Medications: Errors PC.M40

Regulatory Citation(s):	None
L-Tag(s):	None

POLICY: All medication errors are documented on an adverse event report and reported immediately to the Director of Clinical Operations, the patient's attending physician (if any) and the hospice physician

PROCEDURE:

1. Medication errors include, but are not limited to:
    a. wrong medication administered;
    b. wrong medication dispensed;
    c. wrong dose;
    d. wrong site;
    e. wrong route;
    f. administered at the wrong time;
    g. omission or missed dose; and
    h. extra dose.

2. The patient's response to the medication error is evaluated to determine potential negative effects and reported to the physician. The hospice nurse will initiate an emergency response if necessary and as instructed by the physician.

3. If the patient has a response that requires intervention, the patient shall be placed on continuous care, in the inpatient unit or other General inpatient setting as deemed necessary by the hospice medical director.

4. Documentation of the medication error indicates who made the error: patient, family, hospice staff, facility staff, contracted personnel, pharmacist, or other.

5. The incident report detailing the medication error is completed by the hospice nurse, in collaboration with their supervisor, as soon as feasible following the discovery of the error and submitted to the Director of Clinical Operations.

6. The Director of Clinical Operations reviews and completes the adverse event report, including documentation of corrective actions taken to prevent future medication errors.

Created:	Reviewed:	Revised:	Effective:
9/18	2/19		4/2019
Reviewed:	**Reviewed:**	**Reviewed:**	**Reviewed:**

7. Data related to medication errors is collected and reviewed by the hospice's QAPI Committee on a quarterly basis

Created:	Reviewed:	Revised:	Effective:
9/18	2/19		4/2019
Reviewed:	**Reviewed:**	**Reviewed:**	**Reviewed:**