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Medication Error - Therapeutic Duplication

Practical 6 - Clinical pharmacy case practical

Aim

To analyse a fictional medication error and propose a system improvement.

Principle

Medication-error review examines the process and contributing conditions rather than assigning blame. Harm prevention, factual reporting and system redesign are separate from determining drug causality.

Materials and Requirements

- Fictional or approved de-identified case, medicine chart and laboratory record
- Current local policy, relevant product information and clinical guidance
- Pharmaceutical-care and communication worksheet
- Approved method or teaching-data pack and a dated record sheet

Procedure

1. Define the preparation or dataset, study question and method version. Record identities, units and the criteria to be used before examining the outcome.
2. Identify the question, patient-specific information and missing data. Use the supplied fictional record; do not create a prescription or administer a preparation.
3. Identify the intended order and the erroneous step, containing the risk through the authorised clinical pathway.
4. Map prescribing, transcription, dispensing, administration and monitoring to locate failures and detection opportunities.
5. Assess patient impact with the team and distinguish actual harm from a near miss.
6. Propose a specific system change and an effectiveness measure rather than relying only on reminders.
7. Document the assessment, evidence, proposed action, responsible clinician and follow-up. Separate a student recommendation from an authorised treatment decision.
8. Retain the original observations and calculations. State deviations, missing information and the limits of the conclusion; do not replace measured values with expected results.

Observations and Record

Enter actual measurements or the supplied teaching data. Record the method, material identity, conditions and units.

Problem / evidence	Goal / priority	Proposed action / owner	Monitoring / follow-up
Safety or urgent issue	Define	Escalate appropriately	Specify
Effectiveness / adherence	Define	Discuss with team	Specify
Information gap	State	Obtain evidence	Review

Worked Example

The assigned case below contains an intentional teaching error. It must never be copied as a valid medication order.

Intentional error exercise

• A combination product duplicates an active ingredient already prescribed separately. Reconcile ingredients, determine intended treatment and seek authorised correction before further supply.

Result and Interpretation

• Deliver a factual incident map, contributing-factor analysis, immediate response and prevention plan.

Precautions

• Protect confidentiality and use actual units and timing.
• Check allergy, indication, organ function, interactions and the complete medicine list.
• Urgent clinical findings need timely clinical assessment; teaching notes do not replace care.

Viva Questions and Answers

What is a near miss?

An error intercepted before reaching the patient under the stated reporting definition.

Why assess the system?

Workflow and design can make errors more or less likely.

Why measure effectiveness?

A change must demonstrably reduce the relevant failure.

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