Name of Policy:	**Medication Occurrences**
Policy Number:	3364-133-53
Department:	Pharmacy
Approving Officer:	Senior Hospital Administrator
Responsible Agent:	Director of Pharmacy
Scope:	University of Toledo Medical Center

THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Effective Date: 6/1/2023

Initial Effective Date: 8/10/2004

_____ New policy proposal
_____ Major revision of existing policy
__x__ Minor/technical revision of existing policy
_____ Reaffirmation of existing policy

(A) Principle statement and purpose of policy

All medication errors and near misses will be documented, reported, investigated, and appropriate measures will be instituted. The purpose of this policy is to establish uniform definitions for medication errors and near misses and to describe the institutional process whereby medication errors will be detected, documented, and followed up with to prevent future medication errors.

(B) Scope: University of Toledo Medical Center Inpatient Main Facility

(C) Definitions

Under the scope of this policy, the following will be documented and resolved through mechanisms to described hereafter in this policy.

(a) Medication Error: any error occurring in the medication use process[1]

(i) Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional or patient

(ii) Medication errors may be related to: professional practice, health care products, procedures, and systems including: prescribing; order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use

(b) Near Miss: In the context of this medication policy, a near miss refers to a medication error that occurred, but was captured and did not reach the patient.[2]

(D) Categories of Medication Errors

Medication errors may occur at any point or at any point in the continuum of the medication use process. Medication errors can be multidisciplinary and multifactorial.

(1) Prescribing Error

(a) Prescribing errors include, but are not limited to: inappropriate medication, dose, frequency, formulation, route, therapy duration selected; illegible order; duplicate order; incorrect patient/chart selected; contraindications; miscommunication of verbal order; drug interaction or alert information (including allergies and/or adverse reactions) inappropriately bypassed; use of unapproved nomenclature or abbreviations used in orders

(2)Transcription Error

(a) Transcription errors may occur through miscommunication, which cold include telephone and verbal orders, of a medication order from a prescriber to agent(s).
(b) Transcription errors may occur through the medication order entry process from the physician based electronic or paper order entry to the pharmacy based medication electronic or paper system. Examples of this type of transcription error include, but are not limited to: entering a different drug, dosage form, route, frequency, product, duration, start time, than intended by the ordering prescriber

(3) Product Labeling, Packaging, and Nomenclature Error

(a) Medication errors involving this category include, but are not limited to: inappropriate or misleading labeling, failure to use institution approved medication safety auxiliary labels, misidentification of look-alike/sound-alike medications, improper protection of hazardous materials

(4)Compounding Error

(a) Compounding errors include, but are not limited to: unsterile procedure and/or reagents utilized; physical and/or chemical incompatibilities, including precipitation; using incorrect or expired components; inappropriate quantities or proportions of components

(5)Dispensing Error

(a) Dispensing errors include, but are not limited to: dispensing the wrong medication, dosage form, dose; medication that is contraindicated; medication that interacts with another; medication to which the patient is allergic

(6)Distribution Error

(a) Distribution errors include, but are not limited to: Acudose refill error; delay in medication delivery; cartfill or first dose error

(7)Administration Error

(a) Administration errors include, but are not limited to: wrong patient, dose, time, medication, route, route; inappropriate omission of medication; unauthorized dose given; automated pump not programmed properly; inappropriate override of guardrails; incorrect documentation of wastage; missed dose given; extra dose administered; inappropriately bypassing patient's five rights before administering a medication (see Administration of Medications, Nursing Policy Number 3364-110-05-03)

(8)Storage Error

(a) Storage errors include, but are not limited to: failure to store medication according to the drug manufacturer's information and in the medical literature; temperature

excursions that compromise the stability and/or composition of a drug product; improper safeguards to prevent access to medications by unauthorized persons

(b) Storage errors may also occur through the inappropriate physical placement and location of a medication that may pose a safety risk of selecting an incorrect drug product. An example of this type of storage error is the adjacent placement of look-alike/sound-alike medications without proper signage and/or barriers to aid the user in selecting the appropriate drug product.

(E) Identification and Reporting of Medication Errors

(1) The individual who discovers the medication error will take one of the following actions prospectively:
   (a) Directly contact the attending physician if the medication error has reached the patient or if further action from a physician is needed to prevent future harm.

(2) Additionally, the individual who discovers the medication error or an appropriate pharmacy designee will complete a Patient Safety Net (PSN) report, describing in detail the occurrence.
   (a) Medication errors will be reviewed through a multidisciplinary review process.

(3) In the event of a near miss, after confirming that the error did not reach the patient, the identifying individual will file a report of the incident through Patient Safety Net (PSN).

(4) Reports of medication errors will be forwarded to the pharmacy management team, safety control technician, or medication safety officer.

(5) Medication errors will be internally reported to: location manager as designated in Patient Safety Net (PSN), the attending physician if applicable, institutional quality management personnel, safety control technician and/or medication safety officer, and pharmacy administrators if applicable.

(6) Medication errors are also internally reported to the institutional Pharmacy and Therapeutics committee on a routine basis.

(7) Medication errors will be externally reported through Patient Safety Net (PSN) to the University Health System Consortium (UHC), a national alliance of academic medical centers and their affiliated hospitals.

(F) Resolution of Medication Errors

(1) Medication error data is utilized to improve medication safety through the institution’s performance improvement process.

(2) A multidisciplinary team of health care practitioners and quality management professionals in quality assessment and performance improvement organization will be alerted to act upon medication errors through Patient Safety Net (PSN).
   (a) Medication errors will also be evaluated by safety control technician and/or medication safety officer.

(b) Consults for thorough analysis of the medication error will be referred through Patient Safety Net (PSN).

(3) If applicable, a root cause analysis of potential causes of the medication error will be commenced for prevention of subsequent medication errors.
(4) As feedback, a non-punitive e-mail correspondence is sent to prescribers directly involved and supervisors on service at the time of the medication occurrence.

Approved by:		**Review/Revision Date:**
		1/31/08
		6/21/2011
/s/	05/23/2023	10/1/2011
Lindsey Eitniear, PharmD, BCPS, AAHIVP	Date	10/24/2012
Director of Pharmacy		9/1/2014
		5/1/2017
		2/20/2020
/s/	05/24/2023	
Russell Smith, Pharm D, MBA, BCPS, CPEL	Date	
Senior Hospital Administrator		
Review/Revision Completed By:		
Pharmacy		
		Next Review Date: 6/1/2026
Policies Superseded by This Policy:		