Care CEUs

Medication Error Prevention

1. Which of the following statements is INCORRECT regarding the definition of a medication error?

A. It includes events related to prescribing and order communication.
B. It refers to any preventable event causing patient harm under healthcare control.
C. It is solely concerned with the administration of medications.
D. It may involve packaging and labeling errors.

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2. When dealing with high-risk medications, which strategy would most effectively help prevent errors?

A. Relying largely on automated dispensing systems.
B. Utilizing mnemonic devices to remember medication categories.
C. Increasing the speed of medication rounds to keep up with demand.
D. Implementing independent double checks for critical medications.

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3. In considering organizational risk factors, what is the primary issue when there is a mismatch between nurse-to-patient ratios and expected workload?

A. It reduces the need for detailed medication documentation.
B. It often leads to mishandling due to increased stress and workload.
C. It allows more time for patient interaction, thus reducing errors.
D. It encourages the development of safe medication practices.

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4. What is a major concern with improper dose administration as a type of medication error?

A. Prescribing a medication with no therapeutic indication.
B. Increasing the risk of adverse effects due to drug interactions.
C. Causing harm to the patient by deviating from the ordered dose.
D. Failing to consider alternative routes for drug administration.

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5. How could fatigue and shift work specifically contribute to medication errors according to recent studies?

A. They improve alertness, allowing nurses to perform duties with higher accuracy.
B. They enhance nurse's metabolic rate, leading to faster cognitive processing.
C. They provide opportunities for constant rest periods to recover during shifts.
D. They diminish attention and vigilance, increasing error risks in administration tasks.

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6. What are potential sources of procedural-related medication errors in a clinical setting?

A. Use of standardized procedures and clear labeling.
B. Ambiguous instructions and manual preparation of infusions.
C. Verbal orders complemented by standardized abbreviations.
D. Frequent monitoring and clear communication with pharmacy.

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7. How can healthcare organizations encourage the reporting of medication errors to improve patient safety?

A. By implementing a robust anonymous reporting system and creating a non-punitive culture.
B. By rewarding nurses who do not report errors unless patient harm occurs.
C. By focusing on individual blame to hold staff accountable.
D. By sharing error reports only with senior management.

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8. What are LASA drugs, and how can they contribute to medication errors?

A. LASA drugs are medications with similar names that are easily distinguished by sound alone.
B. LASA drugs refer to medications with different packaging that usually have different patient responses.
C. LASA drugs are those with similar names or packaging that may lead to confusion at any stage of the medication process.
D. LASA drugs are medications prescribed in pediatric populations where weight-based dosing is routine.

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9. How can high-tech interventions like computerized order entry systems prevent medication errors?

A. They completely eliminate the need for nurse monitoring of medication administration.
B. They reduce errors by ensuring that all medication orders are visually confirmed by the patient each time.
C. They remove the need for sole reliance on patient self-reporting of allergies and adverse reactions.
D. They minimize transcription and legibility errors by digitizing medication orders and updates.

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10. What is a key strategy that could help prevent medication errors in high-risk inpatient areas?

A. Distributing tasks evenly among all nurses to ensure workload balance.
B. Implementing double-check systems for high-risk medications involving independent verification by a second nurse.
C. Allowing the primary nurse to bypass barcode scanning in emergencies.
D. Using written labels for all medications prepared in shared spaces to improve visibility.
