Medication Safety

If you or one of your loved ones is currently taking some type of prescription drug or medication, you should be aware of the steps you need to take to use your medicines safely and beneficially.

A wide variety of prescription and non-prescription products are currently available. With greater choices and increased access to medicines, the chance of medication errors is also increased, making safe medication use more important today than ever before. Although they are not often serious, medication mistakes happen every day – in the hospital, the clinic, and at home, and these mistakes can be made by health care providers as well as patients themselves. Yet, medication errors are the single most preventable cause of patient injury.

> *How can we increase the safety of medications taken by our family and ourselves?*
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> *How can we ensure that we are prescribed and given the right medications in the right dose, and that we are taking them correctly?*
>
> *What about interactions between medications, including those available to us 'over the counter'?*

These are important questions for you as a consumer, to ask. Knowing the answers to these questions and planning ahead can make all the difference in avoiding medication mistakes.

■ What goes wrong?

Ideally, patients are given (and take) the right dose of the right medication at the right time and by the right route. However, medication errors can be made during any one of the three stages of prescribing, dispensing and administering. Problems are often due to factors such as: failed communication, poor drug distribution practices, dose miscalculations, drug and drug device related problems, incorrect drug administration and lack of patient education.[i]

For example, illegible handwriting, misplaced decimal points, overuse of abbreviations and verbal orders can lead to mistakes. Dispensing and administration errors can occur when medicines look alike and have similar sounding names, and when it is difficult to distinguish between generic and brand names.

Sometimes patients are not thoroughly informed about their medication, either through discussion with their doctor, nurse or pharmacist, or written material. Though many medications come with leaflets, these are not widely read. For example, an estimated 75% of patients in the United States throw out medication leaflets without reading them.[ii]

■ What can you do to prevent medication errors?

You, as a patient or caregiver, are one of the best safeguards against medication errors. You can reduce or prevent problems by serving as a 'final check' in the medication delivery chain. Follow the tips below:

✓ Ask your nurse, doctor or pharmacist about the brand and generic names of medication, the reason for the medication, the amount of medication to be taken and its frequency, special precautions to take and possible side effects.

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- ✓ When receiving a new medication, make sure you are given information describing the medication. Review all written information and ask your health professional to clarify any questions you may have.
- ✓ Remind doctors, nurses and pharmacists about any allergies before taking new medication. This is especially important if you receive a drug sample rather than a prescription.
- ✓ Have a list of all substances that you take regularly. A medication list can include prescription and non-prescription medication, herbal remedies, vitamins and nutritional supplements. This list is especially helpful if you are admitted to a hospital. Medical staff can review this medication list prior to starting therapy or treatment, which can prevent the risk of serious drug/herbal interactions or false blood test results.
- ✓ If you find that your medicine cabinet is getting crowded with prescription medicines and other remedies, you should do an inventory to ensure the medicines you have are all ones that you need. Look carefully at each label to see if the expiry date has passed and return medicines that your doctor has said you no longer need to the pharmacy for disposal. If you have any questions about any medicines you find in your personal pharmacy, especially if you feel you are taking too many medicines, ask your doctor, nurse of pharmacist for their advice."
- ✓ In the hospital, make sure your identification or barcode bracelet is checked prior to taking medication. Look closely at medication before taking it and ask questions if it appears different from what you usually take.
- ✓ With liquid medicines, ask the pharmacist to demonstrate how to properly use the measuring device and obtain correct dosage. Use only the measuring device provided with the medicine or by the pharmacist.
- ✓ If you have trouble swallowing medication, discuss this with your healthcare professional. Chewing, crushing or mixing tablets with food or drink can change the effect of a drug.
- ✓ To the extent possible, have a designated pharmacy and a primary physician in charge of all your medications and products.

■ How health care professionals are looking out for your safety

Your safety is of utmost importance to health care professionals – doctors, nurses and pharmacists. In addition to increasing their communication with consumers, health care professionals are also working to understand the causes of medication errors and prevent them from happening in the future. Increasingly, actual and potential errors in all health care situations are tracked and analysed. The quicker the mistakes are identified and understood, the quicker they can be corrected and prevented. You can help by reporting any errors or ‘near misses’ to your health care providers.

Capturing and verifying medication information electronically is another way that health care providers are improving medication safety. You may notice more computers on your next health care visit, as more electronic systems are being introduced to ensure proper prescribing, dispensing and administering of drugs.

For more information, see The National Patient Safety Foundation® web site **www.npsf.org**, dedicated to improving the safety of patients.

[i] Cohen, Michael. R. Editor. (1999). Medication Errors: Causes, Prevention and Risk Management. Jones and Bartlett, Massachusetts.

[ii] Cohen, Michael. (2002). Nursing 2002. Medication Errors. Volume 32, Number 1.