

Too many medication errors, not enough pharmacists

The media have recently seized on medication errors as a newsworthy issue. Thanks in part to the 1999 Institute of Medicine (IOM) report¹ and President Clinton's reaction, the need to reduce medication errors is finally getting national attention. ASHP's long-standing efforts have also been instrumental, as noted by the IOM.

A likely contributor to the medication-error problem is inadequate pharmacist staffing. Data collected by ASHP in 1999 indicate that approximately half of health systems and hospitals have vacant pharmacist positions. Shortages in the community pharmacy arena have also been reported. Heavy workloads caused by understaffing can overtax pharmacists and force them to rush through their work. Shunting pharmacists toward a distributive role in response to the workload crunch is another factor in errors. Qualified pharmacists, working collaboratively with physicians and other health care professionals, can provide valuable and cost-effective drug therapy management. Similarly, pharmacist involvement with patients has proven to be a key component in improving medication use.² But pharmacists who are used primarily for dispensing are too far removed from the point of prescribing, order transcription, and drug administration to play an adequate role in ensuring safe medication use. ASHP has sent a letter to all hospital chief executive officers describing the link between the pharmacist shortage and the problem of medical error (see www.ashp.org.)

Medication errors are costly in financial as well as human terms. Each year an estimated \$8.8 billion is spent in health systems as a result of preventable errors that cause serious harm.³ Preventing medication errors can reduce that huge bill—and the risk of malpractice suits.

Errors can be minimized in part by recruiting pharmacists to work directly with patients, with physicians at the point of prescribing, and with nurses at the point of medication administration. To make this possible, pharmacy directors whose departments handle a high volume of prescriptions should consider employing more certified pharmacy technicians.

For decades ASHP has worked to prevent medication errors—39% of which occur during prescribing.⁴ ASHP took a

leadership role in influencing the Medicare Payment Advisory Commission to include in its recommendations to Congress that pharmacists can and should play a critical role in creating a fail-safe medication-use system. Recent research confirms what previous research in pharmacy has found: Involving pharmacists in prescribing, order transcription, drug administration, and dispensing can reduce medication errors as much as 66%.²

Recent ASHP activities to prevent medication errors include research on developing, implementing, and testing a fail-safe medication-use system; analysis of existing health systems to determine the characteristics of an ideal medication-use system; advancement of recommendations from the Joint Commission of Pharmacy Practitioners Conference on Re-engineering the Medication-Use System; participation in the Harvard Executive Session on Medical Error and Patient Safety; and work with ASHP's affiliated state societies as state regulators begin implementing IOM's recommendations.

Ultimately, though, it is up to the individual practitioner to take steps to prevent medication errors. Consider recommending computer systems (hand-held or desktop) that will allow physicians to enter prescriptions directly into a network linked to the pharmacy. Calculate all doses and compound all intravenous admixtures in the pharmacy and deliver them to the patient. Keep up-to-date drug references available. Be responsible for policies on the use of automated dispensing devices in patient care areas, since medications placed in these devices are usually acquired through the pharmacy.

National pharmacy organizations are doing what they can to alleviate the pharmacist shortage, but your assistance is needed. Encourage administrators and pharmacy managers to eliminate the barriers to safe medication use (e.g., underutilization of pharmacists.) Strengthen efforts to fill the vacancies. Ask for higher salaries and better benefits packages to attract and retain qualified professionals. Emphasize that investing in pharmacists is a wise cost-avoidance strategy.

The time to push for changes to ease the pharmacist shortage and defeat the scourge of medication errors is now—while medical error is still in the national spotlight.

1. Institute of Medicine Division of Health Care Services Committee on Quality of Health Care in America. To err is human: building a safer health system. Washington, DC: National Academy Press; 1999.
2. Leape LL, Cullen DJ, Clapp MD et al. Pharmacist participation on physician rounds and adverse drug events in the intensive care unit. *JAMA*. 1999; 282:267-70.
3. Thomas EJ, Studdert DM, Newhouse JP et al. Costs of medical injuries in Utah and Colorado. *Inquiry*. 1999; 36:255-64.
4. Leape LL, Bates DW, Cullen DJ et al. Systems analysis of adverse drug events. *JAMA*. 1995; 274:35-43.

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