Editorial

MEDICATION ERRORS: RESOURCES FOR PRACTICE

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The process of giving medication in an acute care hospital is an example of chaos principles. Each medication order, dispensing, administration and monitoring, and evaluation is unique. Each patient situation and concurrent medical problems is unique. Each person in the process of dispensing, administering, monitoring, and evaluation is unique. This sets up thousands of variables in interaction with medication administration. Because these variables are highly dependent on communication and human behavior, the outcome is that patient deaths occur. These problems were first highlighted by Kohn, Corrigan, and Donaldson (1999) in a report published in the Institute of Medicine's (IOM). The challenges of making medication administration safer are even more acute in the rural hospital environment because resources are sparse.

There are five resources that may assist rural nurses to dissect the processes that contribute to medication errors in their facilities.

- The first with the greatest specificity to rural health environments is from the Institute for Safe Medication Practice. This program is a summary document of the current research and best practices in medication processes specific to rural environments. The website is http://www.ismp.org/Consult/ruralhospital/default.asp.
- The second resource is associated located on the JCAHO website. JCAHO advocates a program called "Speak Up" where the patient is encouraged to partner in their care to help prevent medication misadventures. A patient informational brochure can be downloaded from http://www.jointcommission.org/NR/rdonlyres/BF7973E4-BCEC-42E1-BB59-7D7D207D4870/0/speakup_brochure_meds.pdf. Additional resources are also located on this site and the website cites that "There are **NO** copyright or reprinting permissions required for the Speak Up materials or copy. In references to the materials or copy, we do ask that The Joint Commission be credited as the source for the materials or copy."
- The third resource is the electronic newsletter from the Agency for Health Care Policy and Research. This newsletter highlights problem areas and reports best practices in medication safety. The link to register for this resource is http://www.ahrq.gov/qual/errorsix.htm.
- The fourth resource is from the IOM and is a text called Quality through Collaboration this resource has several chapters specific to quality improvements in rural hospitals. http://www.nap.edu/catalog.php?record_id=11140.
- The final resource is specific to medication adverse effects and updated labeling. This resource is from the FDA and is a free access website. http://dailymed.nlm.nih.gov/dailymed/about.cfm.

Access and utilization of these resources can help rural hospitals examine the process of medication use throughout the facility safer. Learning from the mistakes of others and incorporating simple measures into clinical practice could diminish the chaos that cost patients their lives.

REFERENCES

Kohn, L.T., Corrigan, J.M., & Donaldson, M.S. (Eds.). (1999). To err is human: Building a safer health system. Institute of Medicine. Washington, DC: National Academy Press.