

## Medical Errors Report Released

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### FOR IMMEDIATE RELEASE

USP Releases the MedMARx 2000 Data Report

Report Analyzes Hospital and Health Care Facilities Medication Errors

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Rockville, Maryland -- The U.S. Pharmacopeia (USP) today released its MedMARx 2000 Report, Summary of Information Submitted to MedMARx in the Year 2000: Charting a Course for Change. This second annual report from the MedMARx Program is the most comprehensive and current compilation of medication error data submitted by hospitals and health systems nationwide. MedMARx is an Internet-accessible and anonymous medication error reporting program and quality improvement tool used to track and trend medication errors.

The 2000 report includes data for 41,296 errors reported by 184 health care facilities. The first MedMARx report summarized data from 1999 for 6,224 medication errors from 56 facilities. Of those 56 facilities reporting, 47 continued to participate in the 2000 report, while 137 facilities joined the program in 2000. These facilities include the full spectrum of sizes and types, including community, government, and teaching institutions of varied size and characteristics.

Of the errors reported in the MedMARx 2000 Report, 92 percent (37,999/41,296) were categorized as errors that occurred, and 8 percent (3,297/41,296) were categorized as potential errors. Of the errors that occurred:

-- 97 percent (36,766/37,999) were errors that did not result in patient harm; 3 percent (1,233/37,999) resulted in patient harm

-- 31 percent (11,786/37,999) were errors that did not reach the patient, and 69 percent (26,213/37,999) were errors that reached the patient.

Less than one percent of errors resulted in patient death (a total of three records).

MedMARx categorizes errors based on the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Error Outcome Category Index (see page 9 of the Report), which classifies the error by categories from A to I based on the potential for harm or level of harm to the patient. The NCC MERP Category Index identifies four major error categories, "potential for error," "no harm," "harm," and "death," and nine subcategories.

MedMARx supports the systematic reporting, tracking, documentation, analysis, and sharing of medication error information within and among hospitals as outlined in the 1999 Institute of Medicine Report, To Err is Human. It also supports the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) Patient Safety Standards, which were instituted in July 2001, and the American Society of Health-System Pharmacists' Guidelines on Preventing Medication Errors in Hospitals. The MedMARx 2000 Report indicates that "strong reporting by facilities suggests an internal culture that focuses on patient safety and encourages medication error reporting as a means of improving patient safety and controlling costs."

"The information in this report can serve as a compass for directing local health care facility efforts and resources to those areas that will benefit from system-based improvement strategies," said Roger L. Williams, M.D., executive vice president and chief executive officer of USP. "The information can be used by hospitals and national organizations to develop quality indicators and to identify policies and procedures that work," he continued. "Crucial steps in this journey will be a deeper analysis of errors and a paradigm shift in approaches to thinking about medication errors and their solutions."

Key MedMARx 2000 Report findings include:

-- Errors occurred in the prescribing, documenting, dispensing, administering, and monitoring "Nodes," or phases, of the medication use process. The most frequently reported nodes in which errors originated were administering, documenting, and dispensing.

-- Out of 11 possible selections for "Types of Error," the most frequently reported included errors of omission, improper dose or quantity, and unauthorized drug.

-- Overall, 60 percent of the records reported one "Cause of Error" per record, and 40 percent reported more than one cause per record. The top causes of errors included performance deficit, procedure or protocol not followed, and transcription inaccurate or omitted.

-- "Contributing Factors" were selected for 26 percent of records citing errors. Overall, 76 percent of those records reported one contributing factor per record, and 24 percent reported more than one contributing factor per record. The most frequently reported contributing factors included distractions, workload increase, and inexperienced staff.

-- Overall, 72 percent of the records reported 33,806 "Products" from the product table. One product was selected per record for 90 percent of the records, and 10 percent of records documented more than one product involved with each error. The most common products associated with both potential errors and actual errors are insulin, heparin, and morphine.

-- An "Action Taken" was documented from the pick list for 46 percent of the records. One action taken was documented per record for 74 percent of the records, with the remaining 26 percent documenting more than one.

The most frequently documented actions taken were: informed staff who made the initial error, informed staff who was also involved in error, and education or training provided.

"This second MedMARx report provides a strong indication that health care professionals and institutions are more willing to report errors and to understand that they can learn from the mistakes of others," said Diane D. Cousins, R.Ph., USP vice president for practitioner and product experience. "We hope that this trend continues and that these entities get support--both legislatively and professionally--for the important work they are doing in reporting medication errors."

USP has been a leader in medication error reporting since 1991, when it began operating the Medication Errors Reporting (MER) program with the Institute for Safe Medication Practices (USP purchased the program in 1994). In 1995, USP founded the National Coordinating Council for Medication Error Reporting and Prevention (see [www.nccmerp.org](http://www.nccmerp.org)), and the Advisory Panel on Medication Errors in 1996. At USP's Quinquennial Meeting in April 2000, the Safe Medication Use Expert Committee was established under the Council of Experts, and thus became a formal constituent of USP's standards-setting process. USP's medication error tracking activities contribute to USP's mission of assuring high quality and safe medications through its pharmaceutical standards-setting program. USP collects medication errors to enhance its drug standards-setting activities and provides feedback to reporting professionals, product manufacturers, and regulatory agencies.

A copy of the MedMARx 2000 Report along with additional MedMARx program background information, graphics and past news releases are available at USP's Web site, [www.usp.org/medmarx2000](http://www.usp.org/medmarx2000) . Members of the media can access the MedMARx 2000 Report media kit and additional information regarding USP's role in patient safety at [www.usp.org/e-newsroom](http://www.usp.org/e-newsroom) .