Summary

Medication errors are an infamously frequent phenomenon that burdens the health care system budgets and considerably adds to morbidity and mortality worldwide. Over 1.5 million of patients annually suffer from medication errors, 44,000 of them succumb in the U.S. only. However, a medication error is a potentially preventable accident.

A survey on 15 peer-reviewed articles from the CINAHL database was performed and all papers carefully analyzed. Numerous ways to solve the problem of medication errors are under intensive study currently, but their effectiveness is yet not absolute, suggesting this problem needs a multi-stage approach. Active involvement of patients, pharmacists and nurses into discussion about drug’s name, regimen, dose, etc. is recognized as a beneficial check of medication process. The available literature suggests administrative interruptions and poor environment worsen the situation and sometimes are direct causes if errors. Previous studies have outlined the key issues leading to medication errors – overactive administrative interruptions, poor environment, lack of feedback from the patient and absence of double-check in drug prescriptions. In this research, a PICOT approach was designed to introduce the beneficial effects on medication errors from a hospital with policies of minimal interruptions during medication administration vs. hospitals that have no such policies. The new approach if integrated into the organizational structure, culture, and workflow aims at lowering lethality and improving health
care delivery quality in hospitals.

Medication administration is a complex medical activity. If errors occur, they may be fatal. According to the new approach to reduce the risk of mistakes, patients are encouraged to ask, physicians are suggested to double-check, and pharmacists are to communicate in order to reduce the risks of mistakes, while administration is recommended to pay more attention to nurses’ environment.