Institute Name: Al Masarra Hospital

Document Title: Policy and Procedure of Medication Error Reporting

Approval Process

	Name	Designation	Institution	Date	Signature
Written by	Ph. Athari Al Maskari	Pharmacist	Al Masarra Hospital	November 2022	
	Ph.Saif Al Mandhari	Pharmacy &Medical Store	Al Masarra Hospital	November 2022	
Reviewed by	Ph. Shareefa Al Ruzaiqi	Pharmacy &Medical Store HOD	Al Masarra Hospital	November 2022	
Validated by	Kunooz Al Blushi	Document Manager	Al Masarra Hospital	8/01/23	
Approved by	Dr. Bader Al Habsi	Executive Director	Al Masarra Hospital	Jan 2023	

سلطنة عمان - وزارة الصحة
مستشفى المسرة
قسم إدارة الجودة
QUALITY MANAGEMENT DEPT.
AL-MASARRA HOSPITAL
SULTANATE OF OMAN- MINISTRY OF HEALTH

Contents Table

Acronyms

AMRH	Al Masarra Hospital
HOD	Head Of Department
Vers.	Version Number
OPD	Outpatient Department
P&P	Policy & Procedure
SOP	Standard Operating Procedure
D&TC	Drug and Therapeutic Committee
ASHP	American Society of Health System Pharmacists

Policy and Procedure of Medication Error Reporting

1. Introduction

Medication errors compromise patient confidence in the health-care system and increase health-care costs. The problems and sources of medication errors are multidisciplinary and multi-factorial. Errors may occur due to lack of knowledge, performance under the influence of substance or mental defects, or failures in systems. Medication errors may be committed by both experienced and inexperienced staff which may include pharmacist, physician, nurses, and other staff with involvement on any phases of medication administration.

2. Scope

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

3. Purpose

3.1 To outline the role of all health care professionals in identifying and handling medication errors and initiating appropriate corrective and preventive measures.

3.2 To describe the mechanism for multi-disciplinary review to allow appropriate implementation and follow-up of change to prevent future medication errors.

4. Definition

4.1 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.

4.2 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.

4.3 Significant Medication Error: Any medication error that if not prevented may cause significant harm to the patient (i.e. permanent harm or death)

4.4 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.

5. Policy

5.1 The pharmacy department has an effective and consistent policy on how to handle medication errors, give appropriate instructions and procedures on how to identify report, intervene and analyze medication errors, and have a system in place for monitoring and preventing future incidences.

5.2 The medication Safety officer/ Pharmacy Quality Management Coordinator will monitor the finding of medication errors not only those related to dispensing errors but also prescribing, repackaging, administrating or monitoring errors.

5.3 Confidentiality of medication error report will be maintained at all times. All these will also be followed accordingly even for officially approved designated studies and statistical reports.

6. Procedure

6.1 The following actions are recommended upon error detection:

6.1.1 Any necessary corrective and supportive therapy should be provided to the patient.

6.1.2 The error should be documented and reported immediately after discovery in accordance with written procedure. For clinically significant errors, an immediate verbal notice should be given to the concerned physician/nurse/pharmacy professional and a written medication error report should follow promptly.

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

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

6.1.5 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.

6.1.6 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.

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

6.1.8 The supervisor or the area managers should collect the medication errors reports periodically and submit to medication safety officer. The medication safety officer should collect the data periodically and submit a statistic report to the Department manager and Drug and Therapeutic Committee (D&TC).

6.1.9 Department manager and D&TC should periodically review report errors, determine their causes and develop actions that prevents their recurrences.

6.1.10 Medication errors should be reported to the national monitoring program (i.e., Pharmaco-vigilance Committee/ Medication Safety Advisory committee) so that the shared experiences of pharmacists, nurses, physicians and patients can contribute in improved patient safety.

6.2. Medication errors that are identified within the same shift in which the incident occurred or was discovered must be reported immediately by health care providers via Medication Error Reporting form (Annex-A).

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

6.4. Mentioned guidelines below are recommended by American Society of Health System Pharmacists (ASHP) for pharmacy professional to prevent medications errors in the hospital:

6.4.1. Pharmacy professional should participate in drug therapy monitoring when indicated for the assessment of therapeutics appropriateness, possible duplicate therapies or any possible interactions.

6.4.2. 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 continuing professional education programs.

6.4.3. Pharmacy professionals should be available to provide medication information required to all health providers and patients

6.4.4. Pharmacists should be familiar with the medication ordering system and drug distribution policies and procedures established.

6.4.5. 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.

6.4.6. 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.

6.4.7. 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.

6.4.8. Whenever possible, Pharmacy professional should dispense medication in ready-to-administer dosage forms.

6.4.9. For in-patients, the unit dose system is strongly recommended asits the more effective process for reduction of medication errors.

6.4.10. Pharmacy professional should review the use of auxiliary labels and use them prudently whenever its use may prevent errors.

6.4.11. Pharmacy professional should observe how medications are actually being use in patient care areas to insure that dispensing and storage procedures are followed.

6.4.12. 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).

6.4.12. 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.

6.5. Medication errors can occur anywhere in the distribution system:

6.5.1. Prescribing

6.5.2. Repackaging

6.5.3. Dispensing

6.5.4. Administration

6.5.5. Monitoring

6.6.Common causes of such medication errors include:

6.6.1. Poor communication and proper counseling

6.6.2. Ambiguities in product name, direction of use, medical abbreviation or order

6.6.3. Poor procedure or techniques

6.6.4. Poor understanding of the product usage and direction by the patient

6.6.5. Job stress

6.6.6. Lack of product knowledge or training

6.6.7. Similar labeling or packaging

6.7.Factors that may influence medication errors include:

6.7.1. Factors associated with health care professionals.

6.7.2. Lack of therapeutic training

6.7.3. Inadequate drug knowledge and experience

6.7.4. Inadequate patients knowledge

6.7.5. Inadequate perception of risk

6.7.6. Overworked or fatigued health care professionals

6.7.7. Physical and emotional health issues

6.7.8. Poor communication between health care professionals and with patients

6.8.Factors associated with patients:

6.8.1. Patient characteristic (e.g. personality, literacy and language barriers)

6.8.2. Complexity of clinical care including multiple health conditions, poly-pharmacy and high-risk medications.

6.9.Factors associated with work environment:

6.9.1. Workload and time pressure

6.9.2. Distractions and interruptions (by primary care staff / patients)

6.9.3. Lack of standardized protocols and procedures

6.9.4. Insufficient resources, issues with the physical work environment (e.g. lighting, temperature and ventilation)

6.10. Factors associated with medicines:

6.10.1. Naming of medicines

6.10.2. Labeling and packaging

6.10.3. Special requirements .(Handling , Storage, Administration, etc)

6.11. Factors associated with tasks:

6.11.1. Repetitive systems for ordering and authorization

6.11.2. Patient monitoring (physician/patient dependent on such practice or other health care settings)

6.12. Factors associated with computerized information system:

6.12.1. Difficult processes for generating first prescriptions (e.g. drug pick lists, default dose regimens and missed alerts)

6.12.2. Difficult processes for generating correct repeat prescriptions

6.12.3. In accurate and inadequate patients records

6.12.4. Inadequate design that allows human error

6.13. Factors associated with Primary, secondary and tertiary care interface:

6.13.1. Limited quality of communication with secondary and tertiary care

6.13.2. Inadequate justification of secondary and tertiary care recommendations

7. Responsibilities

7.1 All Healthcare Professionals (Doctors, Nurses and Pharmacy professionals) shall:

7.1.1 Identify and handle medication errors and initiate appropriate corrective and preventive measures involved during prescribing, dispensing, administration, and monitoring.

7.1.2 Submit the reports to the medication Safety officer/ Pharmacy Quality Management to implement the multi-disciplinary review thus allow appropriate monitoring and follow-up of the changes to prevent future medication errors.

7.2 The Medication Safety officer/ Pharmacy Quality Management shall:

7.2.1 Periodically review error reports and determine causes of errors and develop actions to prevent their recurrences.

Submit the reports to the national monitoring program (i.e. Pharmacovigilance committee/ Medication Safety Advisory committee

8. Document History and Version Control Table

Document History and Version Control			
Version	**Description of Amendment**	**Author**	**Review Date**
01	Initial Release	Athari Al Maskari Saif Al Mandhari	November 2025
02	Update		
Written by	**Reviewed by**	**Approved by**	
Athari Al Maskari Saif Al Mandhari	Shareefa Al Ruzaiqi	Dr. Bader Al Habsi	

9. Related Documents

9.1 Appendix 1. Medication Error Reporting form

9.2. Appendix 2. Audit Tool

9.3. Appendix 3. Document Request Form

9.4. Appendix 4. Document Validation Checklist

10. References

Title of book/Journal/Website	Author	Year of Publication	page
Pharmaceutical Care Policies & Procedures in MOH Health Unit	Directorate General of Medical Supplies	Jan 2019	197-202
American Society of Health System Pharmacists (ASHP) guidelines on the prevention of medication errors.	ASHP	1993	9

Appendix 1. Medication Error reporting form

Sultanate of Oman
Ministry of Health

Medication Error Report

Patent Hospital ID/ Sticker: .....
Patient initials:..... .....
1. Date of Incident:..... .....
Time of incident:.....

2. Location of Incident:
OPD Ph. Inpatient Ph. A/E Ph. Clinical Ph. Ward
Clinic Other place, please specify..... .....

3. In which process did the error occur?
Prescribing Preparing Transcribing Administration Monitoring
Dispensing Discharge Others, please specify... .....

4. Has the error reach the patent? (taken by the patent) Yes No

5. Error, Harm: Treatment/intervention required - caused temporary harm
Initial/prolonged hospitalization - caused temporary harm Caused permanent harm
Near death event

6. Indicate the possible error cause(s) and contributing factor(s)

Staff Factors
- Inexperienced personnel
- Inadequate Knowledge

Work & Environment...
- Heavy workload
- Peak hours
- Stock arrangement/ storage problem
- Distraction

Medication Factors
- Look alike/Sound alike
- Incorrect dose/Drug
- Incorrect frequency/
- Duration
- Incorrect time of admin.
- Incorrect route
- Given expired medication
- Omitted dose/Drug
- Wrong quantity
- Quality defect

Task & Technology
- Failure to adhere to organization policy
- Use of abbreviations
- Missed patent information
- Wrong labeling/ Packaging
- Wrong counseling
- Incorrect computer entry

Patient Factors
- Patient compliance/ Adherence
- Patient took medication by himself
- Inadequate patent education

Others, please specify .....

7. Please describe the error (include discrepancies/ sequence of event/ work environment)
.....
.....

8. What correction measures has been taken.....
.....

9. Recommendations:.....
.....

Reporter name:..... ....Sign:.....

Appendix 2. Audit Tool

Department: _____
Date: _____

S.No.	Audit Process	Description of Criteria	Yes	Partial	No	N/A	Comments
1	Interview	Staff aware about the medication error report form?					
2	Interview	For high-risk drug products, (e.g., psychotropic), work is independently checked by a second individual, preferably another pharmacist\ nurse					
3	Interview	Are Errors and close calls are analyzed and investigated to develop measures to prevent reoccurrence? Or Staff able to handle the detected error?					
4	Interview	Pharmacy professionals aware about the special recommendation for preventing medication errors.					
5	Interview	Individuals who report events are notified of safety improvements that have occurred as a result; this information is also shared more collectively at staff meetings.					
6	Interview	Are the individual informed about the errors that they made?					
7	Interview Observation	Is the institution has a pharmacist (focal point) dedicated to medication safety?					

Appendix 3. Document Request Form

Document Request Form			
Section A: Completed by Document Requester			
1. Requester Details			
Name	Athari Al Maskari	Date of Request	November 2022
Institute	Al Masarra Hospital	Mobile	-
Department	Administration	Email	-
The Purpose of Request			
● Develop New Document	☐ Modification of Document	☐ Cancelling of Document	
1. Document Information			
Document Title	Policy and Procedure of Medication Error Reporting		
Document Code	AMRH/PHARM/P&P/020/Vers.01		
Section B: Completed by Document Controller			
☑ Approved	☐ Cancelled	☐ Forward To:……..	
Comment and Recommendation: proceed with the document			
Name	Kunooz Al Balushi	Date	November 2022
Signature	for Kunooz	Stamp	

Appendix 4. Document Validation Checklist

Document Validation Checklist

Document Title: Policy and Procedure of Medication Error Reporting		**Document Code:** AMRH/PHARM/P&P/020/Vers.01			
No	Criteria	**Meets the Criteria**			**Comments**
		Yes	**No**	**N/A**	
1.	**Approved format used**				
1.1	Clear title – Clear Applicability	✓			
1.2	Index number stated	✓			
1.3	Header/ Footer complete	✓			
1.4	Accurate page numbering	✓			
1.5	Involved departments contributed	✓			
1.6	Involved personnel signature /approval	✓			
1.7	Clear Stamp	✓			
2.	**Document Content**				
2.1	Clear purpose and scope	✓			
2.2	Clear definitions	✓			
2.3	Clear policy statements (if any)			✓	
3.	**Well defined procedures and steps**				
3.1	Procedures in orderly manner	✓			
3.2	Procedure define personnel to carry out step	✓			
3.3	Procedures define the use of relevant forms	✓			
3.4	Procedures to define flowchart			✓	
3.5	Responsibilities are clearly defined	✓			
3.6	Necessary forms and equipment are listed	✓			
3.7	Forms are numbered	✓			
3.8	References are clearly stated	✓			
4.	**General Criteria**				
4.1	Policy is adherent to MOH rules and regulations	✓			
4.2	Policy within hospital/department scope	✓			
4.3	Relevant policies are reviewed	✓			
4.4	Items numbering is well outlined	✓			
4.5	Used of approved font type and size	✓			
4.6	Language is clear, understood and well structured	✓			

Recommendations ..... For implementation ..✓..... More revision ..... To be cancelled

Reviewed by: Kunooz Al Balushi — for kunooz

Reviewed by: Maria Claudia Fajardo-Bala

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