Hospital Data Shows Errors Increase When In-House Pharmacy Is Closed

(PRNewswire-USNewswire) Between June 2004 and September 2010, Pennsylvania hospitals submitted 519 medication error reports to the Patient Safety Authority that implied an event occurred while the pharmacy department was closed, according to information published in the March *Pennsylvania Patient Safety Advisory* released today.

On-site 24-hour pharmaceutical services can provide a more secure drug storage and distribution system and potentially reduce the need for night cabinets, non-pharmacist access to the pharmacy and access to medications stored in automated dispensing cabinets (ADCs) without prior order review by a pharmacist. Without safeguards in place, medication errors can occur, some with tragic outcomes, especially if non-pharmacists have complete access to the pharmacy after hours.

The most common types of medication errors reported by facilities when the pharmacy was closed include wrong-drug events and prescription or refill delays. According to the data, the incorrect drug was retrieved from an automated dispensing cabinet or night cabinet in 82 percent of 130 wrong-drug events. "Eighty-seven percent of the events reached the patient, but only two resulted in harm significant enough to require additional treatment," Michael J. Gaunt, PharmD, Senior Patient Safety Analyst for the Pennsylvania Patient Safety Authority said.

"However, facilities should heed the warnings these near-miss events have given them to identify system-based causes of the medication errors that took place because the on-site pharmacy services were not available," he states. Gaunt added that of the top 10 medications involved in the events, four were high-alert medications, or drugs that have an increased risk of causing significant patient harm when used in error.

"Further, more than 62 percent of events that originated in the prescribing node of the medication-use process involved a patient that was prescribed a medication to which he or she had a documented allergy," Gaunt said. "Only one documented allergy was caught before reaching the patient, 95 percent of these events reached the patient, with one requiring additional treatment." Gaunt said that while an ideal solution is to establish an on-site 24-hour pharmaceutical service, there are other options that can decrease the likelihood of a medication error.

"Off-site pharmacy order entry services can provide a viable option for those facilities that cannot establish a 24-hour on-site service," Gaunt said. "There are also many medication access and storage risk-reduction strategies that can be employed to help prevent these types of errors as well."

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