APPENDIX 8-2

CHECKLISTS TO ASSIST IN PREVENTING MEDICATION ERRORS

Use the following checklists in the appropriate areas of your office, facility or practice to assist in preventing medications errors:

A. Medication Errors

_____1. What is the organization's process for monitoring, tracking, and trending medication errors?

_____2. Are medication errors tracked and trended by profession (e.g., nurse, pharmacist, and physician)? How is the information gathered utilized to reduce the likelihood of medication errors?

_____3. What are the common caused/trends and patterns for medication errors? Are errors trended by patient care unit?

_____4. What processes does the organization have in place to reduce the likelihood of transcription errors?

_____5. What is the organization's frequency of:

- _____a. transcription errors?
- _____b. dosing errors (including age-related dosing for neonates, infants, adolescents, adult, and geriatric populations)?
- _____c. administration errors?
- _____d. double dosing?
- _____e. administering medications not ordered?
- _____f. untimely administration of medications?
- _____g. administering a medication to the wrong patient?
- _____h. packing errors by pharmacy staff?
- _____i. packaging errors by drug manufacturers?
- _____j. errors due to illegible and/or ambiguous handwriting?
- _____k. administering medications to the wrong patient?
- _____l. administering the wrong drug?
- _____m. administering medications at the wrong frequency?
- _____n. not administering medications at the designated time?
- _____o. medications not being administered?
- _____p. unordered medications being administered?
- _____q. administering medication after it has been discontinued?

_____r. administering medications after the expiration date?
_____s. administering medications prior to the designated start date?
_____t. administering medications without obtaining consent?

_____6. Is consent obtained for the use of investigational drugs and high-risk medications?

_____7. What is the frequency of "missed" doses?

_____8. What educational processes have been implemented to reduce the likelihood of medication errors?

B. Use Improvement and Safe Administration of Medications

1. Is patient education on use and effects of medications conducted on a collaborative basis?

   a. What is the role of the nurse?
   b. What is the role of the pharmacist?
   c. What is the role of the physician?
   d. What is the role of the dietitian?

2. How is education to patients on medications provide in ambulatory care settings?

3. What is the organization's process for evaluating high-risk, high-volume, problem-prone, and high-cost medications?

4. Does the organization have a multidisciplinary medication use improvement team?

5. What are the team's goals?
   a. promoting a nonpunitive approach to reducing medication errors?
   b. increasing detection and reporting of medication errors?
   c. understanding the cause of errors?
   d. educating staff as to the cause and prevention of errors?

6. How is information on medication monitoring obtained?

7. How has the organization's cost-reduction activities affected patient care?

8. Describe the kinds of aggregate data available for performance improvement activities.

C. Control of Medications

_____1. Who is responsible for overseeing the storage and control of medications maintained on patient care units?

_____2. What risk reduction activities does the organization have in place to reduce the likelihood of adverse drug reactions and medication errors?

_____3. What disciplines have been credentialed to prescribe medications (e.g., physician's assistants and nurse practitioners)?

_____4. How are controlled substances monitored, inventoried, and wasted (is wasting witnessed and documented)?

_____5. What is the organization's mechanism for monitoring the effect of medications on patients?

D. Adverse Drug Reactions

_____1. How do reported adverse drug reactions compare with like organizations?

_____2. Is there a mechanism in place for monitoring side effects?

_____3. Is there a mechanism in place for reducing the frequency of adverse drug reactions?

E. Emergency Medications

_____1. How are emergency medications obtained when the pharmacy is closed?

_____2. How are medications obtained that are not included in the hospital's formulary?

F. Investigation Drugs

_____1. Is informed consent obtained from patients prior to the used of investigational drugs?

_____2. Describe the organization's procedure for reviewing and approving research protocols.

_____3. Does the organization have a mechanism in place for approving and overseeing the use of the investigational drugs in the organization?

_____4. How are investigational drug protocols and criteria developed and approved?

G. Sound-Alike Drugs

_____1. Review the list of drugs that sound-alike or have similar sounding names.

_____2. Make a list of all drugs that are commonly used in your practice or department that have sound-alike names. Clearly note next to each the sound-alike drug that is incorrect using wording to indicate that it is not correct.

_____3. Train all office personnel, transcriptionists, nursing personnel, in-house pharmacy personnel, and medical personnel to be on the lookout for the similar sounding incorrect name being used.

H. Look-Alike Drugs

_____1. How are potentially dangerous look-alike drugs separated in the pharmacy?

_____2. Are look-alike medications repackaged or relabeled in the pharmacy?

I. Sample Drugs

_____1. Does the organization permit the dispensing of sample medications?

_____2. What information is maintained in patient records in the event a sample drug is recalled?

_____3. Does the organization maintain a medication log for tracking the dispensing of sample drugs?

_____4. Does the log include th following pertinent information: medication dispensed; date medication was dispensed; patient name; patient record number; dosage and amounts given; medication control/lot numbers for purposes of recalls; expiration date; and physician signature?

J. Medications From Home

_____1. Are patients permitted to self-administer medications (e.g., insulin)?

_____2. Where are self-administered medications stored?

_____3. How is monitoring conducted?

K. CRASH CART MEDICATIONS

_____1. Who is responsible for stocking medications in crash carts?

_____2. Who is responsible for ensuring that medications have not expired?

_____3. Who is responsible for ensuring the integrity of "crash carts" (e.g., that appropriate medications, equipment, and supplies are available when needed)?

_____4. Are logs maintained?

_____5. Does the organization maintain the appropriate equipment on crash carts for treating both children and adults?

_____6. Are staff members appropriately trained in the testing and use of equipment contained in or on the crash cart?

_____7. How are staff members who participate in codes evaluated?

_____8. Do pharmacists attend codes?

_____9. What value might be added if pharmacists attended codes (calculations based on age, weight, and height, drip rates or mixing)?

_____10. Is there a collaborative approach to reviewing the organization's procedures after a code?

_____11. What mechanisms are in place for reviewing medications administered during a code?

L. Multiple Medications

_____1. What systems does the organization have in place to minimize the likelihood of drug-drug interactions?

_____2. What is the protocol for handling patients on multiple medications?

_____3. What stat lab tests does the organization have in place for patients who have overdosed?

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