Child Health Patient Safety Organization®

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

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

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.

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Immediate Recommendations

- 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

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

References

- 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.

Find solutions

Members can find detailed prevention plans in Child Health PSO's Riskonnect 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.