MM.41.7 There is active reporting of medication errors, near misses, and hazardous situations.

MM.41.8 The hospital conducts intensive root-cause analysis for all significant or potentially significant medication errors.

MM.41.9 Medication errors, near misses, and hazardous situations are documented in the patient's medical record.

MM.41.10 The hospital utilizes reported data to improve the medication use process, prevent medication errors, and improve patient safety.

MM.41.11 Healthcare professionals are provided with feedback on reported medication errors, near misses, and hazardous situations.

MM.41.12 The hospital reports sentinel events related to serious medication errors to the relevant authorities.

Standard Intent:

In its 1999 landmark paper, "To Err is Human," the U.S. Institute of Medicine stressed the fact that medical errors are the eighth most frequent cause of death in the United States, more frequent than car accidents, breast cancer, or AIDS. On average, every hospital patient is probably subjected to at least one medication error every day. Fortunately, many of these errors do not cause harm. Regardless of numbers, medication errors are common and that they can happen to all of us. We all—from patients to providers to policymakers—need to take this issue more seriously so that we can make medication use as safe as we would like it to be and as safe as it deserves to be. Also, medication errors compromise patient confidence in the health-care system and increase health-care costs. Risk managers are taking a more proactive approach to preventing medication incidents in hospitals.

Medication errors may be committed by both experienced and inexperienced staff. The outcome(s) or clinical significance of many medication errors may be minimal, with few or no consequences that adversely affect a patient. Tragically, however, some medication errors result in serious patient morbidity or mortality. Determination of the causes of medication errors should be coupled with assessment of the severity of the error. Medication error reporting has been shown to improve medication-use systems and aid in conducting a cause analysis of a medication error.

The fundamental purpose of medication error reporting system is to learn how to improve the medication use and prevent errors recurrence. Reporting of medication errors must become culturally accepted throughout health care. A major investment of resources will be required in the health care system to apply the lessons derived from the reporting of medication errors. Medication error reporting system should include near misses, hazardous conditions, and at-risk behaviors.