IDENTIFYING AND REPORTING MEDICATION ERRORS HELPS PHARMACISTS TO HAVE A GREAT ROLE IN PROMOTING PATIENT SAFETY

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INTRODUCTION

Background It is important to identify medication errors (MEs) in the health system in order to prevent them in the future. Pharmacists have the knowledge and experience to recognize MEs and to help with the strategies to prevent MEs.

Purpose As clinical pharmacy service is still being established in this country then error reporting and analysis was a good way for pharmacists to show their worth and also get more involved in everyday clinical work. This study was a part of a cross-country project.

RESULTS

During the reporting period 87 MEs were reported. The majority of MEs occurred in patients over 65 (44%, Figure 1), in surgery departments (29%, Figure 2) and most of the patients did not have renal and liver failure. The most frequent types of medication errors were documentation errors, dosing errors, contraindications and double prescriptions (Table 1). 97% of the errors were caused by lack of knowledge. The MEs were categorized according to severity into 6 groups. 42% of the MEs were errors that reached the patient but did not cause patient harm and 36% of the MEs were errors that reached the patient and required monitoring to confirm that it resulted no harm to the patient. There are three examples of MEs that were documented.

DISCUSSION

There are some limitations to this project. Firstly the fact that in Estonia only a few pharmacists take part in clinical work. So more MEs were reported in departments that clinical pharmacists visit daily. To get a better overview of all MEs the project should be extended and more pharmacists should be involved in documenting MEs.

CONCLUSION

After this study the pharmacists were able to identify which wards had the most MEs and where could clinical pharmacy service be implemented. As the majority of MEs were caused by lack of knowledge this study encouraged pharmacists to educate medical staff and develop local guidelines to avoid MEs in the future.