Recent Medication Mix-up Highlights System Errors

Multiple news agencies have since reported that "parents who thought they were picking up fluoride...were actually getting...tamoxifen." Since this story broke over the weekend, few answers have yet been given by those closely involved. During an interview a pharmacist related to the incident claimed that the similarity of the tablets was blamed for the mix-up, which "went on undetected for at least two months, exposing more and more kids." According to the AP, "the state attorney general's office has begun a preliminary investigation into the matter."

Thankfully, no child appears to have been injured by these medication errors. With that said, stories like these serve as examples and continual reminders of the need to examine our systems to ensure we are designing them with safety in mind. Although more information will need to be made available before root causes can be reviewed and discussed, the Center for Medication Safety Advancement (CMSA) always encourages a systems-level approach be used to improve the processes that lead to medication errors. CMSA will continue to follow this story and will be cognizant in using the lessons learned to assist others in improving medication safety processes.

For more information about medication errors and improving systems, visit: [www.ismp.org](http://www.ismp.org)

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