Medication errors disclosure and ethics /legalities

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Medication errors occur when health care workers inappropriately prescribed, dispensed, or administered drugs. Medication errors are a multifaceted problem which may arise in any health care setting. According to Arcangelo and Peterson (2013), many outpatient prescriptions have mistakes that can be prevented. The purpose of this paper is to explain the ethical and legal implications of medication errors disclosure and nondisclosure; specific state laws and different strategies used to minimize medication errors

**Ethical and Legal Implications of Disclosure / Nondisclosure**

As healthcare providers, we are obligated to protect our patients from harm and not reporting a medication error is illegal unethical and harmful to the patient. Sometimes clinicians are afraid to report errors for fear of losing their jobs, reputation, and licenses. However, disclosing errors can prevent an adverse outcome for the patient. According to the code of ethics found in the American Nurses Association (2015), clinicians must report all medication errors to the proper authority to ensure patients safety and quality of care. Healthcare providers must maintain an open, honest working relationship with their patients. That may include disclosing medication errors. It is our duty to uphold honesty with our clients regardless of the consequence (Ehsani et al., 2013). Our patients may have confidence in us if we are honest and attempt to repair the problem. Nondisclosure can cause great harm to a patient and can lead to complete lack of trust in the provider. Disclosure of error is not only illegal but unethical and unprofessional. When an error occurs, patients and family need to know (Brandom, Callahan & Micalizzi,2011)

**Federal and State about Disclosure**

Disclosure is informing the patient and or family that a mistake or error has occurred and explaining the situation. Some states have disclosure laws while others have apology laws. The state of Texas has an apology law which is an expression of sympathy (Mastroianni, Mello, Sommer, Hardy, Gallagher, 2010). Full apology includes acceptance of responsibility providing an explanation and making amends. Admission of guilt can lead to malpractice lawsuit and some states give health care workers legal protections when they apologized to patients for medical mistakes. The U.S Department of Health and Human Services (HHS) sponsored pilot studies which introduced medical liability reforms including programs that provide for disclosure and apology as well as offers for compensation (Mastroianni, Mello, Sommer, Hardy, Gallagher, 2010). Practitioners must prescribe according to federal law, and the state guidelines, that makes is challenging for advanced practice register nurses (Arcangelo & Peterson, 2013). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO**)** in 2001 institutes the first national requirement for patient’s adverse events disclosure which instruct clinicans to inform patients about unexpected outcome (Brown, Lehman, Truog, Browning & Gallagher, 2012.

**My Reaction to the Scenario**

In this scenario, the advanced practice nurse (APRN) made an error when prescribing a drug to a patient and therefore is responsible for reporting this mistake immediately to avoid further negative impact. A prescription is a legal document that communicates from the prescriber to the pharmacy (Arcangelo & Peterson, 2013)**.**  APRNs may face consequences of mistrust, civil and criminal charges as well as license revocation after a medication error (Wittich, Burkle, & Lanier, 2014). I will inform my patient about the medication error. According to Wittich, Burkle, & Lanier (2014), keeping a healthy relationship and promote trust with clients, will encourage clinician and patient to have a healthy relationship post medication errors. It would be difficult, but I will meet with my patient and immediate family to inform them of the error, apologize and make amends.

**Strategies to Minimize Medication Errors and prescription writing**

Medication errors, occur in the U.S occur frequently. The Institute for Safe Medication Practices (2012), issues a list of abbreviations that can lead to the misinterpretation of prescriptions and therefore leads to medication error. I will utilize this list to prevent prescription writing mistakes.  Drug checking software reduces medication errors by checking the drug dose, allergies and other medications the patient is currently taking (Arcangelo & Peterson, 2013). Electronic health record (EHR) can prevent medication errors and enhance patient safety, especially in pediatric patients by automatically calculate the weight based dosage. Arcangelo and Peterson (2013) , emphasized the importance of taking a thorough history and performing a physical examination before prescribing medication to anyone. Health history may include current medications, height and weight (pediatric patients) and known allergies. The risk for medication errors decreases when clinicians follow the rules of prescribing medications.

**Summary**

Medication error is a serious problem in the U.S and clinician must exercise caution when prescribing, making sure they follow all the laws about prescribing in their states. As APRNs, we have an ethical, professional and legal obligation to protect our patients from preventable harm. Our patients trust us and expect us to protect them from harm. We must do all that lies in our power to maintain that confidence and keep our patients safe from unnecessary harm.

References

American Nurses Association. (2001). Code of ethics for nurses with interpretive

statements. *Nursing World*. Retrieved from

[http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Code of EthicsforNurses/Code-of-Ethics-For-Nurses.html](http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics-For-Nurses.html)

Arcangelo, V. P., & Peterson, A. M. (Eds.). (2013). *Pharmacotherapeutics for advanced*

*practice: A practical approach* (3rd ed.). Ambler, PA: Lippincott Williams & Wilkins.

Brandom, B. W., Callahan, P., & Micalizzi, D. A. (2011). What happens when things go wrong?.

*Pediatric Anesthesia*, *21*(7), 730-736.

Brown, S. D., Lehman, C. D., Truog, R. D., Browning, D. M., & Gallagher, T. H. (2012).

Stepping out further from the shadows: disclosure of harmful radiologic errors to patients.

*Radiology*, *262*(2), 381-386.

Ehsani, S. R., Cheraghi, M. A., Nejati, A., Salari, A., Esmaeilpoor, A. H., & Nejad, E. M.

(2013). Medication errors of nurses in the emergency department. *J Med Ethics Hist Med*,

*24*(6), 11.

Institute for Safe Medication Practices. (2012). *ISMP's list of error-prone abbreviations,*

*symbols, and dose designations*. Retrieved

from <http://www.ismp.org/Tools/errorproneabbreviations.pdf>

Mastroianni, A. C., Mello, M. M., Sommer, S., Hardy, M., & Gallagher, T. H. (2010). The flaws

in state ‘apology’and ‘disclosure’laws dilute their intended impact on malpractice

suits. *Health Affairs*, *29*(9), 1611-1619.

Wittich, C. M., Burkle, C. M., &Lanier, W. L. (2014). Medication errors: an overview for

clinicians. In *Mayo Clinic Proceedings* (Vol. 89, No. 8, pp. 1116-1125). Elsevier.