مؤسسة مستشفى سرطان الأطفال-مصر Children's Cancer Hospital Foundation - Egypt 57357	Policy Name: **Medication Error Reporting and Follow-up**		
Prepared By: إعداد:	Dr. Mohammed Nagy– Pharmacy Director Dr. Salwa Sayed – Section Head decision support	**Document Code: IPP-PSSD-016**	
		Issue Date:	01.09.2015
Reviewed By: مراجعة:	Dr. Hend Alsayed- Senior supervisor pharmacy	**Issue No.:**	04
		No# of Pages:	04
CPID Director: مدير ادارة تحسين الاداء المستمر:	Dr. Shaimaa El-Meniawy – CPID Director	**Review Date:**	01.01.2023
		Next Review Date	31.12.2025
Approved By: موافقة:	Dr Moataz Elzemaity – CMO	**No# of Copies:**	01-DMS 01-Depart.
Authorization By: إقرار:	Dr. Sherif Abouelnaga – CEO 57357 Group	**Department:** **Pharmaceutical Service and Science**	

1.0 Change of policy

1.1 No changes

2.0 Purpose

2.1 To describe the procedures for reporting a medication error and the mechanism for multi-disciplinary review to allow appropriate follow-up and implementation of change to prevent future medication errors

3.0 Policy

3.1 Policy statement:

3.1.1 It is the policy of CCHE to prevent, detect and report medication errors through a collaborative work of all healthcare providers in the hospital.

3.2 Scope:

3.2.1 Any adverse event occurs at any patient care areas in the hospital.

3.3 Responsibilities

3.3.1 Medical director

3.3.2 Nursing director

3.3.3 Director of pharmaceutical services

3.3.4 Related healthcare staff

3.3.5 Patient safety committee

4.0 Definitions /abbreviations:

4.1 **CCHE:** Children Cancer Hospital – 57357 Egypt

4.2 **CPID:** Continuous Performance Improvement Department

4.3 **DPS:** Department of Pharmaceutical Services

4.4 **MMU:** Medication Management & Use

4.5 **MMS:** Medication Management & Safety

4.6 **Medication Error:** A medication error is 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, patient or consumer. Such events 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.

4.7 **Near miss medication error:** Any process variation that did not affect an outcome (occurrence prevented before taking place) but for which a recurrence carries a significant chance of an adverse outcome (incident).

4.8 **Significant Medication Errors:** Medication errors categories: F, G, H, I.

5.0 Procedure:

5.1 **Medication errors are categorized along each functional step of the medication cycle: ordering, transcription, preparation and dispensing, administration, monitoring**

5.1.1 **Order Error:** Types of ordering errors include: inappropriate medication selected, inappropriate dose, illegible order, duplicate order, order not dated/timed, wrong patient/chart selected, contraindications, verbal order misunderstood, verbal order not written in the chart, wrong frequency, route, therapy duration, alert information bypassed or use of nonstandard nomenclature or abbreviations.

5.1.2 **Transcription error:** Transcription involves both the orders that are manually transcribed onto manual record (e.g., medication administration record (MAR)) and electronically transcribed into computer systems (e-MAR). Types of transcription errors include: wrong medication, time, dose, frequency, duration, rate patient/chart, verbal order misunderstanding, verbal orders not entered into MISK system, orders entered into MISK that are discrepant from the medication history, order not manually transcribed onto MAR, wrong scheduling of doses in the e-MAR.

5.1.3 **Preparation/Dispensing Error:** Types of preparation and dispensing errors include: Inaccurate labeling, wrong quantity, medication, dose, diluent, formulation, expired medication, Pyxis refill error, and delay in medication delivery.

5.1.4 **Administration Error:** Types of administration errors include: Wrong patient, dose, time, medication, route, rate, omission, extravasation (may be an ADR) and unauthorized dose given.

5.1.5 **Equipment Environmental Factors Types of equipment environmental problems included:** lookalike/sound-alike problems, pump problems, Pyxis problems, computer problem, equipment availability, system down time and packaging/design problem.

5.1.6 **Contributing Factors Types of contributing factors include:** fatigue, calculation error, knowledge deficit, performance deficit, workload, computer software issue, computer downtime, hybrid system (manual/computer processes), lack of communication between practitioners, missing critical info, alert bypassed, MAR reconciliation process, order entry into pharmacy systems, accessed via override, charting related error, medication reconciliation at transitions. Other - Any system breakdown that is not captured with one of the above predefined breakdown points should be classified as "other" and described.

5.2 Medication Error Categories:

Category	Description
Category A	Circumstances that have the capacity to cause error.
Category B	An error occurred but the error didn't reach the patient.
Category C	An error occurred that reached the patient but did not cause patient harm
Category D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm.
Category E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.
Category F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization
Category G	An error occurred that may have contributed to or resulted in permanent patient harm.
Category H	An error occurred that required intervention necessary to sustain life.
Category I	An error occurred that may have contributed to or resulted in the patient's death

5.3 Reporting Medication Error:

5.3.1 Upon discovery of an unusual incident regarding a medication, the staff member should immediately notify the nursing staff and attending physician.

5.3.2 The staff member will report the incident immediately by submitting a Medication Error Report using the paper form- incident report -and submitting it to department of pharmaceutical service director.

5.3.3 Pharmacists will report Medication errors by submitting errors into Clinical Intervention Note on MISK or incident report.

5.3.4 If the error occurred that resulted in potential patient harm, the patient primary consultant and DPS director should be notified and are required to follow up. If the

patient has sustained serious illness/injury as a result of the incident, Patient Safety Committee Head must be notified.

5.4 Medication Error Review

5.4.1 The medication errors report is reviewed monthly by the director of DPS

5.4.2 Medication errors are referred to Patient safety committee & PNT committee for reviewing.

5.4.3 For all significant medication errors, Medication Error Review Meeting is appointed to recreate the sequential activities that resulted in the error, the staffs involved in the error are asked to describe in detail the process they followed. The focus of the review committee is on fixing the system and not disciplining an employee for human mistakes; however, compliance with written policy and procedures is essential.

5.5 Regular Medication Error Report analysis is done monthly by the pharmacy and analysis report is introduced to patient safety committee Head for discussion and action plan.

6.0 References:

6.1 University of Kentucky Hospital

6.2 Pharmacy Departmental Manual

6.3 National Coordinating Council for Medication Error Reporting and Prevention.

7.0 Appendices:

7.1 Related Forms:

7.1.1 Incident Report form.

7.2 Related Policy(S):

7.2.1 Medication Management Program

7.2.2 Reporting & management of near miss and sentinel events

7.3 Related Standards:

7.3.1 JCI standards 7th edition – MMU Chapter. (MMU.7.1)

7.3.2 GAHAR Standards name. MMS.18

7.4 Attachments

7.4.1 N/A