24th European Association of Hospital Pharmacists (EAHP) Congress
Learning from Medication Errors Workshop

Case 1

Watch the clip and note the steps followed during the medicines use process

- How would you determine what the possible causes and contributory factors were?
- Can you identify any possible stages for, or barriers to, error or harm?
- What controls do you have at your organisation? How effective do you think these are?
- What can you do to prevent this in your organisation? What controls would you consider designing or implementing for a safer system?

Case 2

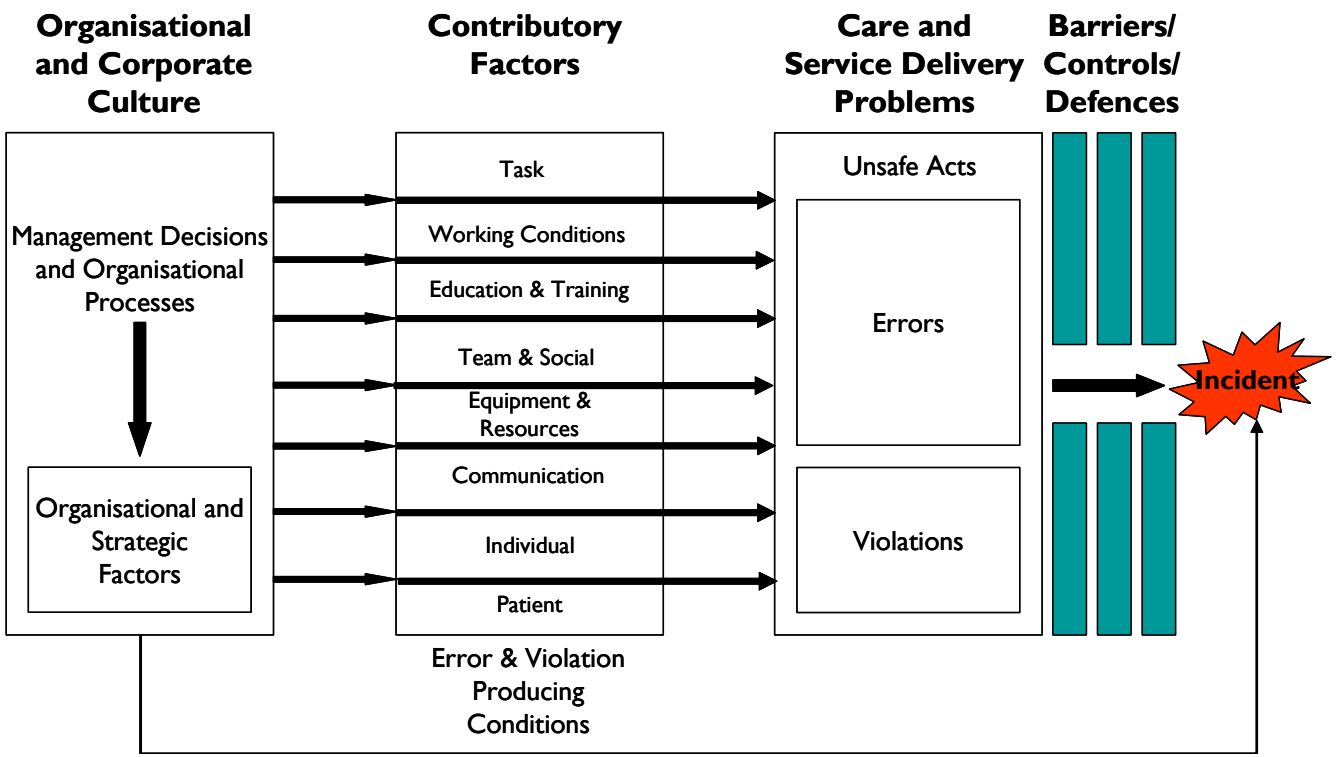
Review the incident and note the steps followed during the medicines use process.

- Consider the causative and contributory factors; are there any legislative factors that need to be considered?
- What strategies may help prevent recurrence?

- Mr Jameson was a patient on an acute ward in a prison. In a prison environment there is increased pressure to dispense drugs quickly on a ward round because of the possibility of drug misuse. One of his prescription charts was written by a doctor with poor handwriting, who did not usually treat him. The prescription chart was faxed to a pharmacist, Mr Cryer, who was busy because it was the Friday before a bank holiday weekend. He was also feeling under the weather but had come into work that day because he knew there would be staff shortages and he did not want to let the team down.
- Mr Cryer dispensed hydralazine (for hypertension) instead of hydroxyzine (for itching). The medicine was sent to the ward in a bottle labelled with the patient's name.
- On the ward, nurses were often under time pressure and a culture of not thoroughly checking patient identity prior to administering drugs had developed, primarily because the nurses felt that they knew the patients identities and what medications they were taking.
- Mr Jameson was given the wrong drug three times a day for five days before the error was recognised by another pharmacist, who was checking prescription charts on the ward. All the staff treating Mr Jameson had given him the drug over the five days but no-one had noticed that it was the wrong drug. Fortunately, Mr Jameson did not have any side effects.

From: Implementing human factors in healthcare: how to guide, Patient Safety First, Version: 2010-05-20

Reason's Model of Accident Causation



Adapted Organisational Accident Causation Model, from:
https://report.npsa.nhs.uk/rcatoolkit/resources/word_docs/guidance/guidance_introduction_to_human_error_theory.doc

University College London Hospitals NHS Foundation Trust

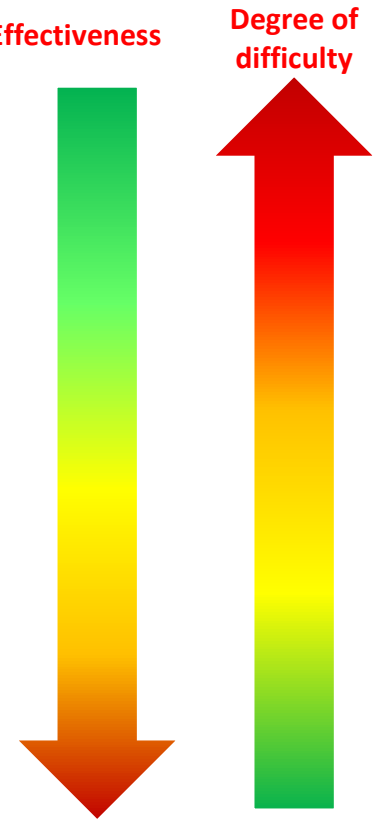
Solutions - Hierarchy of effectiveness

Stronger Actions
Change cultural approach
Architectural / physical plant or equipment changes
Standardise and usability testing of equipment or care plans
Simplify the process and remove unnecessary steps

Moderately Strong Actions
Effective use of skill mix
Eliminate look and sound-a-likes
Eliminate / reduce distractions
Checklist / cognitive aids

Weaker Actions
Double checks
Warnings and labels
New procedure / policy
Re-Training focused on an individual not cohort

From: C Lee, K Hirschler. How to make the most of actions and outcomes



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