From Psychology to Regulations: Interdisciplinary Approaches to Improve Medication Safety
Nathaniel M. Rickles, PharmD, PhD, BCPP
Learning - Assessment Questions

1. Pharmacist Snoopy sees a clearly written “qd” as “qod” and labels the prescription for every other day use. Which of the following is the most likely cause of this error?

   a. failed communication
   b. confirmation bias
   c. lack of pharmacist knowledge
   d. poor drug distribution practices
   e. excessive prescription volume

2. According to the presentation, medication errors have been shown to impact which of the following:
   a. hospital admissions
   b. office visits
   c. nonadherence
   d. hospital costs
   e. accidental injuries

3. Nonpreventable and preventable injuries due to the use of drugs are good examples of:
   a. medical errors
   b. drug-related problems
   c. adverse drug events
   d. adverse drug reactions
   e. near misses

4. As a broad term, medical errors includes:
   a. nonadherence
   b. medication errors
   c. side effects of medications
   d. patient-initiated injuries
   e. automatic mode of thinking

5. Which of the following statements correctly reflects the characteristics of automatic mode of thinking?
   a. rapid and effortless
   b. less likely to involve slips
   c. involves mental guidelines
   d. involve activities that we don’t do that often
   e. used in problem-solving drug-related issues

6. The pharmacist interprets a Lasix® prescription as being Lozol®. The source of this error is most likely due to:
   a. inadequate staffing
   b. failed communication
   c. poor environmental conditions
   d. little organizational culture on medication errors
   e. poor pharmacist education

7. Medication errors can result from:
   a. positive beliefs about the medication
   b. inadequate medication monitoring
   c. knowing health terms
   d. increased number of multilingual patients
   e. the lack of pharmacist impact on patient outcomes

8. When Pharmacy Inspector J. Edgar Hoover comes to Marshmellow Pharmacy, he notes in his comments about how the pharmacy has a consistent culture supportive of the reduction of medication errors. These comments are most likely based on Hoover's observance of which of the following:
   a. one person double-checking a prescription order
   b. staff members who have different views about errors
   c. the report of an error reduction program five years ago
   d. regular pharmacy meetings on error reduction
   e. several individuals completing a CE program on medication errors

9. Which of the following pieces of information will be needed when reporting a medication error to the FDA?

   a. names of all persons involved in the error
   b. how will future errors be prevented
   c. if proper counseling had occurred
   d. why the error occurred
   e. did the pharmacy have a CQI program

10. Examining a high number of individual errors and finding the common causes can be best accomplished by:
    a. anonymous self-reports
    b. critical incident technique
    c. chart review
    d. CPOE
    e. Pedigree Tracking System

11. A pharmacist forgets to clear his screen of the previous patient and fills the next prescription under the previous patient. A systems analysis would most likely suggest which of the following:

    a. the pharmacist was tired and hungry
    b. need for more pharmacist counseling on medications
    c. poor communication between physician and pharmacists
    d. need for a change in prescription verification procedures
    e. pharmacist re-training on computer procedures

12. An example of an equipment design failure in community pharmacy practice is:
    a. reduced patient medication counseling due to poor workflow
    b. reduced patient medication counseling due to no patient counseling areas
    c. increased medication errors due to stressful work environment
    d. reduced medication errors due to introduction of automated pill counters
    e. increased allergic reactions due to no computer prompts for allergy information

13. A human error mode and effects analysis of a pharmacy setting typically:
    a. determines what can go wrong in the system
    b. involves how do individuals intervene when the error occurs
    c. explores what happens to individuals who make errors
    d. examines the pharmacy's culture regarding errors
    e. avoids identifying the consequences of the errors

14. According to lecture, the use of pre-printed order forms in hospitals is an example of:

    a. decreasing written prescribing error
    b. decreasing dispensing error
    c. increasing administering error
    d. decreasing distribution error
    e. increasing written prescribing error

15. Reducing administration errors can be best accomplished by using:

    a. improved lighting
    b. patient counseling
    c. electronic pedigree tracking system
    d. bar coding
    e. computer physician order entry

16. The results of the court case Hundley vs. Rite Aid (2000) indicate that:
    a. prior incident reports are admissible in court
    b. the pharmacist is not responsible for medication errors
    c. complaints filed with a Board of Pharmacy can not be used in court
    d. employers are liable for error-prone work conditions
    e. employers are required to maintain a CQI program

17. According to the CQI regulations going into effect on December 15, 2005, pharmacies are required to:

    a. contact prescribers about QREs
    b. analyze QREs
    c. maintain QRE records for at least five years from report date
    d. receive at least 1 credit of continuing education credit on CQI
    e. keep QRE records on site

18. The pharmacist who reports a QRE needs to document:

    a. monthly trends in QREs
    b. analysis of the pharmacy's earnings related to QREs
    c. recommendations for changes in pharmacy policies
    d. the names of all staff present at the time of the QREs
    e. patient attitudes about the QRE

19. Learning how to develop a quality pharmacy practice program can be achieved by accessing which of the following resources:

    a. www.theleapfroggroup.org
    b. www.ahrq.gov
    c. www.alphanet.org
    d. www.nacds.org
    e. www.ismp.org

20. When responding to a patient regarding an error, it is best:

    a. deny the error occurred
    b. avoid implicating the pharmacy's role in the error
    c. assure the patient you will take care of the problem
    d. assign blame on others in the pharmacy
    e. avoid talking with the patient about error