

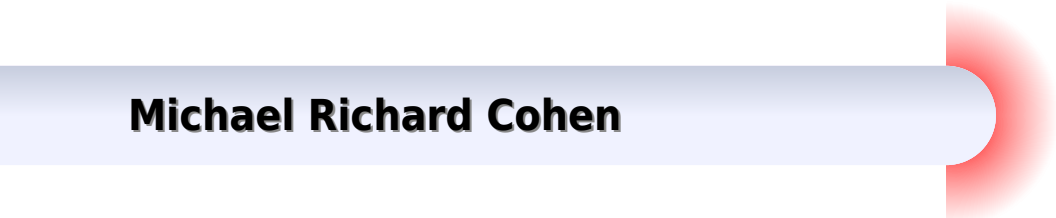
The most common types of medication errors

Most studies refer to five main types of medication errors, namely those related to prescribing, preparing, dispensing, administering or monitoring. In reality, however, they can be broken down further:

- 1 Manufacturing**
Wrong strength, wrong or misleading packaging, the introduction of contaminants or adulterants
- 2 Medicine selection**
Irrational, inappropriate, or ineffective prescribing, under- or over-prescribing
- 3 Monitoring**
Failure to alter or optimise therapy when necessary, or wrong or erroneous alteration to therapy
- 4 Writing the prescription**
Mistakes and illegibility
- 5 Dispensing**
Wrong drug, formulation, or label
- 6 Administration**
Wrong dose, route, frequency, or duration

Medication Errors Medication Errors

Michael Richard Cohen



Medication Errors Medication Errors:

Medication Errors Michael Richard Cohen, 2000 Given the large number of new drugs approved over the past 25 years many highly potent and complex it is no surprise that medication errors occur Although most are not serious some cause irreparable harm and fatalities Medication Errors takes an in depth look at factors that contribute to medication errors and recommends steps for preventing them at the micro and macro levels

Medication Errors Neil M. Davis, Michael Richard Cohen, 1981

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

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 significant

Preventing Medication Errors Institute of Medicine, Board on Health Care Services, Committee on Identifying and Preventing Medication Errors, 2007-01-11 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 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 hospitals 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

Medical Errors and Medical Narcissism John D. Banja, 2004 Using the concept of medical narcissism the author examines both the psychological and biological factors involved when a physician decides not to disclose when a medical error has occurred **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 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

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

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