MAXABILITIES OF YORK COUNTY

POLICY TITLE: Medication Error/Event Reporting

EFFECTIVE DATE: December 21, 2007

POLICY REVISION: June 25, 2026
February 22, 2018
January 26, 2017
January 24, 2008

REFERENCE: OIDD (Office of Intellectual & Developmental Disabilities) DD 100-29
OIDD Departmental Directive 100-26

RELATED PROCEDURAL DOCUMENTS:
MaxAbilities Procedure: Medication Error Committee Protocol

PURPOSE: To establish a standardized definition and reporting system for medication errors which occur in the residential and day programs. To establish a process for analyzing and follow up of medication errors.

DEFINITION: The National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) has adopted the following standardized definition of medication error.
"A medication error is 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, patient or consumer. Such events may be related to professional practice, health care products, procedures and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use"

1. Bona fide (true) medication errors are any violation of the " *Rights of medication delivery*":
    - Wrong person given a medication (*right person*)
    - Wrong medication (*right medication*)
    - Wrong dosage given (*right dose*)
    - Wrong route of administration (*right route*)
    - Wrong time (*right time*)
    - Medication not given by staff (omission)
    - Medication given without a prescriber's order
    - Pharmacy errors directly involving individuals
    - Order Expired

2. Transcription Errors:
    - Transcription error (i.e.: from prescriber's order to label, or from label to MAR)
    - Transcription: Wrong Individuals
    - Transcription: Wrong Medication
    - Transcription: Wrong Dose
    - Transcription: Wrong Route
    - Transcription: Wrong Time
    - Transcription: Omission
3. Charting (Documentation) Errors:
    - Other: Medication not documented (i.e.: not signed off) by the end of the shift. This includes the absence of follow-up documentation on the THERAP electronic EMAR.
    - Other: Medical Observation/ Pre-Treatment Requirements included on the EMAR are not documented as completed. The error/omission is related to a specific activity prescribed for collecting data to monitor medication effects.
4. Red Flag Events
    - Person refused medication. In this event, documentation of specific actions taken to address the refusal should be maintained.
    - "Near misses" (i.e.: medication error almost occurs)
    - Unsafe circumstances (situation that may lead to a medication error in the future)
    - Discarded medication found
    - Pharmacy event that indirectly involves individuals
    - The person is not in the correct position to receive the medication
    - The texture of the medication is not consistent with orders for food and fluid intake

PRACTICES:

1. Data collection for all medication errors are done via the THERAP GER (General Event Report) documentation system. Medication errors reported in the THERAP system must list a cause as noted below:
    - Forgot to send to program
    - Forgot to take on outing
    - Medication refused
    - Medication not available
    - Omission unavoidable
    - Pharmacy error
    - Staff Action/Inaction
    - Other

2. For all medication errors involving the medication "rights", the person will be observed and vital signs taken. If the person is experiencing seizures, trouble breathing or other emergency medical issues, 911 should be called immediately.
3. In addition to the "rights", if there was a problem with medication presentation texture or body positioning during the medication pass, this information should also be reported.
4. All medication errors will be immediately reported to the nurse and house manager by the staff member finding the error.
5. The nurse will use his/her professional judgment regarding whether a call to the prescriber is indicated.
6. If the prescriber is contacted, the nurse will take the orders if given, write them on a physician's order form and relay them to the staff. The orders and supporting documentation will be completed in the nurse's notes section of THERAP. **Only nurses can take verbal or telephone orders.**
7. The person should be observed and monitored for any adverse reaction, including but not limited to changes in behavior, levels of alertness, changes in vital signs or other physiological responses.
8. Document all findings in the THERAP system and follow up with the physician as needed.
9. The staff member finding the error is responsible for submitting the THERAP GER entry before the end of the shift.
10. The Coordinator will review the GER entry within twenty-four (24) hours for correctness and approve. Once approved on the THERAP system, all pertinent staff members can read the information.
11. The Director of Nursing/designee will be responsible to ensure the medication error database is maintained and monthly reports generated.
12. All medication error GERs are expected to be received for database review weekly.
13. Medication errors are categorized as follows:
    - Severity Level 1: An error resulting in no or minimal adverse reactions.
    - Severity Level 2: An error resulting in reversible adverse consequence requiring medical monitoring and/or medical treatment. This is a "high" notification and the CEO/Designee is to be alerted.
    - Severity level 3: An error resulting in life-threatening and/or permanent adverse consequence. This is a "high" notification and the CEO/Designee is to be alerted. In this instance, an OIDD Critical Incident Report is also required within 24 hours of the error.
14. The Director of Nursing will assure that this data is available to the facility's quality assurance/ risk management team for analysis, trend identification and follow-up as needed. Medication error trending data will include a medication error rate (as outlined in OIDD Department Directive 100-29) for each program participating in medication delivery monthly as outlined by OIDD. This information will be available for review by regulatory agencies as further outlined in the 100-29 DD)

15. Medication error reviews will be conducted based on the Medication Error Review Committee Protocol.
16. Reactive and proactive analysis of trends with appropriate corrective actions will be handled according to the Medication Error Review Committee Protocol and may include but are not limited to: additional training, changes in procedure, securing additional technical assistance from the consulting pharmacist and improving levels of supervision. Trends will be reviewed in monthly risk management meetings and quarterly healthcare team meetings.
17. Medication errors that are a result of pharmacy errors will be reported to the pharmacist for immediate corrective action.
18. Trends from this data will be compiled and made available to the Director of Nursing, CEO, Medical Consultant and Risk Management Committee for analysis and follow-up activities as needed.

PROCEDURE: All related procedural documents/ practices are to be developed and maintained by the MaxAbilities CEO/designee in keeping with the dictates of the most current version of 100-29 DD.