

# SAFETY WATCH

Stay aware of these known risks to avoid preventable harm.

## Discharge medication errors

Medication errors are one of the top causes of patient safety events and comprised approximately 28% of events reported in 2024. Pediatric patients are at **high risk of medication errors** due to age- and weight-based dosing and because some patients may not be able to recognize medication discrepancies. Pediatric medication errors occur in **up to a third of hospital discharges**.

### Causes

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Contributing factors may include:

- Difficult coordination of care during the discharge process, particularly in medically complex patients or those with chronic diseases.
- Communication barriers between the health care team and external pharmacies related to system interfaces and communication pathways.
- Inadequate discharge medication reconciliation practices, including the omission of pertinent medications or the incorrect addition of medications due to prescription typos or other errors.
- Unrecognized prior authorization requirements and compounding medication requirements leading to delayed or absent treatment.
- Multiple commercially available medication concentrations.
- Communication and language barriers between the health care team and the patient and family.

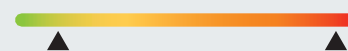
### Harm

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Gaps in the medication process during discharge have led to an increase in patient visits, progression of illness, need for higher levels of care, permanent disability, and the utilization of additional resources.



Harm Range



No Detectable Harm to  
Severe Permanent Harm

Pediatric  
medication  
errors occur in  
**up to a third**  
of hospital  
discharges.



## Immediate Recommendations

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- Communicate with the family using the “[teach back](#)” method and medication administration demonstration.
- Provide convenient access to interpreters and direct contact information for post-discharge concerns.
- In the standard discharge process, include review of all medications, rationale, and education; refill information; and verification of accuracy and acquisition of all prescriptions.
- Use a [discharge checklist](#) or cognitive aid to ensure all essential discharge steps are completed.
- Leverage technology, such as the use of dose range alerts, medication order templates, and system interfaces, to reduce the risk of medication-related harm.
- Establish a multidisciplinary workgroup that includes frontline staff, pharmacy, and leadership to evaluate discharge medication practices.
- Create a process to assess the patient’s insurance requirements for specific medications regarding prior authorizations and cost before discharge.

## Resources

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- [Discharge Checklist, Hospital Discharge and Readmission, Up to Date, Updated 2023](#)
- [Designing the Medication Reconciliation Process, AHRQ, Last reviewed 2022](#)

## References

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- [Pediatric Neurology, Incidence of medication-related problems following pediatric epilepsy admissions, 2023](#)
- [Up to Date, Prevention of Adverse Drug Events in Hospitals, Updated 2024](#)
- [Up to Date, Hospital Discharge and Readmission, Updated 2023](#)

Data for the Safety Watch is compiled from Child Health PSO safety analysis.

This safety watch is approved for general distribution to improve pediatric safety and reduce patient harm. This safety watch meets the standards of non-identification in accordance with 3.212 of the Patient Safety Quality Improvement Act (PSQIA) and is a permissible disclosure by Child Health PSO. In accordance with our Terms of Use and Code of Conduct, this material cannot be used for any commercial transactions that are unrelated to the original intent of Child Health PSO Patient Safety Action watch.

## Find solutions

Members can find detailed prevention plans in Child Health PSO’s Riskconnect Action Plan repository where children’s hospitals share deidentified mitigation processes for various issues.



## Join Child Health PSO

Over 55 children’s hospitals are actively engaged with Child Health PSO, and we are currently enrolling new members. Join the only PSO solely dedicated to children’s hospitals.