

# Medication Error & Near Miss Reporting



Basic Medication Safety (BMS) Certification Course  
King Saud bin Abdulaziz University for Health Sciences  
Ministry of National Guard – Health Affairs

# Learning Objectives

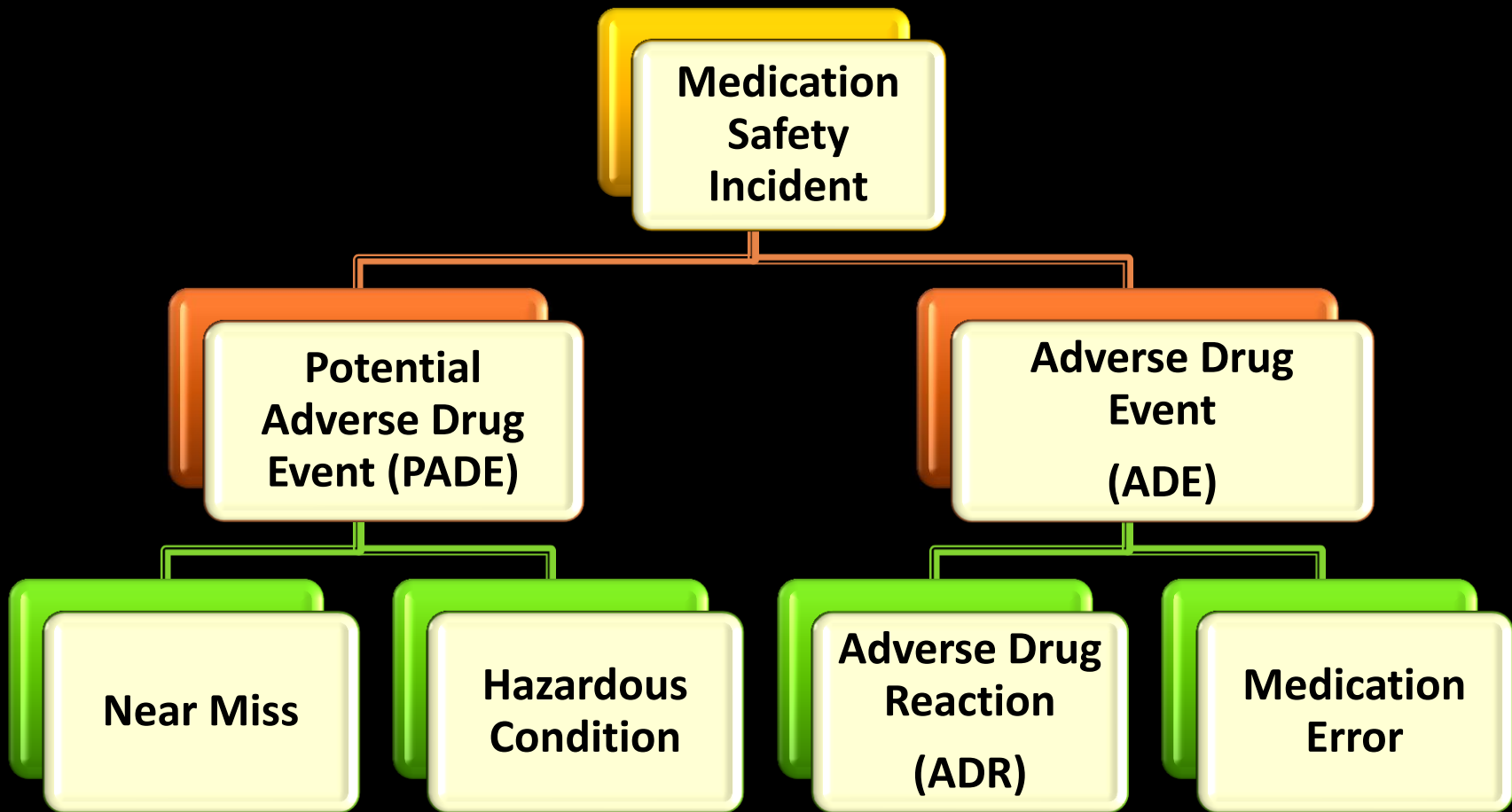
- Explain the reasons for reporting medication safety incidents
- State the types of reportable medication safety incidents
- Submit relevant information when reporting medication safety incidents
- Recall the local medication errors / near misses data
- Explain the mistake lesson learning cycle

# Why Report?

- Ethical / medico-legal obligation
- Help identify hazards and risks in the system
- Sharing and learning



# What to Report?



Source: AMNCH Tallaght: Medication Safety Incident Reporting Policy DTC4/2002

# What Information to Report?

- **JUST THE FACTS** - include a factual description of what happened, how it happened, why it happened and the patient outcome
- Include names of products if the event involves a problem with labeling or packaging
- Include any additional patient monitoring or testing performed or medications administered as a result of the event



# How to Report?

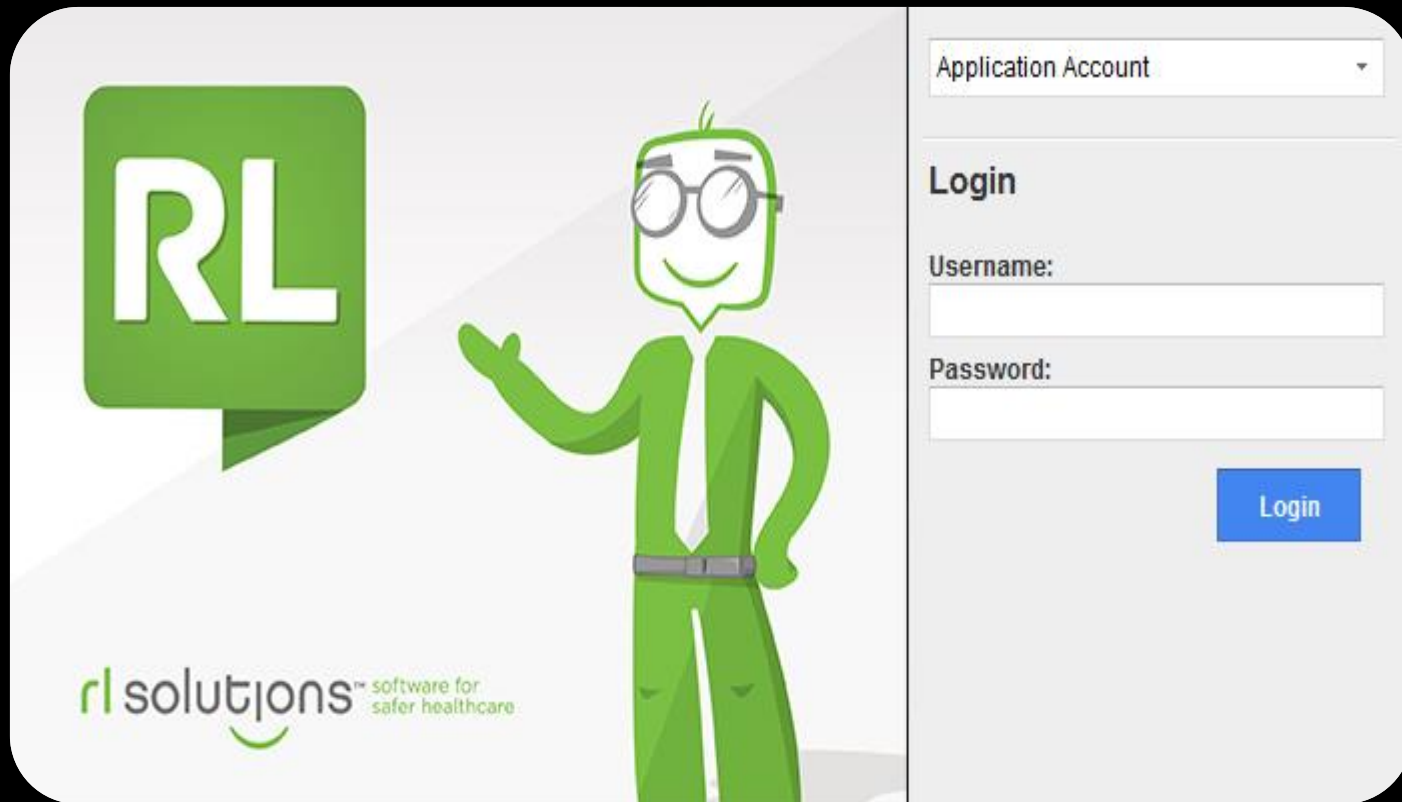
**SRS** Safety Reporting System

LOGIN TO SRS

## Why Reporting

Safety Reporting system (SRS) helps us to assess process/system failures and identify ways in which we can reduce adverse incidents from recurring.

# How to Report?



rl solutions™ software for safer healthcare

Application Account

Login

Username:

Password:

Login



Adverse Drug Reaction



X-ray Management



Blood/Blood Product



Care Coordination



Diagnosis/Treatment



Diagnostic Imaging



Equipment/Medical Device



Fall Event



ID/Documentation/Consent



Infection Control



IV/Line/Tube Device



Lab Specimen/Test



Maternal / Child



Medication/Fluid



Professional Conduct



Environmental Safety/Security



Skin/Tissue



Surgery/Procedure



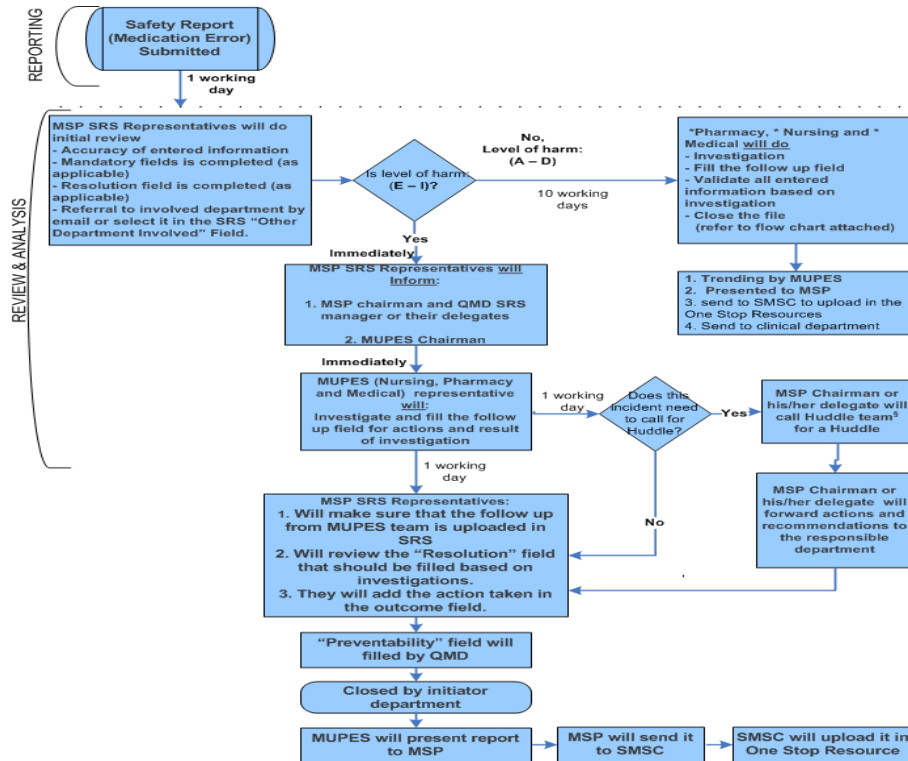


# What Happens to the Report?



Kingdom Of Saudi Arabia  
MNG-HA, King Abdulaziz Medical City – Riyadh  
Medication Safety Program  
High Reliable Organization (HRO) Journey

Process map for reviewing, analysis and action taken for medication related incidents.



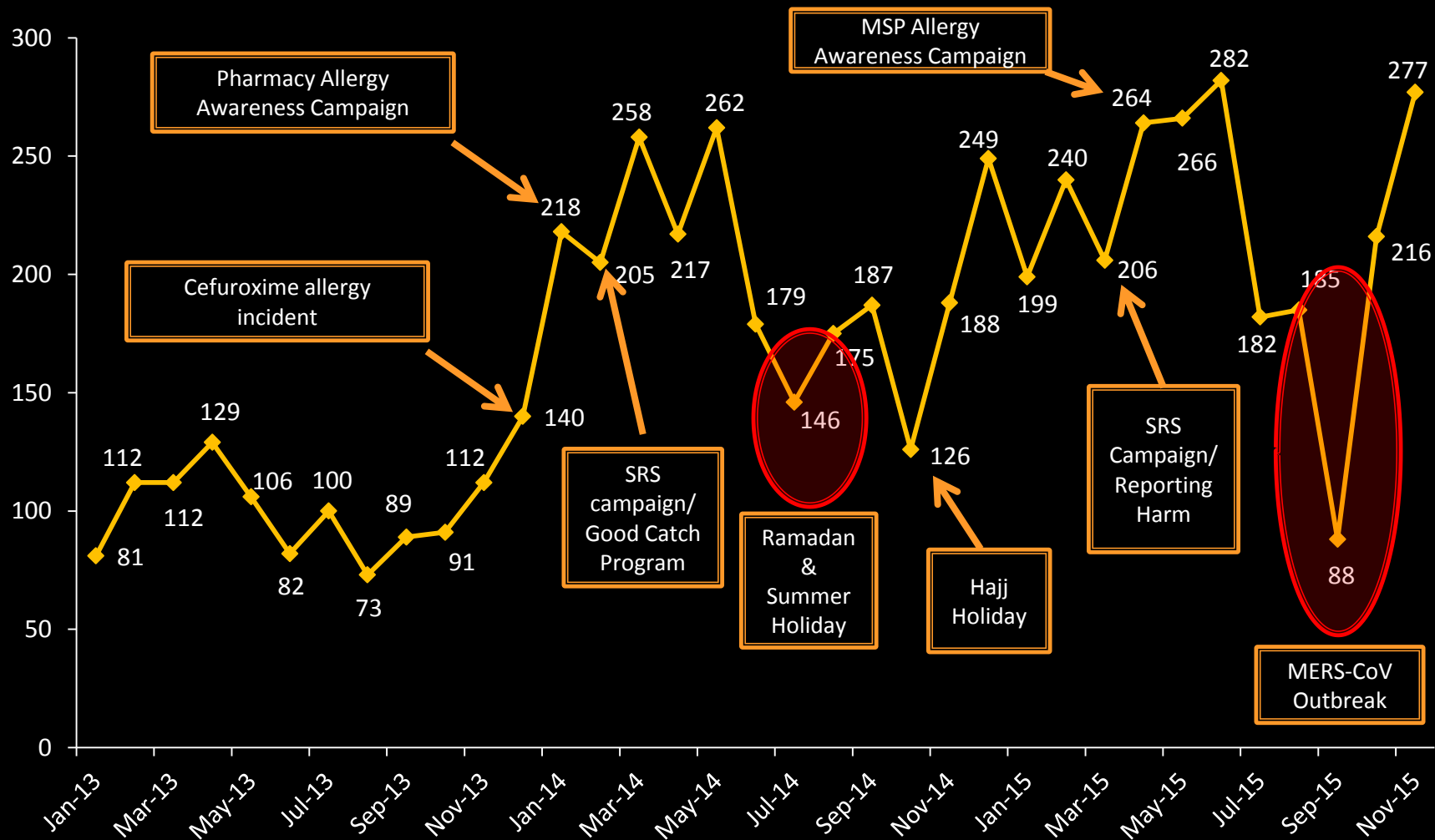
\* The assigned person from the department such as QI representative in the department, Liaison person, Nurse Manager, etc...  
§ MSP Chairman, AED Nursing, Director of Pharmacy, QM SRS manager, MUPES chairmen, etc.

# What Happens to Me?

MNG-HA adopts a “**JUST CULTURE**” approach in error reporting:

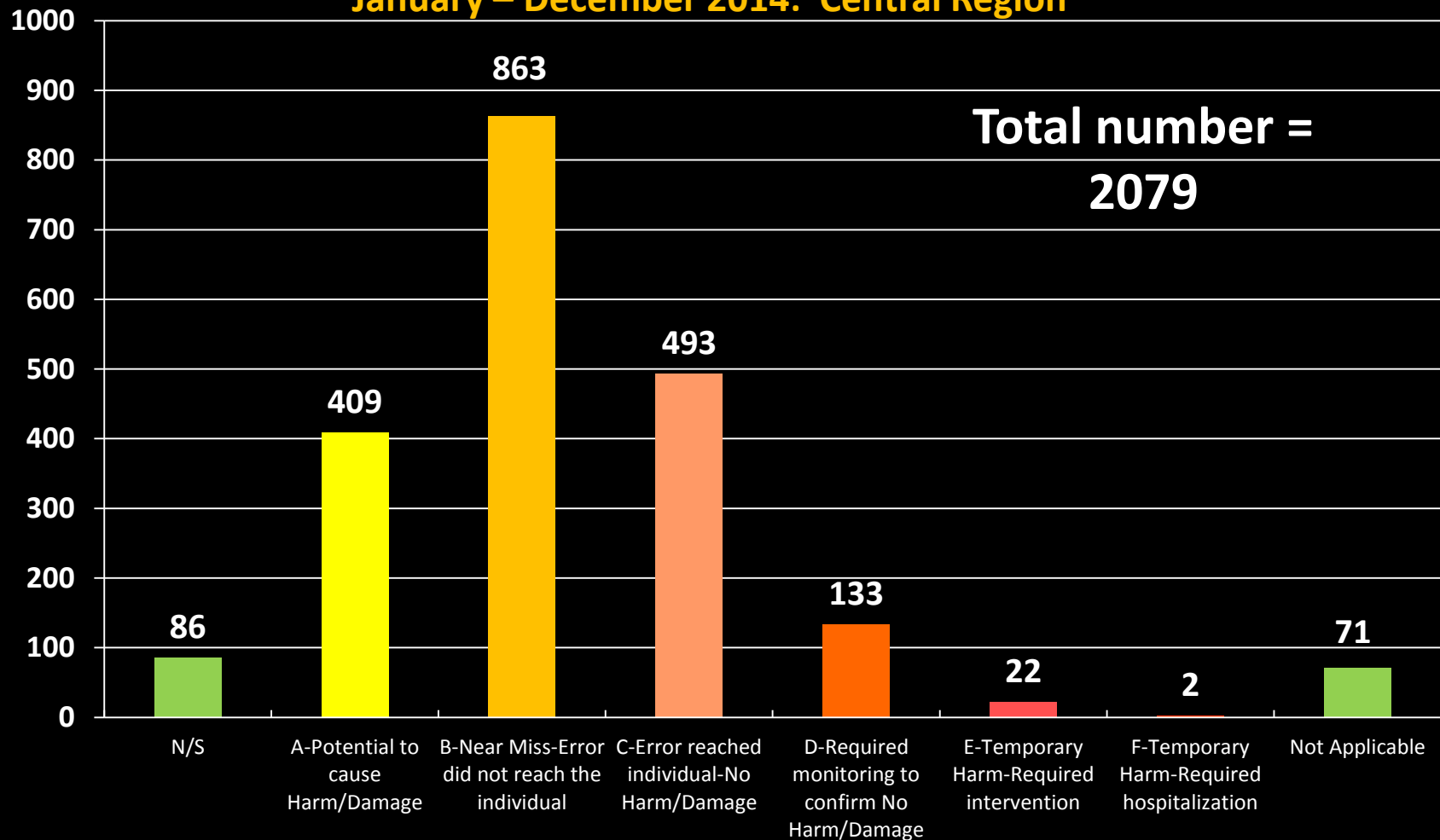
- Creating an open, fair, and just culture
- Creating a learning culture
- Designing safe systems
- Managing behavioral choices

# Number of Medication Error at KAMC - Riyadh from Jan 2013 – Nov 2015



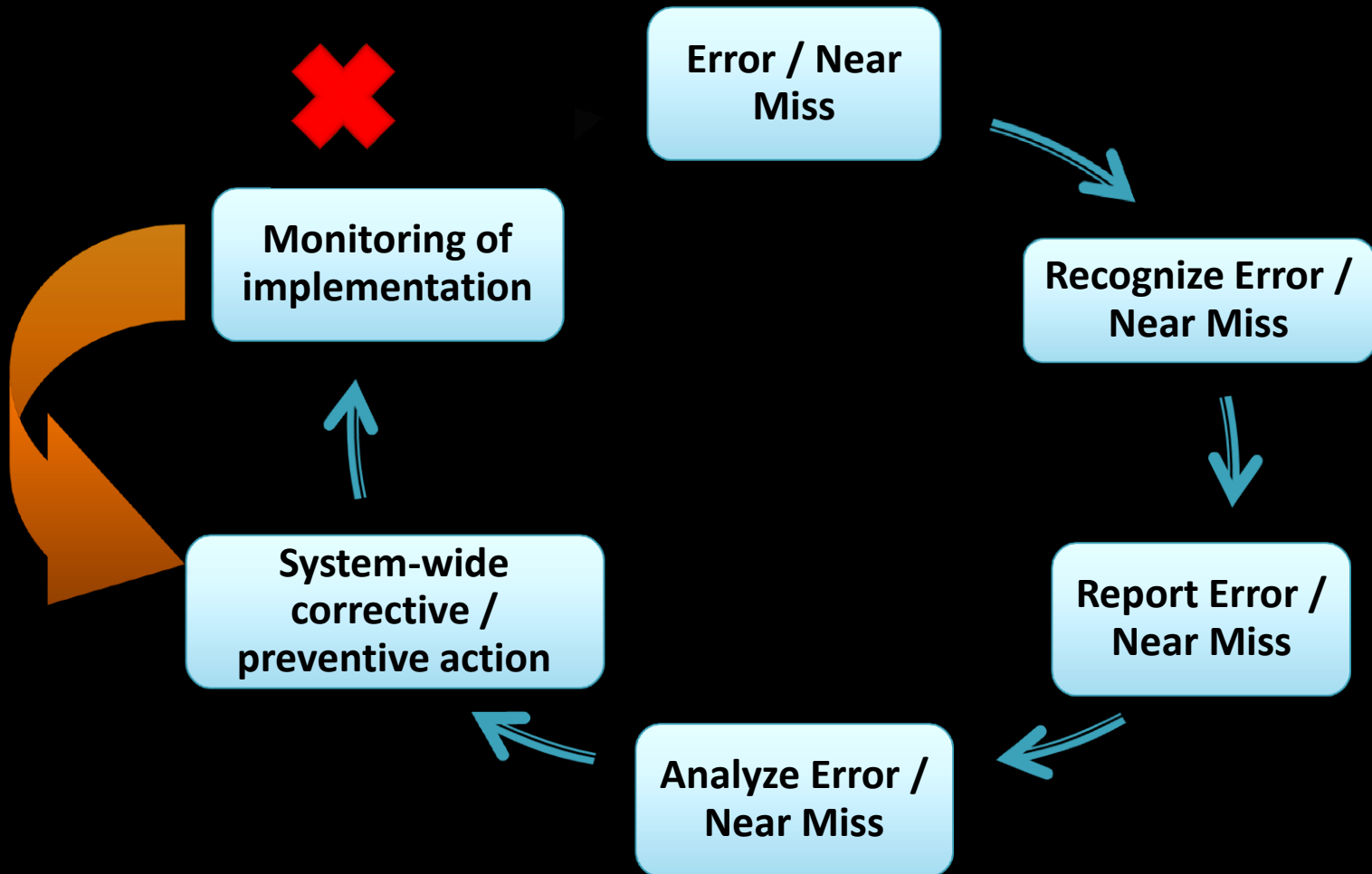
# Medication Error and Near Miss: Harm Category

January – December 2014: Central Region



# What Did We Learn from the Data?

## Lesson Learning Cycle



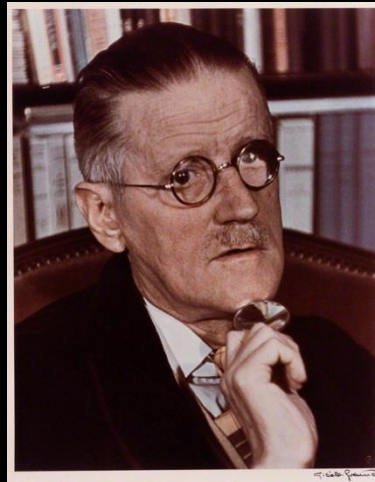
# Overall Lessons Learned

**Medication Safety is a Team Sport**



**“Mistakes are the portals of discovery”**

*James Joyce*



**Safe Patient Care Is Our Goal**