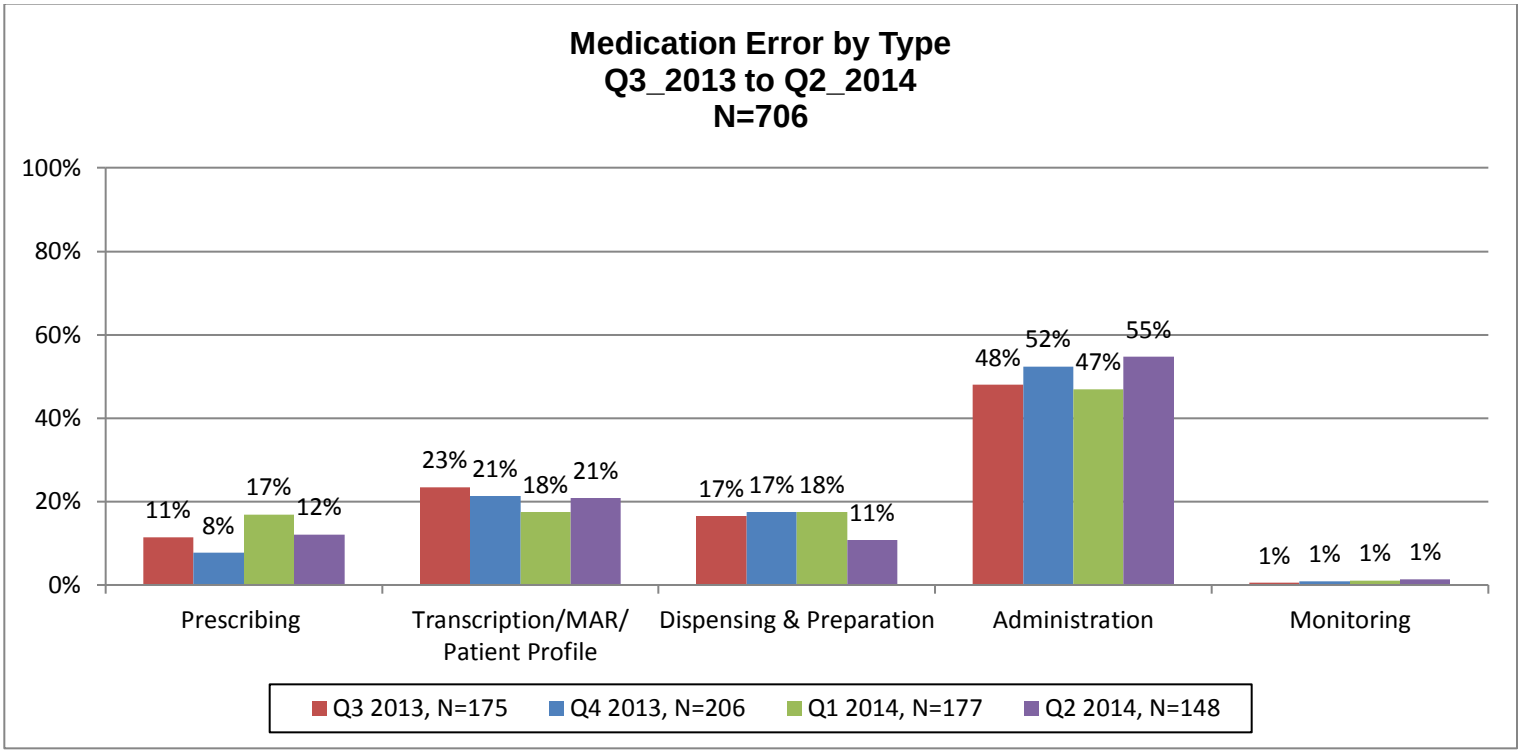
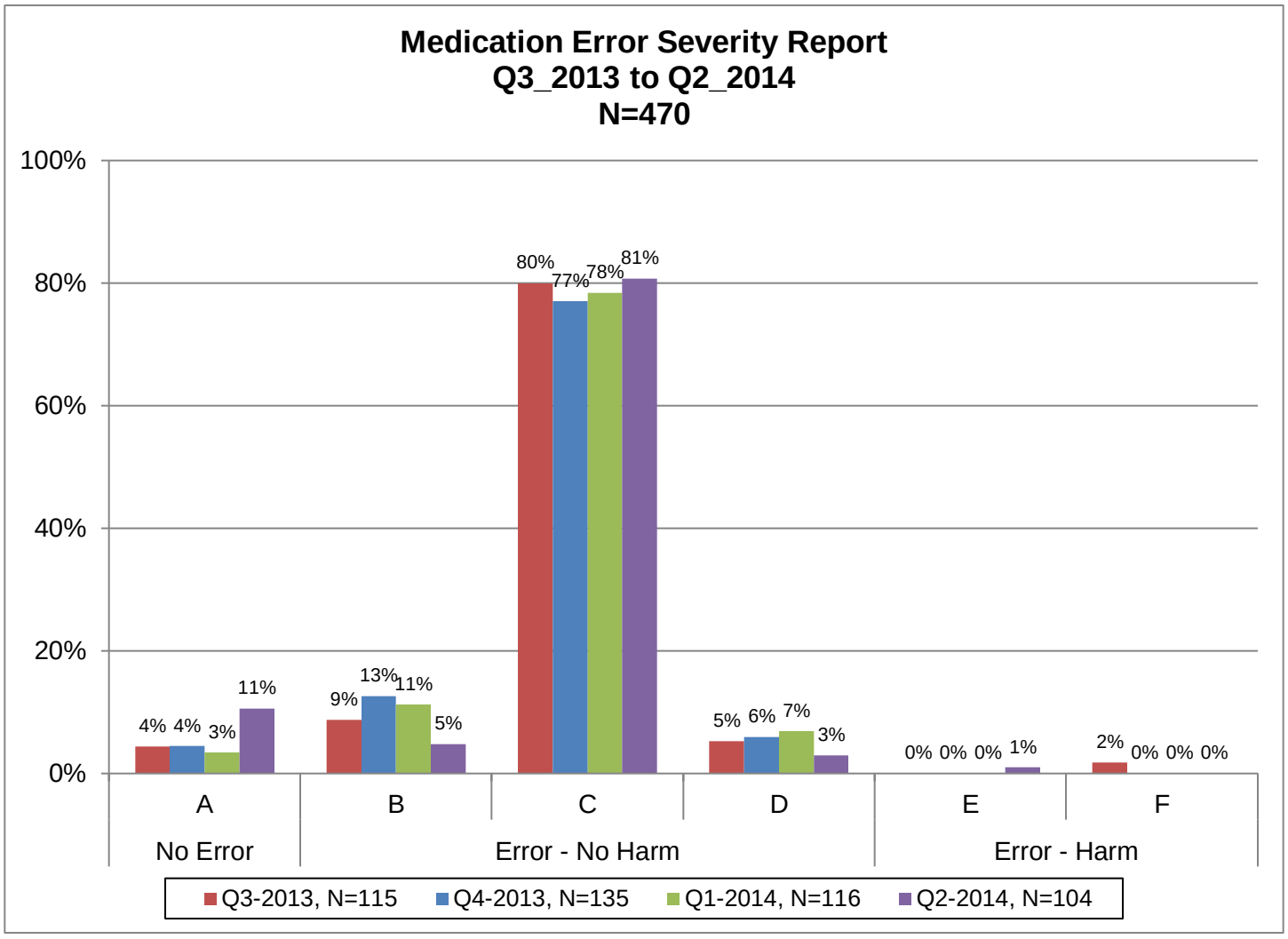
Q2-2014 Medication UO Error Analysis Report



***---One UO may represent multiple error types.**

Error Type Categories				
Prescribing	Transcription Errors	Dispensing and Preparation	Administration	Monitoring
• Prescriber name • CHN number • Unclear order • Illegible order • Incorrect dose ordered • Incorrect drug ordered • Incorrect frequency ordered • Incorrect route ordered • Ordered on wrong patient • Unauthorized prescribing provider • Drug ordered for patient with documented allergy and no justification • Other	• Order not faxed/delay in faxing order to Pharmacy • Order transcribed on wrong patient chart • Order missing on patient's profile • Verbal order taken incorrectly • Previous dose given but not charted/charted incorrectly • Transcription discrepancy • Computer entry wrong dose • Computer entry wrong route • Computer entry wrong frequency • Computer entry wrong drug • Other	• Drug not available to hospital • Expired drug stocked in Omnicell • Inaccurate dose calculation • Nurse labeled drug incorrectly • Nurse prepared drug incorrectly • Pharmacy labeled drug incorrectly • Pharmacy prepared drug incorrectly • Wrong medication removed from Omnicell • Wrong medication stocked/wrong drug in Omnicell • Other	• Dose omitted: Drug N/A at time of administration • Dose omitted: Order not flagged • Dose Omitted: Patient unavailable • Dose omitted: Nurse missed order • Drug given without order • Duplicate dose given • Expired drug given • Wrong time • Wrong dose • Wrong form of medication • Wrong route • Pump error • Other	• Delay in 30-day patient profile review • Missing documentation of current patient height/weight • Necessary test or procedures not done • Tests/procedures results misinterpreted • Other

Medication Error Severity



	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Total
A. No error occurred, but circumstances or events that have the capacity to cause error have been	5	6	4	11	26
B. An error occurred, but the medication did not reach the patient.	10	17	13	5	45
C. An error occurred that reached the patient, but did not cause the patient harm	92	104	91	84	371
D. An error occurred that resulted in the need for increased patient monitoring, but no patient harm	6	8	8	3	25
E. An error occurred that resulted in the need for treatment or intervention and caused temporary patient harm	0	0	0	1	1
F. An error occurred that resulted in initial or prolonged acute hospitalization and caused temporary patient harm	2	0	0	0	2
Total	115	135	116	104	470

After analysis of the overall data, a more detailed review of the medication errors that had a severity of D or higher was performed.

Analysis of DEF medication errors (April - June 2014):

Example of DEF Errors:

D. *An error occurred that resulted in the need for increased monitoring but no patient harm*

E. *An error occurred that resulted in the need for treatment or intervention and caused temporary pt harm*

F. *An error occurred that resulted in initial or prolonged acute hospitalization and caused temporary pt harm*

1). ***D****.5/28/2014. 4E --Pt admitted for TBI s/p fall and started on antiseizure prophylaxis. Pt received 2 doses of phenytoin equivalents - in ED received fosphenytoin 900mg and in 4E ICU phenytoin 1000mg. Providers notified of medication error. Dc'd maintenance dose of phenytoin and started keppra. MD in ED ordered fosphenytoin and NSU MD ordered phenytoin in ICU. Poor communication between MDs and nursing regarding medications ordered/received. ICU MDs did not review meds received in ER. Pharmacy did not identify duplicate order/indication.*

Action Plan: Pharmacists will be instructed to watch out for fosphenytoin - phenytoin therapeutic duplication since computer system does not point it out to user. ED & ICU working on improved hand-off.