High Drug Error Rate in Hospital Radiology

Medication errors that harm patients are seven times more likely to occur in a hospital's radiology department than in other settings of the health care organization, according to a United States Pharmacopeia (USP) report released Jan. 18. The sixth annual MEDMARX Data Report found that 12 percent of the 2,032 medication errors reported in radiological services from 2000 to 2004 resulted in patient harm, and that radiological services were more likely than other hospital services to result in the need for additional care and resources. Radiological services include complex procedures that use high-risk drugs and, with patients circulating quickly through hospital departments, breakdowns in communication between radiology staff and patients' physicians and nurses may lead to patients receiving the wrong drug, wrong dose of a drug, or not getting the drug at all. To prevent errors, USP recommends that patients carry an up-to-date list of medications; inform health care providers, including radiological services staff, of all allergies; inquire about transfers within the hospital; and ensure that their patient charts accompany them.

JCAHO Issues Drug Reconciliation Alert

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), prompted by the fact that medication reconciliation errors continue to occur despite repeated warnings and rigorous standards, issued a Sentinel Event Alert Jan. 25 outlining the processes that health care organizations should follow to avoid such errors. Failure to compare a patient's medication orders to all of the medications that the patient has been taking when transitioning patients from one care location to another can result in duplicative medications, incompatible drugs, wrong dosages, or wrong dosage forms. United States Pharmacopeia received more than 2,000 voluntary reports of medication reconciliation errors last year, and JCAHO's Sentinel Event Database shows that 63 percent of reported medication errors resulting in death or serious injury were due to breakdowns in communication. Further, half of these errors could have been avoided through effective medication reconciliation. The alert recommends that detailed medication lists be put in a highly visible place on patients' charts, medications be reconciled at each interface of care, and patients be provided with a list of medications upon discharge.