MEDICATION ERRORS

NHPCO Standard(s): CES 4.10, CES 20, PM 4.3

Regulatory Citation(s): COPs 418.58(b)(2)

POLICY

High Peaks Hospice (HPH) staff will report and document all medication errors within 24 hours after discovery.

DEFINITION

A medication error is a violation of the “5 RIGHTS” of medication preparation and administration.

The “5 RIGHTS” are as follows:

1. Right Patient (includes verification of any drug or food allergies or sensitivities)
2. Right Medication (includes drug/drug, and food/drug interactions)
3. Right Dosage (includes proper dilution, solution mixture)
4. Right Route of Administration
5. Right Time of Administration.

PROCEDURES

1. All HPH Clinical staff will be instructed regarding the use of the “5 RIGHTS” listed above.

2. All medication errors are reported as soon as possible to the attending physician, the Patient Care Coordinator (PCC) and Executive Director (ED).
   A. A medication error resulting in a major drug reaction will be reported immediately to the attending physician and the ED. (Refer to Clinical policy “Medication Reactions CP240”.
   B. All medication errors resulting in intermediate or major drug reactions are documented on a “Medication Incident Report” form within 24 hours of occurrence.

2. All medication errors are documented in the patient medical record. The following information is included:
   A. Date and time the error occurred.
   B. Name, dose, and route of medication given or not given.
   C. Specific objective description of the medication error.
D. Nursing assessment of the patient following the medication error.
E. Description of nursing intervention of the patient in response to the error.
F. Date and time physician was notified of the error.
G. Changes in physician’s orders as a result of the error.
H. On-going nursing assessment and intervention as necessary.

3. The completed “Medication Incident Report” form is submitted to the PCC for signature within 24 hours of occurrence/notification.

4. The PCC discusses the medication error with the relevant staff members.

5. Reports are forwarded to the Quality Assurance (QA) Coordinator for review and recording.
   a. Medication errors are reviewed and analyzed by the QA Coordinator to identify any trends and recommend preventative measures.
   b. The incidents are reported on the quarterly QA Report.

LAST REVIEW DATE:  IDT 10/04/17, Clinical Comm 02/13/18, BOD 03/26/18

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BOARD APPROVAL:  May 8, 2018