Department of Pharmacy POLICY AND PROCEDURE

POLICY NUMBER: 895
VERSION: 2

SUBJECT: Pharmacy Quality Assurance Program: Medication Errors

PURPOSE:

The purpose of this policy is to describe outpatient pharmacy staff responsibilities in the discovery of a dispensing incident resulting in a medication error and identifying/reporting a “near miss” incident that may lead to a medication error.

POLICY:

The LA County Department of health services strives to maintain a Safe and Just Culture. Safety shall be an individual and organizational priority, and errors, near misses, and adverse events can be easily reported, and are viewed as an opportunity to learn and improve upon the delivery of care. The Safety Intelligence reporting system is to be utilized at High Desert Regional Health Center by pharmacy staff as a means of reporting these events.

The Pharmacy Quality Assurance Program was established under the requirements of the California State Board of Pharmacy to monitor, prevent, and manage medication errors to determine the cause and appropriate response to improve the quality of pharmacy services.

Dispensing incidents are medication errors resulting in, but not limited to, the following:

- Incorrect drug, strength, or directions for use
- Dispensing a prescription to the wrong patient
- Dispensing of expired or damaged medications
- Overlooked significant drug interactions

Dispensing incidents are to be addressed immediately in a professional manner and are the responsibility of **ALL** pharmacy staff.

These incidents may be a result of unsafe pharmacy practices such as:

- Replenishing original stock bottles with “return to stock” patient vials which were not picked up
- Failure to verify patient identifiers or check NDC # when dispensing prescriptions
- Improper labeling of filled medications or prescription transcribing errors
- Confusion due to look-alike and sound-alike drug names

- Neglect of protocol requiring pharmacist to check high-alert medications and dosing for pediatric prescriptions

DEFINITIONS:

Medication error: any act or omission in the dispensing process that may cause or lead to patient harm. This does **NOT** include acts or omissions that were corrected prior to furnishing the medication to the patient or patient's agent.

Near miss- any mistake or system failure that was identified or resolved before reaching the patient

PROCEDURE:

Dispensing medication errors-

All medication errors committed by the pharmacy must be reported and addressed immediately. Upon detection of a dispensing medication error, all pharmacy staff shall inform the pharmacist on duty.

The **pharmacist on duty** should address the incident by immediately performing the following:

- Research and investigate the alleged incident promptly to verify that a medication error has indeed occurred
    - Verify patient information
    - Validate data entry of prescription on file
    - Identify the product dispensed
- **Contact the patient immediately** to communicate steps required to mitigate the error
    - Determine if ingestion of the medication in question has occurred
    - If yes, determine the length of ingestion and if the patient experienced any adverse effect or reaction
- To ensure patient safety, **retrieve the medication in question** by requesting the patient return the prescription associated with the incident or instructing the pharmacy to retrieve
    - If the patient declines, this should not prevent the pharmacist from correcting the incident at no cost to the patient
- If ingestion did occur or if the dispensing incident resulted in an interruption in therapy, contact the prescribing provider immediately

    - Discuss implications of taking the incorrect medication and communicate directions to mitigate potential impact of the incident
- Fill the correct medication, ensuring the appropriate prescription is dispensed
    - The corrected prescription is to be provided at **no charge to the patient**
    - Provide a new, corrected prescription regardless of cost
    - If the patient is unable to pick up the new prescription, ensure it is delivered
- Complete a **Safety Intelligence report** and report the incident to the pharmacy supervisor or the pharmacist-in-charge
- Follow up with a call to the patient to ensure the patient has no more questions and to ascertain how they are doing if a medication error has indeed reached the patient

The **Pharmacy Supervisor** or **Pharmacist-in-Charge** must perform the following:

- Conduct an investigation of the medication error and complete a **Medication Error Root Cause Analysis and Action Plan** to identify potential improvements and decrease the likelihood of such events in the future
    - An investigation of each medication error must commence no later than two (2) business days from the date the medication error is discovered

The **Pharmacy Director** must perform the following:

- Review the Medication Error Root Cause Analysis and Action Plan and forward the document to the Pharmacy and Therapeutics (P&T) Committee for multidisciplinary review
    - The P&T Committee shall review the medication error and take appropriate action including forwarding issues to the DHS Medication Safety Committee, Quality Council, or other committees and individuals to resolve outstanding issues and prevent the recurrence of the medication error
- Retain a copy of the completed Safety Intelligence report and the “Medication Error Root Cause Analysis and Action Plan” form in the faculty where the error occurred for a period of **no less than one (1) year**.
    - These forms will remain available for potential review by the State Board of Pharmacy

Near miss errors-

It is highly encouraged to document all near-misses or circumstances that may cause or lead to medication errors in the Safety Intelligence system. These near misses are not limited to dispensing events but also prescribing/transcribing/administration events that could reach a patient as a medication error. Pharmacists routinely identify near miss medication ordering errors that might result in harm to patients and put the organization

at liability risk. Documentation will be helpful to determine system failures and to recommend improvements in order to develop a more quality system.

Examples of such “near-miss” incidents that should be reported by pharmacy staff include but are not limited to:

- A dispensing error in which an error is caught by pharmacy staff at the patient “out window” after a prescription has been checked by a pharmacist and marked as complete.

- Prescribing incidents such as use of prohibited abbreviations, incomplete prescription, allergies not checked, and incorrect medication ordered.

- A transcribing error in which a prescription has a different or wrong patient name/blue card stamped on the prescription.

REFERENCES:

California Code of Regulations, Title 16, Section 1711. Quality Assurance Programs.

DHS policy and procedure: Outpatient Pharmacy Quality Assurance Program: Dispensing incidents.

DHS Policy 311.4 Safe and Just Culture

Rite Prescription Program: Handling and Reporting Prescription Incidents, December 2010.

“To Err is Human, Building a Safer Health System,” Institute of Medicine Report,1999

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