

Why you need this policy:

Medications errors are among the medical issues for which medical practices must implement Quality Assurance (QA) standards, policies, and procedures. Although the objective is to prevent such errors, practices also must be prepared to respond effectively should they occur.

How this policy helps you:

Establishing a written Policy for dealing with medication errors is crucial. Although each practice will handle things differently, that policy should, like the Model Policy below, define "medication errors," describe how those errors must be reported and to whom, and set out a procedure for assessment and analysis of medications error data generated by reporting.

How to use this policy:

Adapt this Model Policy for your own practices, personnel and situation.

XYZ Medical Group Medications Error Reporting Policy

1. Statement of policy

XYZ Medical Group and its physicians and medical staff are fully aware that there are inherent risks associated with prescribing medications to patients for therapeutic use, including the risk of error. XYZ Medical Group has adopted policies, procedures, and systems governing dispensing of medications to prevent medication errors from happening in the first place. However, we also recognize the need for procedures to immediately identify, report and correct any errors that may occur.

2. Purpose of policy

The purpose of this Policy is provide for the appropriate identification, documentation, and assessment of medication errors, as well as for the education, and systems improvements necessary to minimize and respond effectively to medication errors committed by XYZ Medical Group personnel.

3. Definitions

For purposes of this Policy:

Medication error: Means 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, which may include a mistake in any step of the medication management process or system (e.g., selecting, prescribing, administering or monitoring), regardless of the causes, and regardless of whether or not the error reaches the patient. (Note: This definition relates to this Policy and is not intended as a legal definition of the term “medication error.”)

Medication administration record: Means any and all forms of record used to document the administration of medications.

4. Patients’ medications “rights” policy

All XYZ Medical Group personnel shall seek to properly prescribe, dispense and administer medications in accordance with the XYZ Medical Group medications policies and procedures, and the provisions on patient “Rights,” namely:

- Right patient;
- Right medication;
- Right dose;
- Right time;
- Right route/administration technique; and
- Right monitoring.

5. Reporting of medications errors

a) Incident reporting: All errors or events associated with the medication system or a step in the medication process must be reported using an XYZ Medical Group Incident Report form regardless of whether the error actually reaches the patient.

b) Notifying physician/prescriber: Physicians or the appropriate prescriber must be notified as soon as reasonable of medication errors that reach the patient when the errors:

- Are deemed to be clinically significant; and/or
- Involve medications that are not administered as ordered. Examples:
 - i. Wrong dose;
 - ii. Wrong route;
 - iii. Omitted dose;
 - iv. Extra dose;
 - v. Medications ordered to be given STAT/NOW that are given late; and
 - vi. Medications not given at the ordered time interval.

c) Documenting physician/prescriber notification: Physician/prescriber notification must be documented in the medical record using the appropriate note. For medications ordered as routine that are given late, communication with the physician/prescriber must occur via documentation on the medication administration record. The physician/prescriber should be notified as above in the event that late administration is deemed clinically significant.

d) Online reporting: Medication errors must also be reported using the XYZ Medical sGroup online Incident Reporting System and managed according to the XYZ Medical Group Administrative Incident Reporting Policy.

e) Trend reports: The individual in charge of Quality Assurance for XYZ Medical Group will generate:

- Quarterly trended reports for physicians and department heads;
- Semiannual reports and analysis for the XYZ Medical Group safety committee; and
- Yearly reports and analysis for the XYZ Medical Group Performance Improvement Committee.

6. Incident reporting procedure

a) Incident reporting: The individual who makes or discovers the medication error must complete and submit a report using the online incident report form listing the following information:

- Name of the medication involved;
- Type of error, e.g., extra dose, improper dose/quantity, omission, wrong administration technique, etc.;
- Indication of where in the medication process the initial error occurred, e.g., prescribing, transcribing, dispensing, administering, or monitoring; and
- Possible causes of error, i.e., the primary or root cause.

