TITLE:		
MEDICATION ERRORS		
FACILITY:	**FUNCTION:**	**ORIGINATING DEPT:**
St. Vincent's East	Medication Management	Pharmacy

HOSPITAL SHARED POLICY?	**EFFECTIVE DATE:**
__X_ Yes __ No	11/11/1985
DOCUMENT NUMBER:	**LAST REVIEW DATE:**
42-7171-130	2/01/2009
ORIGINATION DATE:	**LAST REVISION DATE:**
11/11/1985	2/01/2009
APPROVAL DATE:	**RETIREMENT DATE:**
2/01/2009	

SCOPE:

All areas of St. Vincent's East where medications are given.

PURPOSE:

To provide an effective mechanism for defining, identifying, reporting, reviewing, and monitoring medication errors.

DEFINITIONS:

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.

POLICY:

I. General types of medication errors include the following;

- A. Misinterpretations
- B. Miscalculations
- C. Misadministrations

D. Difficulty in interpreting handwritten orders

E. Misunderstanding of verbal orders

I.

II. Specific causes of errors include the following:

A. **Omission Error**: The failure to administer an ordered dose. However, if the patient refuses to take the medication, no error has occurred.

B. **Unauthorized Drug Error**: Administration to the patient of a medication dose not authorized for the patient. This category includes a dose given to the wrong patient, duplicate doses, administration of an unordered drug, and a dose given outside a stated set of clinical variables (e.g., medication order to administer only if the patient's blood pressure falls below a predetermined level).

C. **Wrong Dose Error**: Any dose that is the wrong number of performed units (e.g. tablets) or any dose above or below the ordered dose by a predetermined amount (e.g. 20%). In the case of ointments, topical solutions and sprays, an error occurs only if the medication order expresses the dosage quantitatively (e.g., one inch of ointment or two one-second sprays).

D. **Wrong Route Error**: Administration of a drug by a route other than that ordered by the physician. Also included are doses given via the correct route, but at the wrong site (e.g., left eye instead of right).

E. **Wrong Rate Error**: Administration of a drug at the wrong rate, the correct rate being that given in the physician's order or as an established policy.

F. **Wrong Dosage Form Error**: Administration of a drug by the correct route but in a different dosage form than that specified or implied by the physician. Examples of this error type include use of an ophthalmic ointment when a solution was ordered. Purposeful alteration (e.g., crushing of a tablet) or substitution (e.g., substituting liquid for a tablet) of an oral dosage form to facilitate administration is generally not an error.

G. **Wrong Time Error**: Administration of a dose of drug greater than plus or minus "X" hours from its scheduled administration time, "X" being set by hospital policy.

H. **Wrong Preparation of a Dose**: Incorrect preparation of the medication dose. Examples are:
(1) incorrect dilution or reconstitution
(2) not shaking a suspension
(3) using an expired drug

(4) not keeping a light-sensitive drug protected from light
(5) mixing drugs that are visually or chemically incompatible.

I. **Incorrect Administration Technique**: Situations when the drug is given via the correct route, site and so forth, but improper technique is used. Examples are not using Z tract injection technique when indicated for a drug, incorrect instillation of ophthalmic ointment, and incorrect use of an administrative device.

J. **Transcription Error**: Errors, which occur due to erroneous interpretation
and subsequent documentation of medication orders.

III. Whenever there is an error concerning a medication, the error should be reported to the attending physician and unit manager/department head.

IV. Following the communication with the attending physician, the medication error should be documented on the SafERSystem Computerized Adverse Event documentation system by the caregiver who discovered the error.

V. The Director of Pharmacy/designee will review each adverse medication event in a timely manner. Medication errors will be summarized on a monthly basis by patient care unit, date, patient number, and description of error. Data will be aggregated and trended to identify medication system problems.

VI. Monitoring of medication errors will be reported as part of the Performance Improvement function involving medication use.

VII. NCC MERP Index for Categorizing Medication Errors

A. Category A: Circumstances or events that have the capacity to cause error
B. Category B: An error occurred but the error did not reach the patient (An "error of omission" does reach the patient).
C. Category C: An error occurred that reached the patient but did not cause patient harm
D. Category D: An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm.
E. Category E: An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.
F. Category F: An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.
G. Category G: An error occurred that may have contributed to or resulted in permanent patient harm.
H. Category H: An error occurred that required intervention necessary to sustain life

I. Category I: An error occurred that may have contributed to or resulted in the patient's death.

PROCEDURE:

A. The SafERSystem is accessed via the St. Vincent's Internet Home Page.

B. The caregiver enters the error using SafERSystem procedures.

C. The report of the error is routed to appropriate individuals including the Director of Pharmacy.

D. The error remains in an open status until the Unit Manager or Designee investigates the error, ranks it by severity class and closes the error.

REFERENCES:

ATTACHMENTS:

APPROVAL ROUTING:

Pharmacy and Therapeutics Committee; Medical Staff Executive Committee

REVIEW HISTORY:

REVISION HISTORY: