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

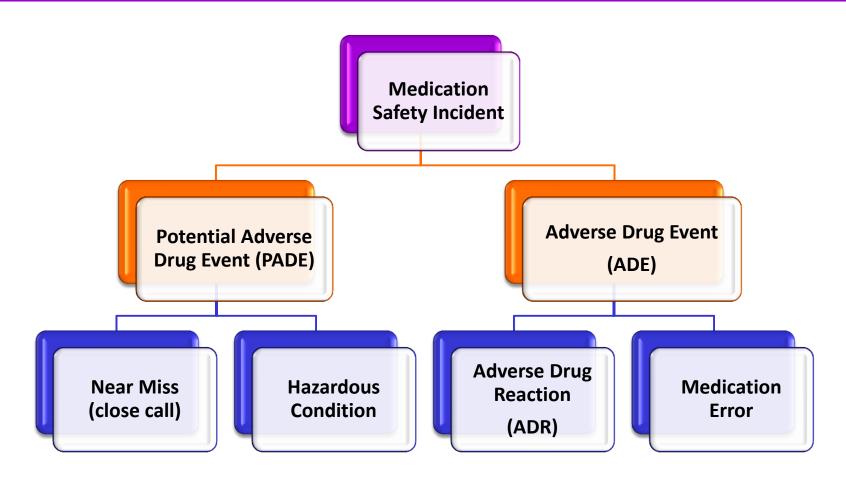


Why Report?

- 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



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



National Reporting and Learning Service

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 1

Care Setting	Clinical Outcome of Incident Reports					
	Death	Severe	Moderate	Low	No Harm	Total
		Harm	Harm	Harm		
Acute / general hospital	27	68	975	4,430	13,027	18,527
Community nursing, medical and therapy service (incl. community hospital)			67	239	1,211	1,517
Mental health service			33	150	1,156	1,339
Total	27	68	1075	4819	15394	21,383



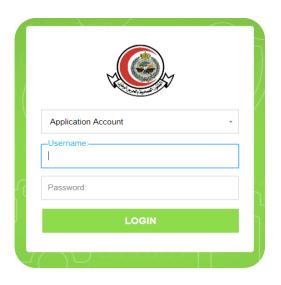
What Information to Report?

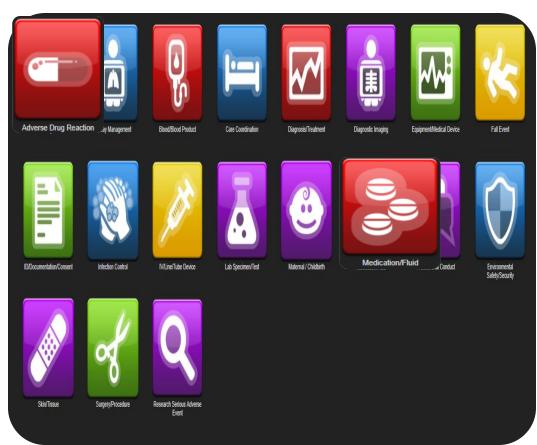
- Just the facts include a factual description of what happened, how it happened, why it happened and the patient outcome
- Include names of products if the event involves a problem with labeling or packaging
- Include any additional patient monitoring or testing performed or medications administered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



How to Report?

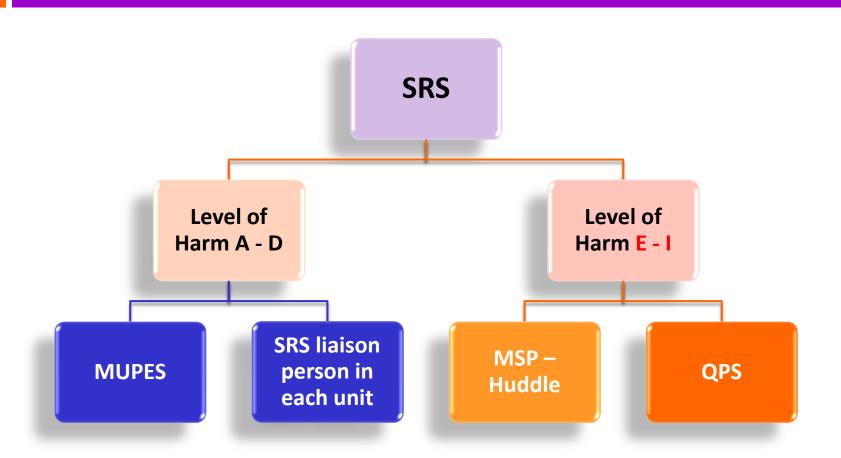








What Happens to the Report?

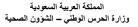




What Happens to Me?

- 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

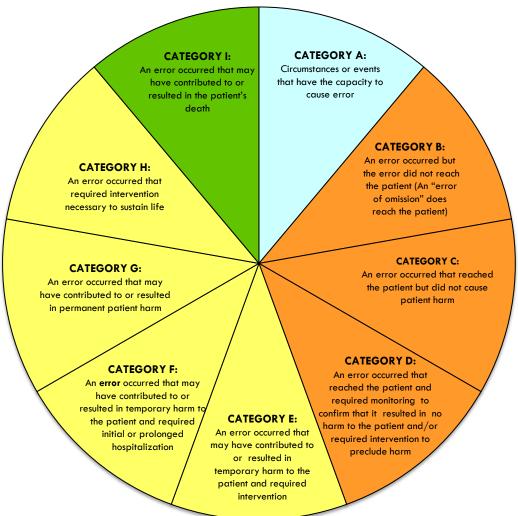






APPENDIX C

NCC MERP Index for Categorizing Medication Errors



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

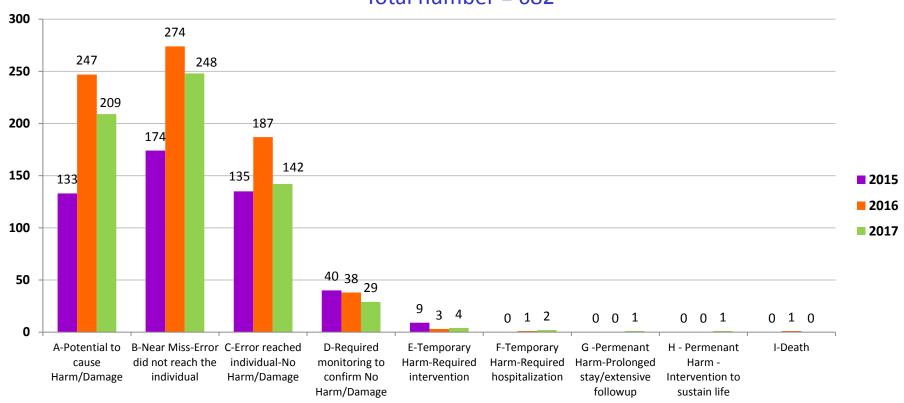
Includes cardiovascular and respiratory support (e.g., CPR, Defibrillator, Intubator, etc.)

- O No Error
- Error, No Harm
- Error, Harm
- Error, Death

Medication Error and Near Miss Harm Category

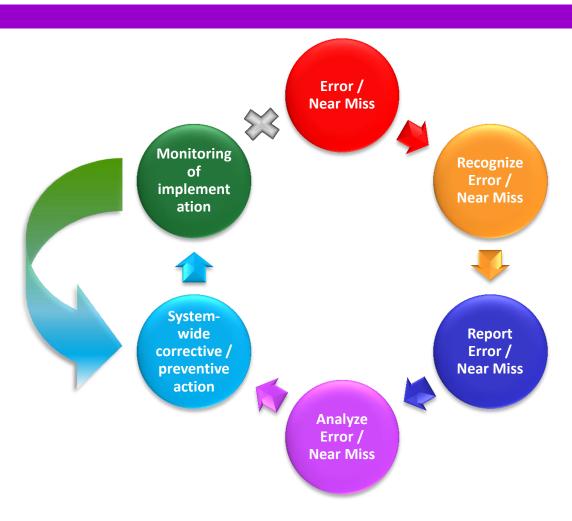
January – December 2017: Central Region

Total number = 682





What Did We Learn from the Data?



Lesson Learning Cycle



Overall Lessons Learned

Medication Safety is a Team Sport





Safe Patient Care Is Our Goal

