Medication safety and communication skills

Medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care provider, patient, or consumer.

Errors occur in communication with health care providers:

A. Errors during verbal communication:

1. Distractions and noise that interfere with clear transmission and receipt of the message.
2. Heavy accents and language differences.
3. Use of terminology that other health care providers do not understand.
4. Speaking too rapidly for the listener to clearly comprehend.
5. Medications that sound alike when spoken (Zantac vs. Zyrtec).
6. Numbers that sound alike (15 vs. 50; 19 vs. 90).

B. Errors during written communication:

1. Poor handwriting.
2. Medication names that looks alike when written out (celexa vs. Celebrex or bisoprolol 10mg and buspirone 10mg).
3. Misplaced zeroes and decimal points in dosing instructions (.5 vs. 0.5; 1.0 vs. 10).
4. Unclear abbreviations within patient care instructions.

How can resolving or minimize these errors?

1. Using written communication rather than verbal communication or computerized physician order entry (CPOE) systems.
2. During dispensing process, the work flow should include numerous opportunities to check the contents and label of the prescription.

Several pharmacy use bar coding and many pharmacists advocate using "Tall Man lettering" when writing drug names that are similar to other agents.

Example: using glipiZIDE and glyBURIDE rather than glipizide and glyburide within prescription order and on the prescription label.

Other example: use chlorproPAMIDE and chlorproMAZINE to differentiate between these two agents that look very similar but have very different use.

3. When taking verbal orders over the phone, you should repeat all components of a verbal order and place a checkmark on the prescription for each component as you read it back to the prescribe.
4. In institutional settings, such as long - term care facilities, hospitals, or ambulatory care centers, communication between pharmacy and nursing staffs must be clear to assure safe administration of the medication.

Example: is the medication labeled clearly? Are doses appropriate? Are the instruction for delivery method (IM, IV) and administration times clearly articulated?

Errors occur in communication with patient:

A. Errors during verbal communication:

1. Inability of patients to understand pharmacists (accent, medical terminology, language, and cultural differences, etc).
2. Hearing and vision impairments.

3. Environmental barriers (noisy pharmacy, no access to pharmacist).

B. Errors during written communication:

1. Patient's inability to read or comprehend material.
2. Lack of effective patient education material.
3. Inability to read label (sight impairments).

C. Other pharmacist – patient communication issues lead to medication errors:

1. Pharmacist's inability to make sure that the correct patient receives the right medication.
2. Patient's inability to clarify verbal and written information with pharmacists.

How can resolving or minimize these errors?

1. When giving information to patient, you should allow patients the opportunity to repeat back key information in order to detect possible error and misunderstand.
2. Counseling should be used to verify the accuracy of dispensing and to assess patient understanding of proper medication use.
3. When giving verbal instructions, difficult drug names should be spelled out for patient.
4. Written patient education leaflets should be given for future reference.
5. You should use the internet or other technologies as effective mechanisms to communicate with patients.
6. You should encourage your patients to keep a list of all their medications and instructions along with critical health information, such as drug allergies.

Suggested questions:

1- Define medication error.
2- What are the medication errors that occur during verbal communication with health care providers?
3- What are the medication errors that occur during written communication with health care providers?
4- What are the medication errors that occur during verbal communication with patients?
5- How can you minimize the medication errors that can occur during communication with patients?