HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER MATERNITY AND CHILDREN HOSPITAL

Department:	Pharmaceutical Care Department		
Document:	Multidisciplinary Policy and Procedure (MPP)		
Title:	Medication Errors Reporting		
Applies To:	Pharmacists, Physicians & Nurses		
Preparation Date:	December 15, 2024	**Index No:**	MM-MPP-016
Approval Date:	December 29, 2024	**Version:**	6
Effective Date:	January 29, 2025	**Replacement No.:**	MM-MPP-016 (5)
Review Date:	January 29, 2028	**No. of Pages:**	04

1. PURPOSE:

1.1 To outline the process for monitoring, identifying and reporting Medication Errors, and initiating appropriate corrective measures.

1.2 To prevent and/or control potential and actual medication errors in order to enhance patient care, improve patient safety, and decrease liability and hospital cost.

2. DEFINITIONS:

2.1 **Medication Error** – any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer. Such events may be related to professional practice, healthcare products, procedures and systems, including prescribing, order communication, product labelling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.

2.2 **Significant Medication Error** – any medication error that if not prevented may cause significant harm to the patient (i.e. permanent harm or death).

2.3 **Near Miss** – an error that has the potential to cause an adverse event (patient harm) but fails to do so because of chance or because it is intercepted

2.4 **Hazardous Situation** – any condition which may lead to a medication error such as confusion over look alike/sound-alike drugs or similar packaging or using prohibited abbreviations.

2.5 **Adverse Event** – an unanticipated, undesirable, or potentially dangerous occurrence in a healthcare organization.

2.6 **Narrow Therapeutic Index Drug** – any pharmaceutical which has a < 2-fold difference between the minimum toxic concentration and minimum effective concentration in the blood.

2.7 **Look – Alike and Sound – Alike Medications** – Look-Alike/Sound-Alike (LASA) medications involve medications that are visually similar in physical appearance or packaging and names of medications that have spelling similarities and/or similar phonetics.

3. POLICY:

3.1 The Pharmacy Department has an effective and consistent policy on how to handle medication errors, give appropriate instructions and precautions on how to identify, report, intervene, and analyse medication errors, and have a system in place for monitoring, and preventing future incidences.

3.2 Medication error reporting is an anonymous, non-punitive and strongly encouraged process.

3.3 To adhere with Maternity and Children Hospital, Hafer Al Batin policies and procedures in avoiding/ minimizing medication error.

3.4 Medications errors, shall be documented in the patient's medical record.

4. PROCEDURE:

4.1 For all discovered medication errors, the treating physician should be notified directly after discovering the medication error. And, Medication Error Report should be completed and forwarded after all necessary information has been gathered to the Pharmacy Department 24- 48 hours.

4.2 Pharmacy Department will submit the Medication Error report to the Medication Safety Officer directly after receiving the medication error report from the discovering department.

4.3 A thorough action is done accordingly for the avoidance of future incidence. The reasons for errors may be due to Doctors ineligible hand writing, Nurses drug handling, faulty dispensing by Pharmacy staff or any other reasons.

4.4 Medication errors could occur during any of the five stages of medication use process (Each of them could be considered as "Error Prone"). These processes are:

- 4.4.1 Physician ordering.
- 4.4.2 Transcribing and verifying/ preparing physician orders
- 4.4.3 Dispensing and delivering medications.
- 4.4.4 Medication administration.
- 4.4.5 Monitoring and reporting of medication effects on the patient.

4.5 The following members of the healthcare service can make medication errors: (Physicians, Pharmacists, Nurses, Patients, Any other member of the healthcare team)

4.6 Steps to Be Followed When a Medication Error is Discovered:

- 4.6.1 Any staff member who discovers a medication error whether it's a (physician, pharmacist, or a nurse, etc.). Medication Error Report Form should be completed and submitted to pharmacy department within the time limit.
- 4.6.2 Occurrence Variance Incident Report (OVR) should filled and combined with Medication Error Report Form for significant and potentially significant errors
- 4.6.3 This staff member must then verbally report to the direct supervisor (e.g. Head Pharmacist, Incharge Nurse and Attending Physician).
- 4.6.4 The physician will assess the patient.
- 4.6.5 Monitor the vital signs and report any abnormalities to the physician.
- 4.6.6 If any adverse reaction has occurred, refer to adverse drug reaction policy and procedure.
- 4.6.7 Continue patient monitoring.
- 4.6.8 Medication error (Significant & potentially Significant medication errors) are documented in patient medical record.
- 4.6.9 The Medication Safety Officer need to complete the medication error from such as assess the severity of incident, conduct Root Cause Analysis (RCA) if need (for all significant or potentially significant medication errors) and suggest recommendation to reduce reoccurrence the error.
- 4.6.10 The Medication Safety Officer need to inform the Pharmaceutical Care General Department by complete the electronic report form through the following link: **https://www.surveymonkey.com/r/535PYDY**.
- 4.6.11 Medication Safety officer in the hospital need to review all the medication errors and to take the Required action to avoid occurring similar errors in the future.
- 4.6.12 Forward to Quality Management and Patient Safety (QM & PS) department in the hospital.
- 4.6.13 All medication errors need to audit and analysis frequently (Monthly or quarterly), investigate the contributing factors and make action plan to enhance the medication safety.

4.7 Guidelines to Prevent Medication Errors:

- 4.7.1 Guidelines for Prescribers:
  - 4.7.1.1 Prescribers should write a complete, clear, unambiguous order that must include drug name, dosage form, strength, dose, route, and frequency or rate of medication administration.
  - 4.7.1.2 Prescribers should use exact metric weight not the apothecial weight of the dosage form prescribed (or concentration in case a liquid is prescribed).
  - 4.7.1.3 They should not use vague instructions (i.e. take as directed) or prohibited abbreviations, instead more specific drug instructions should be given.
  - 4.7.1.4 They should not use abbreviated or unofficial drug names.

4.7.1.5 A zero should always precede a decimal point for doses less than 1 mg (Leading ZERO) but should never follow a decimal point for doses larger than 1 mg (Trailing ZERO). Not following this can lead to a 10-fold overdose.
4.7.1.6 Write the indication for PRN doses (e.g. PRN for pain or fever / analgesic or antipyretic).
4.7.1.7 Avoid illegible handwriting.
4.7.1.8 Minimize Telephone and Verbal Orders.
4.7.1.9 Document drug allergies.
4.7.1.10 Monitor patients on Narrow Therapeutic Index drugs.
4.7.1.11 Prescribers should not write "U" after an insulin dose. It can be interpreted as a zero, or 4 or cc's, causing deadly
4.7.1.12 Write the scientific name of drugs not the trade names on prescriptions.

4.7.2 Guidelines for Pharmacists:

4.7.2.1 Enforce double-checking.
4.7.2.2 Standardize medication administration time.
4.7.2.3 Label medications properly.
4.7.2.4 Use auxiliary labels.
4.7.2.5 Increase awareness and Highlight Look-Alike Sound-Alike "LASA" medications and label them with Blue Stickers.
4.7.2.6 Do not confuse neonates, paediatric doses with adult doses.
4.7.2.7 Minimize floor stock medications.
4.7.2.8 Enforce monthly inspection.
4.7.2.9 Highlight High-Alert Medications and label them with Red Stickers. Take extra care while dispensing them.
4.7.2.10 Ensure proper storage of dispensed medications.
4.7.2.11 Educate staff on the process and importance of medication error reporting.

4.7.3 Guidelines for Nurses:

4.7.3.1 Confirm patients' identity (by patient's 4 names for the Saudi and complete name for the Non - Saudi and Medical Record Number) use the seven (7) rights rule.
4.7.3.2 Independent double check for High Alert Medication.
4.7.3.3 Check the identity and integrity of dispensed medications.
4.7.3.4 Compare used medications with the physician's order and the medication sheet.
4.7.3.5 Verify an unusual dose or volume with a pharmacist.
4.7.3.6 Use standard administration time.
4.7.3.7 Always double-check your calculations.
4.7.3.8 Document any administered drugs.
4.7.3.9 Double check action rates of critical and high-risk medications.
4.7.3.10 Label all prepared syringes with the drug name and total dose,
4.7.3.11 Never use any product that's not labelled.
4.7.3.12 For safety, ask the pharmacist if it's OK to crush the drug.
4.7.3.13 Use aseptic techniques when preparing medications.

4.8 The reported data is utilized to improve the medication use process, prevent medication errors, and improve patient safety using all tools available.
4.9 The Medication Safety Officer will provide feedback and education to healthcare professionals on reported medication errors, near misses, and hazardous situations.
4.10 The Hospital will report sentinel events related to serious medication errors to the relevant authorities.

5. MATERIAL AND EQUIPMENT:

5.1 Occurrence Variance Report (OVR)
5.2 List of prohibited abbreviations
5.3 Occurrence Variance Report (OVR)
5.4 Medication Error Report Form

6. RESPONSIBILITIES:

6.1 Physician
6.2 Clinical Pharmacist
6.3 Nurses

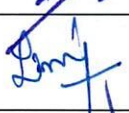
7. APPENDICES:

7.1 N/A

8. REFERENCES:

8.1 Policies &. Procedures Manuals, General Pharmaceutical Care administration, MOH, KSA.

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ph. Reem Al Dhafeeri	Medication Safety Officer		December 15, 2024
Reviewed by:	Ph. Mohamed Al Mutairi	Pharmacy QI Facilitator		December 16 2024
Reviewed by:	Ph. Mutlaq Al Dhafeeri	Pharmaceutical Care Director		December 17, 2024
Reviewed by:	Mr. Sabah Turayhib Al Harbi	Nursing Director		December 18, 2024
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		December 19, 2024
Reviewed by:	Mr. Abdulelah Ayed Al Mutairi	QM & PS Director		December 22, 2024
Reviewed by:	Mr. Fahad Hazam Alshammari	Hospital Director		December 29, 2024