



Improving resident care by making meds easier

Tips from Monthly Webinars

Reducing Medication Errors in Long-Term & Senior Care



Errors can occur at any point during the medication-use process. While they occur most frequently during prescribing (39% – 49%)—which is out of the control of facility staff—and administration (26% – 38%), they can occur at any point during the medication-use process. To limit the potential for harm, it is important to take steps that can prevent errors from occurring.

Where medication errors can occur in facilities after prescribing

1. Transcription

- Reconcile orders against resident's home meds, hospital discharge lists
- Check resident's allergies
- Include diagnosis associated with each med
- Check the 6 Patient RIGHTS
 - Right drug
 - Right dose
 - Right form
 - Right time
 - Right route
 - Right patient
- Check your work (or have someone else check it) before submitting orders to pharmacy

2. Transmission

- Identify what should NOT be dispensed at this time
- Confirm accurate submission to pharmacy (fax confirmation, e-Rx log)

3. Administration

- Review order before administering each med
- Check that medication label info matches order
- Review warnings, interactions, and allergies
- Evaluate resident
- Double-check the 6 Patient Rights
- Administer medication according to directions
- Document administration

4. Monitoring

- Assess resident's response
- Document and report results
- Educate the resident/family

Other errors can involve...

- Omission—failure to include necessary information or administer an ordered medication or dose.
- Improper dose/quantity—any medication dose, strength, or quantity that differs from that prescribed.
- Unauthorized drug/medication dispensed or administered that was not authorized by the prescriber (includes wrong-drug errors).

For more information on how to prevent medication errors, talk with your pharmacy consultant or visit www.forumpharmacy.com.

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