1.0 PURPOSE

1.1 To outline the process for monitoring, identifying and reporting Medication Errors, and initiating appropriate corrective measures.

1.2 To prevent and/or control potential and actual medication errors in order to enhance patient care, improve patient safety, and decrease liability and hospital cost.

2.0 DEFINITION

2.1 Medication Error: Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer. Such events may be related to professional practice, healthcare products, procedures and systems, including: prescribing, order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.

2.2 Significant Medication Error: Any medication error that if not prevented may cause significant harm to the patient (i.e. permanent harm or death).

2.3 Near Miss: Any process variation that did not affect an outcome (did not reach the patient), but for which a recurrence carries a significant chance of a serious adverse outcome. Such a “near miss” falls within the scope of the definition of an adverse event.

2.4 Hazardous Situation: Any condition which may lead to a medication error such as confusion over look-alike/sound-alike drugs or similar packaging or using prohibited abbreviations (Error Prone).

2.5 Adverse Event: An unanticipated, undesirable, or potentially dangerous occurrence in a healthcare organization.

2.6 Narrow Therapeutic Index Drug: Any pharmaceutical which has a < 2-fold difference between the minimum toxic concentration and minimum effective concentration in the blood.

2.7 Look-Alike and Sound-Alike Medications: Look-Alike/Sound-Alike (LASA) medications involve medications that are visually similar in physical appearance.
or packaging and names of medications that have spelling similarities and/or similar phonetics.

3.0 RESPONSIBILITY

3.1 **Most Responsible Physician:** responsible for filling the designated area of the Medication Error Report Form and take appropriate action.

3.2 **Clinical Pharmacist:** responsible for investigating the case and determining whether the medication error has potentiating effect on the patient.

3.3 **Medication Safety Officer:** responsible for presenting the analyzed data periodically to the Pharmacy and Therapeutic Committee for discussion and action plan.

4.0 CROSS REFERENCES POLICY

4.1 Prohibited Abbreviations List.

5.0 POLICY

5.1 The Pharmacy Department has an effective and consistent policy on how to handle medication errors, give appropriate instructions and precautions on how to identify, report, intervene, and analyze medication errors, and have a system in place for monitoring, and preventing future incidences.

5.2 Medication error reporting is an anonymous, non-punitive and strongly encouraged process.

5.3 Adherence to hospital medication policies by concerned individuals will avoid and/or minimize medication errors.

5.4 Medications errors, near misses, and hazardous situations shall be documented in the patient’s medical record.

6.0 PROCEDURE

6.1 For all discovered medication errors, **Medication Error Report** should be completed and forwarded after all necessary information has been gathered to the Pharmacy Department **within 24 hours**.

6.2 Pharmacy Department will submit the Medication Error report to the Medication Safety Officer no later than forty-eight (48) hours after the event discovery.

6.3 A thorough action is done accordingly for the avoidance of future incidence. The reasons for errors may be due to Doctors ineligible hand writing, Nurses drug handling, faulty dispensing by Pharmacy staff or any other reasons.

6.4 Medication errors could occur during any of the five stages of medication use process (Each of them could be considered as “Error Prone”).

**These processes are:**

6.4.1 Physician ordering.

6.4.2 Transcribing and verifying physician orders.
6.4.3 Dispensing and delivering medications.
6.4.4 Medication administration.
6.4.5 Monitoring and reporting of medication effects on the patient.

6.5 The following members of the healthcare service can make medication errors:

6.5.1 Physicians.
6.5.2 Pharmacists.
6.5.3 Nurses.
6.5.5 Patients.
6.5.5 Any other member of the healthcare team.

6.6 Steps To Be Followed When a Medication Error is Discovered:

6.6.1 Any staff member who discovers a medication error whether it’s a physician, pharmacist, or a nurse must immediately complete the Medication Error Report Form.
6.6.2 This staff member must then verbally report to the Head Nurse and the Attending Physician. The Most Responsible Physician should then fill in the designated area of the Medication Error Report Form and take appropriate action. The Form must then be completed by all other involved members in their designated areas of the Medication Error Report Form.
6.6.3 The Head of Pharmacy should be informed and the completed Form should be immediately forwarded to him.
6.6.4 The clinical pharmacist will investigate the case and determine whether the medication error has potentiating effect if taken by the patient, and also submit a written report to the Patient Safety Officer.
6.6.5 The Medication Safety Officer along with the TQM department must do the Root Cause Analysis for Significant Medication Errors and provide recommendations to resolve the problem and prevent recurrence of this type of error, and forward this report to the Head of Pharmacy.
6.6.6 The Medication Safety Officer after analyzing the data will presented to the Pharmacy and Therapeutic Committee Meeting for review and to utilize the data available to develop an action plan to improve medication safety.

6.7 Guidelines To Prevent Medication Errors:

6.7.1 Guidelines for Prescribers:
6.7.1.1 Prescribers should write a complete, clear, unambiguous order that must include drug name, dosage form, strength, dose, route, and frequency or rate of medication administration.
6.7.1.2 Prescribers should use exact metric weight not the apothecial weight of the dosage form prescribed (or concentration in case a liquid is prescribed).

6.7.1.3 They should not use vague instructions (i.e. take as directed) or prohibited abbreviations, instead more specific drug instructions should be given.

6.7.1.4 They should not use abbreviated or unofficial drug names.

6.7.1.5 A zero should **always** precede a decimal point for doses less than 1 mg (Leading ZERO), but should never follow a decimal point for doses larger than 1 mg (Trailing ZERO). Not following this can lead to a 10 fold overdose.

6.7.1.6 Write the indication for PRN doses (e.g. PRN for pain or fever).

6.7.1.7 Avoid illegible handwriting.

6.7.1.8 Minimize Telephone and Verbal Orders.

6.7.1.9 Document drug allergies.

6.7.1.10 Monitor patients on Narrow Therapeutic Index drugs.

6.7.1.11 Prescribers should not write “U” after an insulin dose. It can be interpreted as a zero, or 4, or cc’s, causing deadly

6.7.1.12 Write the scientific name of drugs not the trade names on prescriptions.

6.7.2 **Guidelines for Pharmacists:**

6.7.2.1 Enforce double checking.

6.7.2.2 Standardize medication administration time.

6.7.2.3 Label medications properly.

6.7.2.4 Use auxiliary labels.

6.7.2.5 Increase awareness and Highlight Look-Alike Sound-Alike "LASA" medications and label them with **Blue Stickers**.

6.7.2.6 Do not confuse pediatric doses with adult doses.

6.7.2.7 Minimize floor stock medications.

6.7.2.8 Enforce monthly inspection.

6.7.2.9 Highlight High-Alert Medications and label them with **Red Stickers**. Take extra care while dispensing them.
6.7.2.10 Ensure proper storage of dispensed medications.
6.7.2.11 Educate staff on the process and importance of medication error reporting.

6.7.3 Guidelines for Nurses:

6.7.3.1 Confirm patients' identity (Name & MRN) use the eight rights rule.
6.7.3.2 Check the identity and integrity of dispensed medications.
6.7.3.3 Compare used medications with the doctor's order and the medication sheet.
6.7.3.4 Verify an unusual dose or volume with a pharmacist.
6.7.3.5 Don't borrow medications from other patients' cassettes.
6.7.3.6 Use standard administration time.
6.7.3.7 Always double check your calculations.
6.7.3.8 Document any administered drugs.
6.7.3.9 Double check action rates of critical and high risk medications.
6.7.3.10 Label all prepared syringes with the drug name and total dose, or prepare the syringe at the bedside and administer its contents immediately.
6.7.3.11 Never use any product that's not labeled.
6.7.3.12 Don't trust your hearing when receiving verbal orders, because you may mishear, misunderstand, or mis-transcribe the message.
6.7.3.13 For safety ask the pharmacist if it's OK to crush the drug.
6.7.3.14 Use aseptic techniques when preparing medications.

6.8 The reported data is utilized to improve the medication use process, prevent medication errors, and improve patient safety using all tools available.

6.9 The Medication Safety Officer will provide feedback and education to healthcare professionals on reported medication errors, near misses, and hazardous situations.

6.10 The Hospital will report sentinel events related to serious medication errors to the relevant authorities.

7.0 FORMS

7.1 Medication Errors Reporting Form.
8.0 EQUIPMENT

8.1 N/A.

9.0 REFERENCES