SUBJECT: **MEDICATION ERROR AND NEAR MISS REPORTING**

Policy No.: A210
Effective Date: 1999

Policy Statement: To provide a mechanism for care providers to report medication errors. The information obtained will be analyzed for education and quality or process improvement.

Purpose: To ensure prompt reporting and documentation of medication errors.

Physician's Order Required: No

Performed By: RN, LVN, Affiliated Nursing Students, Providers.

Definitions:

A. Medication error is a mistake in administering medications that can include but is not limited to:
   A. Wrong dosage
   B. Calculation error
   C. Exceeding maximum dose
   D. Wrong route
   E. Wrong medication
   F. Medication omitted
   G. Incorrect time
   H. Wrong person

B. A near miss (or "close call" or "good catch") is a patient safety event that did not reach the patient.

Procedural Steps:

1. Upon discovering a medication error, immediately notify treating physician.

   Key point: The treating physician is responsible for communicating unanticipated outcome of any treatment, procedure, or diagnostic test to the patient or legally authorized representative. (see policy B704- Event Reporting)

2. Errors must be reported immediately to the Nurse Manager or the Administrative Nursing Supervisor upon recognition of the error by whomever discovers the error.
3. The nurse who discovers the error will initiate and complete the event notification reporting process.

4. If the error is serious/critical or caused/contributed to patient's death or permanent disability, notify Nurse Manager, Administrative Nursing Supervisor, other nursing leadership, and Administrator on Duty (AOD).

5. Nurse Manager / ANS involved should contact Risk Management and Chief Nursing Officer/ designee immediately.
   A. During Monday-Friday business hours, notify Risk Management at x57842 or x57475.
   B. During evenings, nights, weekends, or holidays, Risk Management should be consulted by ANS in duty.
   C. Before the shift ends, ensure that that medical records documentation is complete and enter an online event report.
6. The nurse will document the following information in the electronic health record of the patient:
   - name of the medication
   - administration time
   - the dosage
   - the route given

- the condition of patient
- the provider notification of the patient's response.

7. The Nurse Manager/designee is responsible for a full investigation of the incident, completion of the Manager's review, in the event reporting system and the action plan in collaboration with the risk management within 5 business days.

Nursing Student Affiliating at Rancho

1. Errors made by nursing students affiliating at Rancho will be reported in the same manner as outlined above.
2. The Nurse Manager/designee will:
   A. Notify the instructor/student if they were not involved in the reporting.
   B. Notify the coordinator of affiliating schools in the Clinical Professional Development (CPD) Department.

Reviewed by: Myla Maranan, MSN, RN, CNML; Deepa Kannampuzha, MSN, RN, CRRN, NE-BC

References:

California Code of Regulations Title 22, section 5 Article 72313, 73313

Joint Commission - Standards: MM07.01.03, PI 01.01.01
Employee Clinical Risk Management and Patient Safety Handbook 2022
Rancho Policy B704 Event Reporting
Working to Reduce Medication Errors | FDA

1999 – Revised
08/01 – Reviewed
06/05 – Revised
02/06 – Revised
06/10 – Revised
06/13 – Reviewed
09/16 – Reviewed
07/22 – Revised

Attachment – A210A: Types of Medication Errors

Nursing Policy A210 - Attachment A

TYPES OF MEDICATION ERRORS

1. Prescribing error (error resulting from prescribing practice)
   Example: *incorrect drug was prescribed by physician; this is sometimes due to drug names that sound similar*.

2. Omission error (medication administration was omitted)
   Example: *failure to administer dose ordered to patient. Most commonly, this involves the omission of one or multiple doses of a regularly ordered medication.*

3. Wrong time error (medication administered at incorrect time)
   Example: *administration of a medication at a time other than that ordered by the physician, either by specific time or scheduled time (per medication center policies); medication is ordered to be administered at 10:00 a.m., after breakfast, and medication is administered at 2:00 p.m.*

4. Unauthorized drug error (drug administered; no authorized prescription)
   Example: *medication is administered to patient when no valid physician order exists for the particular drug; e.g., duplicate doses, incorrect patient, administration of a drug not ordered.*

5. Improper dose error (dose administered was not correct)
   Example: *quantity or strength is different from that ordered by physician, e.g. 2 mg dose is ordered, and 2 gm is administered.*

6. Wrong dosage form error (incorrect dosage form was administered)
   Example: *administration of a dose in a dosage form other than that ordered by the physician; e.g. medication is ordered intravenously, and oral dosage form is administered to patient.*

7. Wrong drug preparation error (drug was prepared incorrectly)
   Example: *intravenous piggyback is prepared in incorrect diluent, e.g. 5% D/W instead of normal saline; administering drugs that are incompatible.*

8. Wrong administration technique error
   Example: *utilization of improper technique when administering a medication.*

9. Deteriorated-drug error
   Example: *administration/dispensing of a medication that is expired, either by manufacturer expiration date or by expiration date stamped on label when dose is prepared; e.g. administration or dispensing of an outdated drug.*