RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

POLICY AND PROCEDURE MANUAL
PHARMACY SERVICES

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SECTION: **PERSONNEL RELATED POLICIES**

SUBJECT: **QUALITY ASSURANCE PROGRAM - PHARMACY MEDICATION DISPENSING ERRORS REPORTING**

POLICY

Medication dispensing errors, defined as "...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." are to be reported to the primary physician, when available, or in her/his absence the service physician on call, as well as the pharmacist-in-charge or a pharmacy manager, and patient or care giver as applicable. The Pharmacy Manager/designee at his discretion will contact the hospital administrator as applicable. An entry of the medication administered and (if applicable) any adverse consequence as the result of drug administration is properly documented on the Facility Event Notification form. Event Notifications are reviewed monthly and quarterly by the P & T Committee. Technologic innovations which assist in the minimization of medication dispensing errors are ongoing.

PROCEDURES

1. All drug dispensing errors shall be reported immediately to the patient, care giver, pharmacy supervisor or pharmacist-in-charge as applicable.

2. The pharmacy supervisor, pharmacist-in-charge, or involved pharmacist shall contact prescriber immediately. (The hospital administrator may be contacted by the pharmacy manager if in the latter's professional judgment the breadth of the error requires notification at that level).

3. The supervising pharmacist or pharmacy director will assist the pharmacist who made the error in filling out an entry electronically into the UHC Safety Intelligence found on Rancho's intranet. No copies are to be made of the form.

4. An interview is to occur between the pharmacy personnel responsible for the error *and the area pharmacy manager*, in order to determine if a systems-related problem led to the error. The medication error investigation will be initiated no later than two business days from the date the medication error is discovered. Documentation via an "essential cause examination" shall include at least the following:

   a. The date of, location, and participants in the quality assurance review conducted
   b. The record of the facts relating to the medication error
   c. The essential cause examination

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d. The findings and determinations

e. Changes to pharmacy policy/procedures (if any)

f. Activities undertaken with the patient or other healthcare providers to mitigate the error

5. The Facility Risk Manager may perform a follow-up interview as required.

6. The patient's physician shall be responsible for documentation of medication errors into the patient's medical record.

7. To minimize errors, all pharmacy personnel shall:

a. Question prescribers who use abbreviations and chemical symbols **not** approved by the Medical Records Committee on their prescriptions.
b. **Not** fill prescriptions without clarification where there is no use of the leading decimal point (e.g., .25 mg shall be written as 0.25 mg).
c. Use the double check system at all times.

8. *All "near miss" interventions by pharmacists, those where potential errors were intercepted in advance of the patient's receiving the medications, will be entered into Cerner and reported to the P & T Committee on a monthly basis.*

9. The institution of computerized information system programs are ongoing in minimizing the occurrence of legibility errors.