Abstract

To err is human. Everyone makes mistakes, including doctors and nurses. According to studies cited in the Institute of Medicine report, 98,000 Americans die each year as a result of medical errors. This statistic is associated with a cost of US$17 to US$29 billion and ranks medical error the eighth leading cause of death in the United States. Medication errors account for approximately 7,000 deaths per year. Medication errors are any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

To err is human, but errors can be prevented. Improving system defect is a more effective way to reduce errors than blaming individuals. Health care is a decade or more behind other high-risk industries in its attention to ensuring basic safety. Aviation has focused extensively on building safe systems.

To improve safety is first to create an environment that encourages individuals to identify errors, evaluate causes and take actions to improve performance in the future. Non-punishment reporting systems represent one mechanism to enhance our understanding of errors and the underlying factors that contribute to them. A number of error prevention tools are helpful to improve safety. Studies have shown that Computerized Physician Order Entry and Bar-code system are effective in reducing medication errors. Also, pharmacists can play an important role in medication safety by educating the patients to take the drugs properly. Drug companies should pay attention to drug names and drug-looking to minimize confusion between drugs that look or sound alike.

If we want to improve our healthcare system in Macau, we need to be open to discuss the topics about errors. Also, a legal system should be established. HIS should be introduced to help doctors, pharmacists and nurses to reduce errors.

Keywords: medication errors, system defect, non-punishment reporting systems