FNIHB-OR Nursing Policy and Procedure

Section:	**Pharmacy**	Policy Number:	III-09
Subject:	**Medication Error Policy**	Issued: Revised:	**2016-07-28**
Distribution:	**All Nursing Facilities**		

1. POLICY:

1.1 Medications shall be properly prescribed, dispensed, and administered in accordance with FNIHB-OR policies, pharmacy policies and procedures, and patient "Rights" (Right patient, Right medication, Right dose, Right route, Right time and frequency, and Right indication).

1.2 All errors or unanticipated events associated with the medication system or a step in the medication process shall be reported using the medication error report form whether or not the error reached the patient.

1.3 The prescriber must be notified as soon as possible of medication errors that have reached the patient with notification documented in the medical record.

2. PRINCIPLES:

2.1 First Nations and Inuit Health Branch – Ontario Region (FNIHB-OR) is committed to quality improvement strategies to reduce the incidence of adverse client outcomes. Safe medication practices are an important aspect of quality client care.

2.2 Administering a medication requires knowledge, technical skills and judgment. Nurses need the competence to assess the appropriateness of a medication for a client, manage adverse reactions, understand issues related to consent and make ethical decisions about the use of medications (CNO, 2014).

2.3 Administering medications below the drip chamber, via central venous access devices, umbilical lines, and endotracheal tubes and administering immunizations require specialized competence that may not have been included in basic nursing educational programs. In-service education assists the nurses in acquiring the knowledge and skill to perform such activities.

2.4 Each nurse is responsible for ensuring and/or advocating for appropriate resources to monitor and intervene to manage potential adverse drug reactions (e.g. having access to appropriate policies, directives, equipment and supplies to manage anaphylaxis).

3. DEFINITION:

Medication Error: any unanticipated event that may cause or lead to inappropriate medication administration or cause patient harm while the medication is in control of the health care professional or the patient. Unanticipated events may be related to professional practice, health care products,

procedures, or systems, including prescribing, order communication, labeling, packaging, dispensing, distribution, administration, education, monitoring and use.

Medication Administration: is the process of giving a medication directly to the client.

Nurse: Refers to Registered Nurses, Nurse Practitioners, and Registered Practical Nurses.

High Alert Medications: Drugs that bear a heightened risk of causing significant client harm when they are used in error.

Independent double-check: A process that ensures that a second practitioner conducts a verification, either in the presence or absence of the first practitioner. For example, a nurse may use this process to verify a dosage calculation.

4. PROCEDURE:

4.1 The Nurse who discovers the medication error will complete the *Medication Error Report Form*.

4.2 The form is then forwarded to the Practice Consultant assigned to their community; a copy of the form will remain on the patient's chart.

4.3 The Practice Consultant will review the completed form and forward it to the Nurse Manager.

4.4 The Nurse Manager will send the form to the Regional Pharmacist to follow up on the error, file the report and to track for quality assurance purposes.

Note: Any member of the medication error review process may initiate a chart review for quality assurance purposes.

Appendix A: Medication Error Report Form

Approved by:	**Effective Date:**
Director of Nursing, Ontario Region FNIHB **Date:**	
Regional Executive, Ontario Region, FNIHB **Date:**	

MEDICATION INCIDENT REPORTING FORM

Community_____ Client's File # _ M □/ F □ Age

Complete as soon as possible after discovering a medication error and giving appropriate patient care and fax to your Practice Consultant, following discovery of error/incident.

A. EVENT. Date and time of event:

What type of medication incident occurred:

□ Incorrect medication
□ Incorrect dose/ miscalculation
□ Incorrect IV rate
□ Expired solution /medication given
□ Unordered medication given
□ Other (specify, ie dispensing): _____
□ Incorrect client (Describe below)
□ Incorrect route / site
□ Adverse reaction
□ Narcotic loss
□ Extra / repeated dose, medication given

Please describe the error. Include description / sequence of events, time, type of staff involved, and work environment (eg. Short staffing, no pharmacy stock, etc.) Attach separate sheet if necessary

Persons involved in REPORTING & RESPONSIBLE for the initial error/ incident/ potential error / incident

	RN (FT/PTR)	RN (RL)	RN (Agency)	CHR
Person reporting incident:	□	□	□	□
Person responsible for incident:	□	□	□	□
Person who witnessed the incident:	□	□	□	□

How was the error (potential for error) discovered / intercepted? _____

Circle the "**Error Outcome Category: A B C D E F G**" (see section 'F' for definitions)
If *Category A, go to* section C-D. For Categories B-G, complete remaining sections A-D

Please provide client's diagnosis (es).

Original drug order: name, manufacturer, dosage etc: _____
Drug client received: name, manufacturer, dose etc. _____

Describe the direct result of error on the client (include all local / systemic symptoms).

APPENDIX A: Medication Error Report Form

B. INTERVENTION. Indicate all interventions as a direct result of the incident /error.

□ Vital signs monitoring initiated
□ Oxygen administered
□ CPR administered
□ Airway established / patient ventilated
□ Other
□ Drug therapy initiated / changed
□ Client medivac to hospital
□ Laboratory tests performed / sent out
□ Antidote / narcotic antagonist administered

C. ACTION TAKEN. Name & time of those notified:

□ **NIC**
□ **Physician**
□ Other
□ **Practice Consultant**
□ **Pharmacist**

Actions taken to avoid future errors / incidents.

□ Education / training provided
□ Environment modified
□ Other (indicate**)**
□ Inform patient / caregiver / community leader of error
□ Improve on communication process

D. IMPLICATIONS. Nursing implications: risk, future problem, practice issue

Full name of person reporting: **Title** **Date**

E. OUTCOME **Action taken by Management**

Describe any action taken by management:

□ Education / training provided
□ Environment modified
□ Improve on communication process
□ Inform patient / caregiver / community leader of error
□ Formulary change
□ Policy / procedure changed/ instituted /modified
□ Staffing discipline
□ Other

Any other suggestions regarding system changes to prevent error: _____

Name & Signature (Manager):

Title
Date

Medication Incident Outcome Category

E. Definition

A medication error is defined as: "Any preventable event that may cause or lead to inappropriate medication use or patient harm, while the medication is in the control of the health care professional. Such an event may be related to professional practice, procedures, and systems including: prescribing, order communication, product labelling, packaging, dispensing, distribution, administration, education, monitoring and use.
(Adapted from University of Texas health science Centre, 2006)

	Category A	Circumstances or events that have the capacity to cause error
	Category B	Error occurred that reached the client & required monitoring to confirm that it resulted in no harm to the client and /or required intervention to preclude harm
	Category C	Error occurred that may have contributed to, or resulted in, temporary harm to the client and required intervention
	Category D	Error occurred that may have contributed to, or resulted in, temporary harm to the client and required initial or prolonged hospitalization
	Category E	Error occurred that may have contributed to, or resulted in, permanent client harm
	Category F	Error occurred that required intervention necessary to sustain life
	Category G	Error occurred that may have contributed to, or resulted in, the client's death

Medication Incident Reporting Process

Steps to follow: Please complete Sections A-D only.

Section A. To be completed by the nurse who discovers the medication error. Describe the sequence of events that led to the discovery of the error and the circumstances surrounding the error. All information must still be completed even if the error did not reach the patient; steps could be taken to prevent future potential medication errors from occurring.

Please include all staff that are involved, both directly and indirectly, or were direct witnesses to the incident or involved in the potential for error.

In this section, also include the patient symptoms etc., which were manifested as a result of the error or incident, as well as outcome categories [section F]. This is intended to be a guide to determine the type of error and the resulting outcome.

Section B. Include all interventions taken to offset the incident or to correct what has occurred. Include the condition of the patient, action taken, all personnel informed of error, and probable implication to staff / patients; any relevant physiological / psychological signs exhibited by the patient.

Section C. Indicate who was informed of the incident and actions taken to avoid future or potential errors / incidents.

Section D. Describe the nursing implications whether for present or future.

Section E. For your manager to complete who will follow up as necessary.

If more than one patient is involved in the error, a medication incident form must be completed for each one.