Errors and how to Avoid Them** Michael Richard Cohen,1991-01

Improving the Quality of the Medication Use Process Alan Escovitz,Dev S. Pathak,Philip J. Schneider,1998-09-09 Open up Improving the Quality of the Medication Use Process Error Prevention and Reducing Adverse Drug Events and you ll gain instant access to crucial data pertaining to the prevention detection and research of error in health care specifically in the pharmacy profession Under the direction of this collection of current and timely chapters you ll find that you can become more adept at defining error determining the factors that contribute to error and deciding how medication errors can be reduced and even completely prevented Each year an estimated 120 000 preventable deaths and nearly 1 000 000 injuries occur during the course of medical treatment a staggering and alarming figure Improving the Quality of the Medication Use Process takes a hard look at such misguided health care and proposes quick and effective methods for intervention on the part of the individual professional and the health care community at large These and other topics will help you in your efforts to identify error and design methods of error prevention the causes of medication errors strategies relative to system modifications practice standards packaging labeling and product identity accountability issues from various multidisciplinary health care sectors the medical ethical and public policy considerations associated with medication errors and patient injuries various system and practice initiatives currently being implemented to facilitate the medication use process Improving the Quality of the Medication Use Process is a book for physicians pharmacists nurses health care system managers the pharmaceutical industry and the average citizen who has been in the health care system and wants to be informed before the next trip to the office or drugstore Read it and you ll find that you more clearly understand the problems leading up to adverse drug events You ll also feel more dedicated to taking the proactive measures that will minimize or even eliminate medication errors

Factors Contributing to Medication Errors Karen S. Mutsch,2000 Medication errors are a primary concern in today s healthcare environment Over six of every 100 patients admitted to the hospital suffer a drug related injury Bates and all 1999 In order to improve patient safety medication systems have to improve The purpose of this study is to determine that factors contribute to medication errors This was a non experimental descriptive study focusing on the ways in which medication errors can occur The Quality Assurance Model Using Research is the conceptual framework

used for this quantitative study. This study was conducted in the Risk Management Department office in a mid west hospital. Approximately 820 incident reports from two quarters in 2000 were reviewed. The sample size was 109 occurrence report forms involving 132 medications from ten different patient service areas. Data was collected using a researcher created data collection form that included patient service area, drug class and administration errors. The data collection tool also identified the medication process area in which the medication error was made. The data was described using descriptive statistics. The completion of this project provided current data and information that will be useful in identifying those factors contributing to medication errors. Practical implications were identified to aid in the prevention of related medication system errors.

Medication Errors Guidebook Caroline Young, Cyndie Koopsen, Daniel Farb, 2005. This is an authoritative, compelling well-written book that will leave the reader with a comprehensive view of medication errors and what to do about them. It is for everyone in the healthcare field plus the public. Upon completion of this book, readers will be able to discuss the increase in medical and medication errors, describe the scope of the problem and understand how drugs are ordered and delivered.

Preventing Medication Errors with Medication Reconciliation: A Review Article mohamed fathi abdel aal, Preventing Medication Errors with Medication Reconciliation A Review Article **Simulation and Educational Strategies to Decrease the Incidence of Medication Errors in a Small Rural Acute Care Hospital** Queen Victoria Walters, 2015. The Institute of Medicine IOM 2007 estimates that 1.5 million medical errors occur per year. Medication errors are the leading medical error. Medication errors are defined as adverse drug events and are 100% preventable. Some categories of adverse drug events include medications administered at the wrong time by the wrong route using the wrong method of administration and administration of the wrong dose of medication. Adverse drug events also include administration of an overdose of medication or the omission of medications as well as administering the wrong medication. The purpose of this capstone project was to increase the competency of nurses who administer medications that will ultimately result in improved patient outcomes. A pre test was administered to determine the competency of each participating nurse. Evidence based information related to medication administration was presented to the participants followed by completion of a simulated medication administration scenario. The Creighton Competency Evaluation Instrument was used to evaluate each nurse competency in administering medications. Two weeks later a post test was administered to determine retention of knowledge. Significant differences were observed between the pre test and the post test. The nurses who participated in the didactic session followed by a hands on simulation of medication administration demonstrated an increase in competency related to medication administration. This capstone project provides evidence that information in conjunction with simulation does improve the competency of nurses related to medication administration. Page ii *Student Nurses' medication errors* Les Paul Valdez, 2012. Medication errors have been of public awareness largely from an international context for over a decade. As an issue it has prompted investigations concerning its incidence, outcomes and causes as well. Generally these

causes were categorized as system and human failure and have been the basis for error prevention strategies. Across the literature human failures have been the focus of most error prevention strategies. However focusing on human failures alone led to fault finding and punitive organization culture. More importantly it further made error prevention difficult owing to under reporting of errors. Hence the paradigm of error prevention has shifted to system failures acknowledging the multi factorial nature of medication errors. Recognizing medication error and medication administration as complex also meant that it involves health care members from multiple disciplines. Among these are registered and student nurses who play a vital role not only in medication administration but in error prevention as well. Thus from a nursing perspective consideration must be given to the processes by which nurses commit errors and the extent to which education preparation and clinical instruction supports their learning in order to prevent medication errors. Hence there is little argument that if medication errors will be prevented it must begin with education. In view of the foregoing few studies addressed nursing education from student nurses standpoint. Undeniably there is a need to revisit how student nurses commit medication errors and how clinical instructors provide support to help them develop skills to safely administer medications. Such investigation illuminates aspects of nursing practice that place student nurses at risk for error as well as areas of potential development for a more effective teaching in nursing.

Impact of Medical Errors and Malpractice on Health Economics, Quality, and Patient Safety

Riga, Marina, 2017-01-30. Precise and flawless medical practice is imperative due to the delicate nature of patient lives and health. Without methods and technologies to detect medical mistakes many lives would be compromised. Impact of Medical Errors and Malpractice on Health Economics Quality and Patient Safety is an essential reference source for the latest research on the detection and analysis of the various implications of medical errors and addresses the hidden malpractices that exist in healthcare systems globally. Featuring extensive coverage on a broad range of topics such as clinical pathways decision making techniques and health information technology this book is ideally designed for practitioners professionals and researchers seeking current research on various issues in healthcare provision.

Medical Error and Patient Safety

George A. Peters, Barbara J. Peters, 2007-11-01. A difficult and recalcitrant phenomenon medical error causes pervasive and expensive problems in terms of patient injury ineffective treatment and rising healthcare costs. Simple heightened awareness can help but it requires organized effective remedies and countermeasures that are reasonable acceptable and adaptable to see a truly significa

Medical Errors and Patient Safety

Jay Kalra, 2011-05-26. Is the reporting of medical errors changing. This book shows with real cases from health care and beyond that most errors come from flaws in the system. It also shows why they don't get reported and how medical error disclosure around the world is shifting away from blaming people to a no fault model that seeks to improve the whole system of care. The book intends to provide an introduction to medical errors that result in preventable adverse events. It will examine issues that stymie efforts made to reduce preventable adverse events and medical errors and will moreover highlight their impact on clinical laboratories and

other areas including educational bioethical and regulatory issues Varying error rates of 0 1 9 3% in clinical diagnostic laboratories have been reported in the literature While it is suggested that fewer errors occur in the laboratory than in other hospital settings the quantum of laboratory tests used in healthcare entails that even a small error rate may reflect a large number of errors The interdependence of surgical specialties emergency rooms and intensive care units all of which are prone to higher rates of medical errors with clinical diagnostic laboratories entails that reducing error rates in laboratories is essential to ensuring patient safety in other critical areas of healthcare The author maintains that many such errors are preventable provided that appropriate attention is paid to systemic factors involved in laboratory errors This book identifies possible intelligent system approaches that can be adopted to help control and eliminate these errors It is a valuable tool for physicians clinical biochemists research scientists laboratory technologists and anyone interested in reducing adverse events at all levels of healthcare processes

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