Ministry of Health
Al Masarra Hospital

Procedure/s of Medication Error Reporting

(Department of Pharmacy)

Document Title	Procedure of Medication Error Reporting
Document Type	Procedure
Directorate/Institution	Al Masarra Hospital (AMRH)
Targeted Group	All healthcare employees in AMRH
Document Author	Pharmacy Team
Designation	Pharmacists
Document Reviewer	Shareefa Al Ruzaiqi
Designation	Head of Pharmacy Department
Release Date	September 2023
Review Frequency	Three years

Validated by		**Approved by**	
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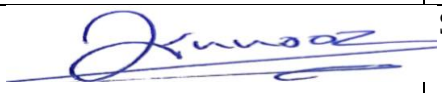
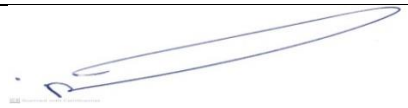
Designation	Document Manager, QMPSD	Designation	Executive Director
Signature		Signature	
Date	September 2023	Date	September 2023

Acknowledgement:

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Table of Contents

Acronyms

AMRH	Al Masarra Hospital
HoD	Head of Department
Vers.	Version
OPD	Outpatient Department
P&P	Policy and Procedure
SOP	Standard Operating Procedures
D&TC	Drug and Therapeutic Committee
ASHP	American Society of Health System Pharmacists
IRLS	Incident Reporting &Learning System

Purpose

- To outline the role of all health care professionals in identifying and handling medication errors and initiating appropriate corrective and preventive measures.
- To describe the mechanism for multi-disciplinary review to allow appropriate implementation and follow-up of change to prevent future medication errors.

Scope

- This document is applicable to all staff that identified medication errors in Al Masarra Hospital (AMRH)

Definitions

- **Medication error:** Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional. Such events may be related to professional practice, healthcare products, procedures and systems including: prescribing, order communication, product labeling and packaging, nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.
- **Near miss:** Any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome.
- **Significant Medication Error**: Any medication error that if not prevented may cause significant harm to the patient (i.e. permanent harm or death)
- **Sentinel Event**: Any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness.

Procedure:

1. Once a medication error identified, it should be properly documented and reported immediately - within the same shift in which the incident occurred or was discovered – by a health care providers; and an electronic medication error report must be accomplished via IRLS in Alshifa system.

    1.1. Medication errors are one of the categories of IRLS. The incident reports used to explore the factors encountered the events and for instructional and educational purpose and not to take an action against the employee involved.

2. For clinically significant errors, an immediate verbal notice should be given to the concerned physician/nurse/pharmacy professional, and any necessary corrective and supportive therapy should be provided to the patient.

3. All medication errors will be forwarded to head of the department (Medical, Nursing, Pharmacy) for appropriate management and corrective actions in a timely manner.

4. For clinically significant errors, fact collecting and investigation should be initiated immediately

5. Reports of clinically significant errors those associated with corrective actions should be reviewed by the supervisor and the area managers involved.

6. When appropriate, the supervisor and the staff members who were involved in the error should discuss on how the error did occur and how to prevent its recurrence.

7. Department supervisor or the area managers and/or the medication safety officer, and/or the Drug and Therapeutic Committee (D&TC) will periodically review medication errors reports via Al AMAN system then will determine their causes in order to develop actions to prevent the recurrences

8. Reported errors should not be used for punitive purposes as those errors often result from fault within the followed systems rather than exclusively from the staff performance or environmental factor but should be used to activate corrections and changes.

9. Information gained from medication error reports and other means that demonstrates continued failure of individual professionals to avoid preventable medication errors .Therefore, those reports should serve as an effective management and educational tool in staff development in order to avoid any possibility of repetition.

10. Follow Recommended Preventive Measures by ASHP for pharmacist/s. (See Annexes)

11. Keep in mind the commonly reported medication error and the factors associated to medication error, to prevent the occurrence. (See Annexes)

Responsibilities:

- **All Healthcare Professionals (Doctors, Nurses and Pharmacy professionals) shall:**
  - Identify and handle medication errors and initiate appropriate corrective and preventive measures involved during prescribing, dispensing, administration, and monitoring.
  - Report the identified medication errors immediately - within the same shift in which the incident occurred or was discovered - by health care providers electronically via IRLS in alshifa system to implement the multi-disciplinary review thus allow appropriate monitoring and follow-up of the changes to prevent future medication errors.

Document History and Version Control Table

Version	Description	Review Date
1	Initial Release	September 2023
2	Version Two	September 2026
3		

References:

- Pharmaceutical Care Policies & Procedures in MOH Health Unit (January 2019)
- American Society of Health System Pharmacists (ASHP) guidelines on the prevention of medication errors (1993)

Annexes

Appendix 1.Guideline Recommendation by ASHP for pharmacy for Medication Error Prevention

Guidelines Recommendation by ASHP for pharmacy for Medication Error Prevention

- Pharmacy professional should participate in drug therapy monitoring when indicated for the assessment of therapeutics appropriateness, possible duplicate therapies or any possible interactions.
- Pharmacy professional should stay abreast of the current state of knowledge through familiarity with literature, consultation with colleagues and other health-care providers and participation in co ntinuing professional education programs.
- Pharmacy professionals should be available to provide medication information required to all health providers and patients
- Pharmacists should be familiar with the medication ordering system and drug distribution policies and procedures established.
- Pharmacy professional should never assume or guess the intent of confusing medication orders. If there are any questions, the prescriber should be contacted prior to dispensing.
- When preparing drugs, pharmacists should maintain orderliness and cleanliness at the work area and perform one procedure at a time with a few interruptions as possible.
- Before dispensing a medication in nonemergency situations, the Pharmacy professional should review the printed medication order. For high risk medications, the full dispensing process should be checked by a second pharmacy professional.
- Whenever possible, Pharmacy professional should dispense medication in ready-to-administer dosage forms.
- For in-patients, the unit dose system is strongly recommended as its the more effective process for reduction of medication errors.
- Pharmacy professional should review the use of auxiliary labels and use them prudently whenever its use may prevent errors.
- Pharmacy professional should observe how medications are actually being use in patient care areas to insure that dispensing and storage procedures are followed.
- Pharmacy professional staff should review medications that are returned to the department. Such review processes may reveal system breakdowns or problems that resulted in medications errors (e.g, omitted doses and unauthorized drugs).
- When dispensing medications to out-patients, Pharmacy professional should counsel patients or caregiver and verify that they understand why the medications were prescribed and its intended use, any special precautions that might be observed and any other needed information. For inpatients, clinical pharmacists should make their

services available to counsel patients, families, or caregiver when appropriate.

Medication Error Useful Information

- Medication errors can occur anywhere in the distribution system: Prescribing , Repackaging, Dispensing, Administration, Monitoring
- Common causes of such medication errors include:
  - Poor communication and proper counseling
  - Ambiguities in product name, direction of use, medical abbreviation or order
  - Poor procedure or techniques
  - Poor understanding of the product usage and direction by the patient
  - Job stress
  - Lack of product knowledge or training
  - Similar labeling or packaging
- Factors that may influence medication errors include:
  - Factors associated with health care professionals.
  - Lack of therapeutic training
  - Inadequate drug knowledge and experience
  - Inadequate patients knowledge
  - Inadequate perception of risk
  - Overworked or fatigued health care professionals
  - Physical and emotional health issues
  - Poor communication between health care professionals and with patients
- Factors associated with patients:
  - Patient characteristic (e.g. personality, literacy and language barriers)
  - Complexity of clinical care including multiple health conditions, poly-pharmacy and high-risk medications.
- Factors associated with work environment:
  - Workload and time pressure
  - Distractions and interruptions (by primary care staff / patients)
  - Lack of standardized protocols and procedures
  - Insufficient resources
  - Issues with the physical work environment (e.g. lighting, temperature and ventilation)
- Factors associated with medicines:
  - Naming of medicines

- Labeling and packaging
- Special requirements .(Handling , Storage, Administration, etc)

❖ Factors associated with tasks:

- Repetitive systems for ordering and authorization
- Patient monitoring (physician/patient dependent on such practice or other health care settings)

❖ Factors associated with computerized information system:

- Difficult processes for generating first prescriptions (e.g. drug pick lists, default dose regimens and missed alerts)
- Difficult processes for generating correct repeat prescriptions
- In accurate and inadequate patients records
- Inadequate design that allows human error

❖ Factors associated with Primary, secondary and tertiary care interface:

- Limited quality of communication with secondary and tertiary care
- Inadequate justification of secondary and tertiary care recommendations

Appendix 2.Audit Tool

Department: _____

Date: _____

Auditor's Name: _____

#	Criteria	Yes	No	N/a	Remarks
Knowledge of the Guideline/Procedure/Protocol (Interview)					
1	Is/are the staff aware of the content of the document?				
2	Are the individual being informed about the errors if they make one?				
3	Are Pharmacy professionals aware about the special recommendation for preventing medication errors?				
Training (Document Review & Interview)					
4	Is there a training conducted?				
5	Are Staff/s aware how to report medication error in IRLS in Al Shifa?				
Observation					
6	Does the institution have a pharmacist (focal point) dedicated to medication safety?				
7	Are Errors and close calls being analyzed and investigated to develop measures or to prevent reoccurrence? Or Staff able to handle the detected error?				

Appendix 3: Document Request Form

Document Request Form MoH/DGQAC/GUD/001/FRM001/Vers.2			
Section A: To be completed by Document Writer			
Writer Details			
Name	**Athari Al Maskari**	Date of Request	September 2023
Institution	Al Masarra Hospital	Contact information	*nil*
Department	Pharmacy		
Purpose of Request: ■ Develop new document ☐ Modify existing document ☐ Cancel existing document			
Document Information			
Document title (for new & existing documents)	Procedure/s of Medication Error Reporting		
Document code (for existing documents)	AMRH/PHARM/SOP/001/Vers.01		
Required Amendments	*nil*		
Reasons	*nil*		
Section B: To be completed by **Document Section of Quality Management and Patient Safety**			
■ Approved ☐ Rejected ☐ Cancelled			
Comment and Recommendation: *proceed with the document*			
Name and Title	**Kunooz Blaushi** **(QMPSD, Document Manager)**	Date	September 2023

Appendix 4: Document Validation Checklist

Document Validation Checklist					
Document Title:		**Document Code:**			
No	Criteria	**Meets the Criteria**			**Comments**
		Yes	**No**	**N/A**	
1.	**Approved format used**				
1.1	Clear title – Clear Applicability	/			
1.2	Footer complete	/			
1.3	Involved departments contributed	/			
2.	**Document Content**				
2.1	Clear purpose and scope	/			
2.2	Clear definitions	/			
3.	**Well defined procedures and steps**				
3.1	Procedures in orderly manner	/			
3.2	Procedures define personnel to carry out step				
3.3	Procedures/methods define the use of relevant forms			/	
3.4	Procedures to define flowchart			/	
3.5	Responsibilities are clearly defined	/			
3.6	Necessary forms/checklist and equipment are listed			/	
3.7	Forms are numbered			/	
3.8	References are clearly stated	/			
4.	**General Criteria**				
4.1	Procedures are adherent to MOH rules and regulations	/			
4.2	Procedures are within hospital/department scope	/			
4.3	Relevant central policies are reviewed	/			
4.4	Used of approved font type and size	/			
4.5	Language is clear, understood and well structured	/			
Reviewed by :	**Kunooz Balushi (Document Manager, QMPSD)** Claudia Fajardo (QMPSD attachment)				