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?

- Medication Safety Incident
  - Potential Adverse Drug Event (PADE)
    - Near Miss (close call)
    - Hazardous Condition
  - Adverse Drug Event (ADE)
    - Adverse Drug Reaction (ADR)
    - Medication Error

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

- Prescribing errors
- Dispensing and preparation errors
- Administration errors
- Monitoring and dose adjustment errors
- Wrong patient
- Wrong medicine
- Wrong formulation
- Wrong calculation
- Wrong dose and frequency
- Wrong rate of administration
- Wrong route
- Known medication allergy
- Expired medicine
- Omitted and delayed medicine doses
Rapid Response Report NPSA/2010/RRR009: Reducing harm from omitted and delayed medicines in hospital

February 2010

Review of evidence of harm

Table 1 below shows the clinical outcomes of incident reports of omitted or delayed medicine reported to the RLS between **29 September 2006 and 30 June 2009.** (RLS datafields IN05=medication incident and MD02=omitted or delayed medicine†).

<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Clinical Outcome of Incident Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Death</td>
</tr>
<tr>
<td>Acute / general hospital</td>
<td>27</td>
</tr>
<tr>
<td>Community nursing, medical and therapy service (incl. community hospital)</td>
<td></td>
</tr>
<tr>
<td>Mental health service</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
</tr>
</tbody>
</table>

Table 1
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?

Safety Report (SR)
Any undesired incident that may affect patient, employee, family member, visitor, facility, equipment and/or property, which is not consistent with the standard operations/care. These incidents may cause actual injury/damage, or have potential to cause injury, loss of function, or death.

Application Account

Username: 

Password: 

LOGIN
What Happens to the Report?

SRS

- Level of Harm A - D
  - MUPES
  - SRS liaison person in each unit

- Level of Harm E - I
  - MSP – Huddle
  - QPS
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
APPENDIX C

NCC MERP Index for Categorizing Medication Errors

**CATEGORY I:**
An error occurred that may have contributed to or resulted in the patient’s death

**CATEGORY A:**
Circumstances or events that have the capacity to cause error

**CATEGORY B:**
An error occurred but the error did not reach the patient (An “error of omission” does not 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 initial or prolonged hospitalization

**CATEGORY F:**
An error occurred that may have contributed to or resulted in permanent patient harm

**CATEGORY G:**
An error occurred that required intervention necessary to sustain life

**CATEGORY H:**
An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization

**DEFINITIONS:**

**Harm**
Impairment of the physical, emotional or psychological function on structure of the body and/or pain resulting therefrom.

**Monitoring**
To observed or record relevant physiological or psychological signs.

**Intervention**
May include change in therapy or active medical/surgical treatment.

**Intervention Necessary to Sustain Life**
Includes cardiovascular and respiratory support (e.g., CPR, Defibrillator, Intubator, etc.)
Medication Error and Near Miss Harm Category

January – December 2017: Central Region
Total number = 682
What Did We Learn from the Data?

Lesson Learning Cycle

- Error / Near Miss
- Recognize Error / Near Miss
- Report Error / Near Miss
- Analyze Error / Near Miss
- System-wide corrective / preventive action
- Monitoring of implementation
Overall Lessons Learned

Medication Safety is a Team Sport
Safe Patient Care Is Our Goal