Subject:	**MEDICATION ERROR REPORTING**	**Number:**	**5.4**
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Approved:		**Date:**	**7-15-15**

PURPOSE

To establish procedures for reporting medication errors for the purpose of developing quality improvement and risk reduction solutions for systems and processes used within the Public Health clinics.

POLICY

All medication errors shall be reported using the Medication Error Reporting Form and shall be reviewed in accordance with this Policy and Procedure.

REFERENCES

CCR Title 16, Div. 17 California Board of Pharmacy Sec. 1711 Quality Assurance Programs

CCR Title 22, Sections 75027 and 75059

National Coordinating Council for Medication Error Reporting and Prevention, www.nccmerp.org/

DEFINITIONS

Harm: A physical state where a patient required some type of intervention beyond monitoring (see the attached Medication Error Reporting Form table "Category of the Error Based on Harm to the Patient").

Medication Error: A preventable event that may cause or lead to inappropriate medication use or patient harm and that occurs while the medication is in the control of the health care professional or patient. Such events include prescribing; ordering, dispensing, transcription and administration.

Significant Finding: A condition or practice in a clinical setting that produces a high risk that a medication error may occur and there is some possibility of a bad patient outcome as a result.

ATTACHMENTS

Public Health Medication Error Reporting Form

PROCEDURE

I. Actions to be Taken in Addition to Reporting

A. Patient Management
   1. Where a medication error reached a patient (Categories C –I, see Att.1 table "Category of the Error Based on Harm to the Patient") and patient is in the clinic, the patient shall be assessed by clinic staff and monitored, treated or referred as needed.
   2. In the instance that face-to-face patient contact is not possible, the supervising nurse, medical director or clinic management shall communicate with the patient if there is possible patient harm.
   3. If the patient seeks care for monitoring or treatment, the medical director shall also communicate with the patient's treating provider as needed.

B. Notification to Prescriber/Dispenser

All medication errors that reach the patient (Categories C – I, see Att. table "Category of the Error Based on arm to the Patient") shall be reported by staff within 24 hours to the prescribing clinic practitioner and/or dispenser, as appropriate.

II. Reporting

A. Error Identification and Form Completion
The clinic staff or manager who identified a medication error shall work with other clinic staff, managers and/or medical director to complete a Medication Error Reporting Form (Att).

B. Form Submission
The Medication Error Reporting Form shall be forwarded by the clinic staff or manager who identified the error (or other person designated by the clinic manager to do so). The reporter shall forward the form confidentially (via hard copy only) to the PH Quality Assurance Coordinator (or designee) within 72 hours of identifying the error.

C. Types of Medication Errors
The major categories of types of medication errors are:
1. Prescribing errors
2. Ordering errors
3. Dispensing errors
4. Transcription errors
5. Administration errors:

The detailed type(s) of errors under the categories shall be checked on the Medication Error Reporting Form under "Types of Medication Errors".

D. Error Causes, Factors and Actions Taken or to Be Taken to Prevent Errors
The types of error causes, factors or actions shall be checked on the Medication Error Reporting Form if they are known at the time of the submission of the form.

III. Documentation of Events

Only facts of the medication error and any medical treatment rendered shall be recorded in the patient's medical record. The entry in the patient's medical record should not indicate that what is recorded is an error or that a Medication Error Reporting Form was completed.

IV. Review of Medication Errors

A. Review of the Form
1. The PH Quality Assurance Coordinator (or designee), the Deputy Health Officer (or designee) or clinical staff designated by the Chief of Operations shall review all Medication Error Report Forms.
2. The Deputy Health Officer (or designee) may discuss errors with clinic management and the clinic/program medical director.

B. Identification of Any Significant Findings and Action Plan
1. If the error reached the patient and, at a minimum, required monitoring (Categories E-I, See Att), the clinic staff and managers shall investigate the systems and process that relate to the error to identify if there are any significant findings related to the error that need to be addressed.

2. If there is a significant finding(s) that need to be addressed, clinic staff and managers shall formulate and document an action plan to ensure such an error is prevented in the future within 30 days of the date of submission of the Medication Error Report Form.
3. The clinic staff and managers shall inform the clinic manager, division manager and Chief of Operations about the significant findings and action plan and shall provide a summary to the QA Coordinator (or designee).
4. The Deputy Health Officer (or designee) and Chief of Operations may request further investigation or planning if these do not appear to be sufficient.
5. The clinic management may request that the investigation and action planning be conducted under the auspices of the PH Clinical Quality Assurance (QA) Committee to ensure confidentiality and that the proceedings are not subject to legal discovery.