

# Cheap Nursing 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.
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