**REPORTING MEDICATION ERRORS POLICY**

1. **Policy**
2. It is the policy of this DHS licensed provider Marshall County Group Homes, Inc. (MCGH) to provide safe

medication setup, assistance, and administration. Any medication errors will be monitored by facility

nursing staff.

1. **Procedures**
2. If a medication error is discovered, the Direct Care Coordinator (DCC) or person discovering the error must call

the employee who was responsible for administration of the medication/treatment and ask them if

they properly gave the medication as prescribed. If they did and the medication count confirms this

the employee who is responsible will return to the facility and properly document.

**When an error has occurred**:

1. The program nurse ***must be notified immediately*** by telephone. Allow time for the nurse to

call you back, however, if the error is of such a nature that you feel it needs an immediate

response, call the prescriber or Emergency Room nurse.

1. The Nurse will determine if an error has occurred and at her discretion give instructions for

the immediate care of the individual and may call other health care professionals such as a

physician if necessary.

1. The “Medication Error Report” form is to be filled out by either the employee who made the

error or the person who discovered the error within a reasonable amount of time. **If person**

**making the error is unknown, the employee discovering the error will complete the form.** All

questions must be answered completely. The form is signed by the employee who discovered

the error, and the facility nurse.

There must be follow-up charting that reflects any adverse effects for the consumer as a result of

the error in the progress notes.

If more than one recipient is involved in the error, a Medication Error form must be completed for

each consumer.

It is the responsibility of the DCC to review the MAR regularly to ensure staff are initialing off

medications and treatments. If an employee has not signed off a medication/treatment that was administered, it is the responsibility of the DCC to call and request the employee come to the facility

and sign off the medication(s) or treatment(s). A note must be left in the MAR regarding the omission

of sign off.

**Protocol for Medication Error Review:**

1. When facility nurse completes the quarterly medication review and it is noted an employee has

a pattern of medication/treatment errors the employee will be required to meet with the facility

nurse to review the concern(s). Nurse discretion will be used to determine corrective action to be

taken depending on seriousness of Medication/Treatment error(s). If Termination or disciplinary

action is to be considered the nurse will have a discussion with the Administrator to determine

appropriate course of action.

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| **MEDICATION OR TREATMENT ERROR OR REFUSAL REPORT** |
| Name of person served:  Date of error or refusal:        Date of discovery, if different:  **The following medication or treatment was involved in this error or refusal:**  **Medication or treatment name(s) and order:** |
| **Instructions**   * This report will be completed if a dose of medication is not administered or treatment is not performed as prescribed, whether by error by staff or the person served or by refusal by the person. * Staff will notify the assigned nurse or nurse consultant, if applicable or the Designated Coordinator and/or Designated Manager or designee upon the discovery of the error or refusal.   **Staff will check the applicable boxes to indicate the nature of the medication-related event**   |  |  |  | | --- | --- | --- | | Medication given at wrong time | Medication was given on wrong date | Medication refused | | Medication given to wrong person | Medication given by wrong route | NA-not a medication-related event | | Incorrect medication dose given | Medication was not given | Other: |   Staff will check the applicable boxes to indicate the nature of the treatment-related event   |  |  | | --- | --- | | Treatment not performed correctly as prescribed | Treatment refused | | Treatment was not completed | NA-not a treatment-related event | | Treatment was completed on wrong date | Other: |   Was the error that occurred a result of staff error or the person served?  Staff : Date & Time staff notified:  Person served:  **Follow up orders per Nurse or Doctor or ER Nurse:**        **The following notifications were made regarding the error or refusal:**  Nurse RN/LPN: Date & Time:  Resident Program Coordinator (Cindy/Sabrina): Date & Time:  Case Manager: Date & Time:  Prescriber: Date & Time:  Legal representative: Date & Time:  Other designee: Date & Time:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff completing the report Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Nurse Reviewing the report Date |