Reporting of Medication Errors and Near Miss Policy

Reviewed Date		**Number**	LG0103
Revised Date	*August 29, 2018*	**Approved Date**	July 24, 2007

Introduction

The Simcoe Muskoka District Health Unit requires the reporting of medication errors to improve the safety of the medication processes. Staff are required to participate in the detection and reporting of medication errors as well as identifying system causes of errors, and the implementation of changes that reduce or eliminate the likelihood of errors. Any staff member who identifies a medication error or potential error (near miss) will follow the procedures as outlined.

Purpose

Medication errors often reflect a problem with the medication system (prescribing, procedures, dispensing and administering), and may cross professional boundaries and programs. Patient safety research indicates that a supportive, non-punitive, inter-professional approach that focuses on why a medication error occurred leads to error prevention.

Legislative Authority

Health Promotion and Protection Act

Regulated Health Professions Act (1991)

College of Nurses – Practice Standard: Medication (Revised 2017)

Simcoe Muskoka District Health Unit Policy (2010) LG0104 Delegation of Controlled Acts

Simcoe Muskoka District Health Unit Policy (2010) GEN0105 Directives/Standing Orders

Policy Definitions and Interpretation

Medication Error: Any preventable event that may cause or lead to 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. Some medication errors occur when a medication is administered unnecessarily that may or may not harm the client such as vaccine.

Medication errors can be further classified into errors of commission i.e. prescribing or administering the wrong medication or wrong dose of medication and errors of omission i.e. not administering an ordered medication

***Near Miss*:** a potential error where the error does not reach the client, but had it, client harm could have resulted.

***Immunizing agent*:** a vaccine or combination of vaccines administered for immunization against a disease specified in regulations.

Product Failure: a manufacturing error in which the medication is the wrong strength, includes contaminants or adulterants.

Policy

Staff are required to participate in the detection and reporting of medication errors as well as identifying the system causes of errors, and the implementation of system changes to reduce the likelihood of errors. Any staff member who identifies the error and/or is responsible for the medication error will follow the procedures as outlined.

Medication Errors and near miss incidents will be managed and reported following the procedures outlined in this policy including completion of the *Medication Reporting Form for Errors and Near Misses* by the individual involved in the medication error or near miss or another staff reporting the medication error or near miss

Procedures

1. Upon identification of a medication error or near miss, the staff member who identifies it and/or is responsible for the medication error or near miss will complete the *Medication Reporting Form for Errors and Near Misses* Sections A, B and C as soon as possible after identification of the medication error or near miss.
2. Where a medication error has occurred that reaches the client, the incident is considered urgent and must be immediately reported to the employee's manager so that consultation can occur. Potential client outcomes that occur with a medication error or a near miss are:
    a. An incident occurred but the incident did not reach the client (i.e. near miss).
    b. An incident occurred that did reach the client but did not cause harm.
    c. An incident occurred that did reach the client and monitoring was required to confirm that it resulted in no harm to the client and/or required intervention to preclude harm.
    d. An incident occurred that may have contributed to or resulted in temporary harm to the client and required intervention.
    e. An incident occurred that may have contributed to or resulted in temporary harm to the client and required initial or prolonged hospitalization.
    f. An incident occurred that may have contributed to or resulted in permanent client harm.
    g. An incident occurred that required intervention necessary to sustain life.

    Where an incident has reached a client, the manager will consult with the department Director the AMOH/MOH, and or Leadership Designate as per Section D of the *Medication Reporting Form for Errors and Near Misses.*

    The *Medication Reporting Form for Errors and Near Misses* will be completed within 24 hours of the medication error or near miss by the individual involved in the incident. If that individual is not available, the medication error or near miss will be reported to the manager and the *Medication Reporting Form for Errors and Near Misses* will be completed by the staff member that identified the medication error or near miss.

3. The Department will maintain information about medication errors and near miss incidents to ensure quality assessments and improvement of processes are implemented appropriately. Completed *Medication Reporting Form for Errors and Near Misses* will be retained by the department for quality improvement purposes and follow agency policies for record retention.
4. If system or practice improvements are required based on a medication error or near miss, the manager will ensure staff education occurs and is appropriate and that related changes to program, department or agency policy is implemented.

Related Policies

Related Forms

LG0103(F1)

Final Approval Signature: _____

Review/Revision History:

September 2010 Policy re-numbered, previous number B9.010

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