LAC+USC MEDICAL CENTER
DEPARTMENT OF NURSING SERVICES POLICY

Subject: **MEDICATION ERRORS**	Original Issue Date: 08/91	Policy # **930**
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Departments Consulted:	Reviewed & Approved by:	Approved by:
Pharmacy	Professional Practice Committee Pharmacy & Therapeutics Nurse Executive Committee Attending Staff Association Executive Committee	(signature on file) Nancy Blake Chief Nursing Officer

PURPOSE

To describe the guidelines utilized for reporting medication errors.

POLICY

The LAC+USC Medical Center has an established means of reporting medication errors. All medication errors shall be reported. Medication errors are reviewed and trended to identify opportunities for preventing/minimizing these events.

A medication error is a violation of the eight (8) rights:

- Right medicine
- Right patient
- Right time
- Right route
- Right dose
- Right reason
- Right response
- Right documentation

The National Coordinating Council for Medication Error Reporting and Prevention defines a medication error 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.

PROCEDURE

Medication error categories:

Safety Intelligence (SI) Categories	Pharmacy Categories
No Harm	
Category 1: Unsafe condition	Category A: Circumstances or events that have the capacity to cause an error
Category 2: Near miss (requires selection of one of the following) • Fail-safe designed into process and/or a safeguard worked effectively • Practitioner or staff who made the error noticed and recovered from the error (avoiding any possibility the event reaching the patient • Spontaneous action by a practitioner or staff member (other than person making the error) prevented the event from reaching the patient • Action by the patient or patient's family member prevented the event from reaching the patient • Other • Unknown	Category B: An error occurred, but the medication was not administered
Category 3: No harm evident, physical or otherwise. Event reached patient, but no harm evident. Category 4: Emotional distress or inconvenience. Event reached patient; mild and transient anxiety or pain or physical discomfort, but without the need for additional treatment other than monitoring (such as by observation; physical examination, laboratory testing, including phlebotomy; and/or imaging studies). Distress/inconvenience since discovery and/or expected in future as a direct result of event.	Category C: An error occurred where medication was administered to the patient, but did not cause patient harm
Category 5: Additional treatment. Injury limited to additional intervention during admission or encounter and/or increased length of stay, but no other injury. Treatment since discovery and/or expected in future as a direct result of event.	Category D: An error occurred that resulted in the need for increased patient monitoring, but did not cause patient harm

Physical Harm	
Category 6: Temporary harm. Bodily or psychological injury, but likely not permanent. Prognosis at time of assessment.	Category E: An error occurred that resulted in the need for treatment or intervention and caused temporary patient harm Category F: An error occurred that resulted in initial or prolonged hospitalization and caused temporary harm
Category 7: Permanent harm. Lifelong bodily, or psychological injury or increased susceptibility to disease. Prognosis at time of assessment.	Category G: An error occurred that resulted in permanent patient harm
Category 8: Severe permanent harm. Severe lifelong bodily or physiological or disfigurement that interferes significantly with functional ability or quality of life. Prognosis at time of assessment	Category H: An error occurred that resulted in a near-death event (Anaphylaxis, cardiac arrest
Category 9: Death. Dead at time of assessment	Category I: An error occurred that resulted in a patient death

When a medication error occurs the person discovering/identifying the error will:

- Complete event notification report in SI
- Notify the provider, nurse manager/supervisor
- For Category **7-9**, Notify Risk Management in addition to provider and nurse manager/supervisor

Events are reviewed and the responsible manager initiates follow-up within 14 calendar days following submission of the event into SI.

Documentation

Documents in accordance with documentation standards.
Documentation on the medical record shall include name of drug, dosage, route, effects of error and provider notification.

Pharmacy is available for consultation on request and will complete analysis and trending.

REFERENCES

Pharmacy Department Policy and Procedure Manual
Joint Commission National Patient Safety Goal #1 “Improve the accuracy of patient identification”

REVISION DATES

92, 93, 94, 95, 96, 98, 04/00, 12/01, 03/02, 08/03, 12/03, 06/04, 02/08, 09/08, 05/16, 10/20, 04/23