DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE	
POLICY AND PROCEDURE MANUAL	**Number: ________**
Nursing Division - Administration	Effective Date: _____________ History: New
SUJBECT: Medication Errors	Page: 1 of 2 + Attachment
REFERENCE: Joint Commission Standard MM.5.10; MM. 6.20; Nurse Practice Act Guam P.L. 16-123	APPROVED: ___________________________________ Title: Director, DMHSA

POLICY:

The Department of Mental Health & Substance Abuse (DMHSA) has a process to respond to actual or potential medication errors. All actual or potential errors identified will be documented through Medication Inadvertent Incident Report (MIIR). The medical or nursing staff assigned to Risk Management will review all significant medication error reports. The nursing supervisor or administrator will review all medication error data as part of the DMHSA quality improvement process. All adverse medication events will be reported according DMHSA requirements.

DEFINITIONS:

- Significant medication errors are those, which require medical intervention and/or result in possible or confirmed morbidity or mortality.

Medication Error Level Criteria

- Level 0 — No error occurred, potential error
- Level 1 — Error occurred without harm to consumer
- Level 2 — Error occurred, increase monitoring but no change in vital signs or any consumer harm
- Level 3 — Error resulted in need for increased monitoring, there was change in vital signs but no ultimate consumer harm; any error needing increased laboratory monitoring
- Level 4 — Error resulted in need for treatment with another drug, increased length of stay, consumer transfer to a higher level of care (i.e., ICU) or required intervention to prevent permanent impairment of damage
- Level 5 — Error resulted in permanent consumer harm
- Level 6 — Error resulted in consumer death

- **Types of medication errors include:**
  - Wrong: drug, dose, route or time

- Omission (not administered before next schedule dose due)
- Unordered dose

PROCEDURE:

- When a medication error occurs the following should occur in this order:
  - Notify the physician and evaluate the consumer.
  - Perform any necessary clinical interventions; within the consumer care provider's scope of practice to reduce the negative effects of the identified error.
  - Record the medication event in the medical record.
  - Record the observed and assessed outcome of the consumer in the medical record.
  - Record notification of physician in the medical record with any resultant orders.
  - Record any actions and clinical interventions taken and the consumer's response to the clinical interventions.
  - Report the medication error in detain on the Medication Inadvertent Incident Report form.
  - The individual who identifies an error will document all relevant information on the Medication Inadvertent Incident Report form.
  - The nursing supervisor or the nursing administrator will review all medication error reports.
  - The individual reviewing the error will categorize the medication error using the Medication Errors Level Criteria.
  - All medication error reports evaluated as significant (Level 4 or above) must be reported the physician.
  - The Nursing Administrator will make reports of actions taken and appropriate follow-up and outcome of the incident will be reported to the DMHSA Director.
  - Refer to policy on Safe Medication Precautions.

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INCIDENT REPORT

I ___/___/___ Reporting Date ___:___ Time AM / PM	CONFIDENTIAL REPORT	TO BE FILLED IN BY QIC IR#: _____-_____-_____-_____ MO DAY YR #

(THIS IS NOT A PART OF MEDICAL RECORDS NOR SHOULD IT BE REFERENCED IN THE CLT'S PROGRESS REPORT)

II. PERSONS INVOLVED: ☐ CONSUMER ☐ VISITOR ☐ STAFF ☐ OTHERS / SPECIFY: ____________

IDENTIFICATION #	DIAGNOSIS (IF CLIENT)	BRANCH / ADDRESS	HOME / WORK PHONE
1. ____	1. ____	1. ____	1. ____
2. ____	2. ____	2. ____	2. ____
3. ____	3. ____	3. ____	3. ____

III. INCIDENT 1 (CHECK MARK ONLY):

☐ 1 Accident	☐ 7 AWOL	☐ 13 Suicide	☐ 17 Breach of Confidentiality	☐ 22 Prgm Modification	☐ 29 Negative Staff
☐ 2 Auto Accident	☐ 8 Theft	☐ 14 Death	☐ 18 Client Complaint	☐ 23 Prgm Coordination	☐ 30 Program Information
☐ 3 Verbal Assult	☐ 9 Fall	☐ 15 Minor's Non-Comp of Rule / Tx	☐ 19 Property Damage	☐ 25 Staff Removal	☐ 99 Other / Specify:
☐ 4 Physical Assult	☐ 10 Medication	☐ 16 Adult's Non-Comp of Rule / Tx	☐ 20 Program Addition	☐ 26 Staff Addition	
☐ 5 Equipment Misuse	☐ 11 Security		☐ 21 Program Deletion	☐ 27 Staff Coordination	
☐ 6 Equipment failure	☐ 12 Suicide Attempt			☐ 28 Positive Staff	

IV. INDICATE ANY NUMBER OF CONCERNED AREA (S):

OVERHEAD	CLINICAL SERVICES		NURSING SERVICES	
☐ 01 Executive Office	☐ 23 Intake / Emergency	☐ 18 D&A / NB	☐ 11 Child / Adole. Inpt. Unit	☐ 09 Medication Clinic
☐ 02 Financial Management	☐ 19 Medical Records	☐ 20 Comm. Support Services	☐ 10 Adult Inpatient Unit	☐ 24 Heal. Hrts. Cri.Cnt.
☐ 03 Research, Planning & Dev/ MIS	☐ 13 Day Treatment Services	☐ 26 Recreational Ther. Prgm.	CHILD / ADOLESCENT SERVICES	
☐ 04 Regulatory / Infection Control	☐ 14 Guma IFIL	☐ 27 Crises Hotline	☐ 17 Child / Adolescent Services CAST / CAMP	
☐ 05 Quality Improvement	☐ 15 Industrial Therapy Prgm	☐ 40 Prevention & Training	☐ 21 Guma Manhoben	
☐ 06 Personnel / Central Files	☐ 16 Adult Counseling	☐ 08 Professional Services	☐ 25 Therapeutic Foster Care	
☐ 07 Facility Operations		☐ 12 Psychiatric Services	☐ 99 Other / Specify: ____	

V. INCIDENT FACTS: DATE: / / TIME: : AM / PM PLACE:

1. Describe ISSUE PROBLEM (What & How occurred in clear, concise fact with precipitating circumstances if any)

____

2. Attempted Solution:

____

3. Disposition:

____

VI. AUTHORITY INFORMED: ☐ GPD ☐ DYA ☐ COURT / PO ☐ OTHER / SPECIFY: ____________

☐ YES ☐ NO

VII. WITNESS (ES): If Applicable

1. Print, Sign & Title: ____________ Address: ____________ Phone: ____________
2. Print, Sign & Title: ____________ Address: ____________ Phone: ____________

VIII. REPORTER

(PRINT NAME)	(SIGNATURE)	(TITLE)	/ / (DATE)	: AM / PM (TIME)

IX. BRANCH SUPERVISOR CHARGE NURSE REPORT DATE: / / TIME: : AM / PM

1. Findings & Disposition:

____

____

____

(PRINT NAME)	(SIGNATURE)	(TITLE)	/ / (DATE)	: AM / PM (TIME)

X. MEDICAL REPORT (If appropriate): DATE: / / TIME: : AM / PM PLACE:

1. Findings & Disposition:

____

____

____

(PRINT NAME) (MEDICAL DOCTOR)	(SIGNATURE)	(TITLE)	/ / (DATE)	: AM / PM (TIME)

XI. DIVISION ADMINISTRATOR REPORT: **RECEIVED:** / / TIME: : AM / PM PLACE:

1. Findings & Disposition:

____

____

____

(PRINT NAME)	(SIGNATURE)	(TITLE)	/ / (DATE)	: AM / PM (TIME)

XII. ROUTING

A. QAC RECEIVED: / / TIME: : AM / PM

1. Findings & Disposition:

____

____

____

(PRINT NAME)	(SIGNATURE)	(TITLE)	/ / (DATE)	: AM / PM (TIME)

B. DIRECTOR RECEIVED: / / TIME: : AM / PM

1. Findings & Disposition:

____

____

____

(PRINT NAME)	(SIGNATURE)	(TITLE)	/ / (DATE)	: AM / PM (TIME)

XIII. FOLLOW-UP:

1ST FOLLOW-UP DATE: / / TIME: : AM / PM

2ND FOLLOW-UP DATE: / / TIME: : AM / PM

A COPY OF THIS INCIDENT REPORT WILL BE FILED AT REGULATORY OFFICE