HIGH DESERT HEALTH SYSTEM

High Desert Health System POLICY AND PROCEDURE

POLICY NUMBER: 334
VERSION: 1

SUBJECT: MEDICATION RECONCILIATION / MEDICATION ERRORS REPORTING / MEDICATION ERROR REDUCTION PLAN (MERP)

MEDICATION RECONCILIATION

PURPOSE: To provide a process whereby the patient's list of current medications is reviewed against a list of medications ordered by the provider while under the care of the organization.

POLICY: All patients will have medications reconciled at each clinic visit.

A complete list of medications is provided to the patient upon discharge from the clinic.

When a patient is referred to another organization for specialty services, the medication list is provided to the next health-care provider.

PROCEDURE:

1. Medications on Entry:

A. During intake, the Medication Reconciliation form must be initiated and all required information must be documented by the following individuals:

1) Primary Care Clinics – Initial visit: Physician or Nurse Practitioner
2) Primary Care Clinics – Follow-up visit: Nursing Attendant (CNA) if a copy of the previous list is available. Otherwise, provider staff.
3) Urgent Care Clinics: Triage Nurse

B. If patient indicates they were hospitalized since their last visit at HDHS, the list of discharge medications should be obtained.

C. The provider will review the list with the patient, when form is completed by nursing staff, to ensure accuracy and completeness, as well as indicate whether the medication(s) is to be continued, discontinued, acknowledged or changed.

2. New Medications Prescribed:

A. During discharge, the provider will document changes to the patient's medications on the Medication Reconciliation form.

B. A copy of the form will be provided to the patient by the discharge nurse.

C. The nurse will instruct the patient to carry the medication reconciliation list with them and provide it to the next provider.

REFERENCES
CAMAC 2007 National Patient Safety Goals: Goal 8

ATTACHMENT:
Medication Reconciliation Form

MEDICATION ERRORS REPORTING

PURPOSE:

To provide guidelines for the hospital-wide reporting of medication errors and establish a systematic approach to monitoring, prevention, reduction and management of medication errors.

POLICY:

1. All health professionals, who either commit or discover medication errors, shall report the error to the Pharmacy Department.

2. Medication error reporting is voluntary.

PROCEDURE:

1. All health professionals (a) who notice circumstances or events that have the capacity to cause error in the use of medication, (b) who experience disagreement with Medical Staff and other Staff dealing with prescribed pharmaceuticals, and C either commit or discover medication errors shall complete a multi-disciplinary medication event tracking tool report (see attached) and send the report to the Pharmacy department.

2. Upon the discovery of a medication error, the health care professional encountering the error must immediately notify the prescriber.

3. When a medication error is reported, the pharmacist will enter the details into the pharmacy database, and will assign a:
   - Type of error
   - System breakdown point within the medication use processes (prescribing, transcription, preparation/dispensing and administration and monitoring)
   - Severity rating

4. For events in categories C to I (see Table on page 2), an additional Event Notification Report must be completed by the Health Professional who reported the error forwarded to the Risk Management Department.

5. Whenever a medication error has reached a patient (as per description in C, D, E, F, G, and H in the Table on page 2), whoever discovers the event shall notify the prescriber. The prescriber will notify the patient and, when appropriate, his/her family when the patient has received care that deviates significantly from an anticipated outcome. The prescriber must take prompt corrective measures as deemed necessary.

6. The Pharmacy Department, on a quarterly basis, will present to the Medication Safety Committee, a summary of all medication error reports, which will include any recommendations for ratification aimed at averting medication errors.

7. The Medication Safety Committee will forward (1) issues regarding safety and risk management to the Patient Safety Committee and (2) recommendations for medication policies and protocols to the Pharmacy and Therapeutics Committee.

DEFINITION AND TYPES OF MEDICATION ERRORS:

Definition:

Medication Errors are those episodes in drug misadventures that should be preventable through effective systems control.

Types of Medication Errors:

Dose omission, improper dose, wrong strength/concentration, wrong drug, wrong dosage form, wrong technique, wrong route of administration, wrong rate, wrong duration, wrong time, wrong patient, monitoring errors.

MEDICATION ERROR REDUCTION PLAN (MERP)

PURPOSE: To provide guidelines to promote safe and effective medication use in the Ambulatory Care Clinics through reduction of preventable medication-related errors and adverse events.

POLICY: High Desert Health System (HDHS) has a system approach to eliminate or substantially reduce medication-related errors. The attached MERP outlines the HDHS plan.

DEFINITIONS:

A medication error is any preventable event occurring in the medication-use process, including prescribing, transcribing, dispensing, using and monitoring, that result in inappropriate medication use or patient harm.

PROCEDURE:

1. Annually, the Pharmacy and Therapeutic committee will review the effectiveness of the MERP and if necessary, will make revisions to the plan.

REFERENCES:

Health and Safety Code Section 1339.63
California Code of Regulations Title 22

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