


2271 MEDICATION ERRORS	
Chapter: Sununu Youth Services Center	Section: Healthcare
	New Hampshire Division for Children, Youth and Families Policy Manual Policy Directive: _____ Approved: _____ Effective Date: 01-01-09 Scheduled Review Date: 01-01-11 William W. Fenniman, DJJS Director
	Related Statute(s): _____ Related Admin Rule(s): Nur 215 Related Federal Regulation(s): _____

In order to provide optimal safety in administering medication to residents, a procedure exists at the SYSC for documenting medication errors as well as guidelines for limiting untoward effects of such errors. Documenting medication errors is necessary for providing both accountability of such errors and a record to assist the Manager of Health Services and Nursing Coordinator in appropriate supervision of nurses responsible for administering medication to residents.

Purpose

The purpose of this policy is to establish the procedure for addressing medication errors.

Procedure

I. Appropriate Steps to Avoid Medication Errors

- A. Appropriate steps shall be taken to avoid medication errors:
 1. Nurses shall consistently check name, dosage, time, and route on all medications administered and shall document administration properly.
 2. Residents shall be carefully identified prior to medication administration.

II. Medical Errors

- A. In the event that any type of medication error occurs, the following steps shall be taken:
 1. Contact the SYSC physician as soon as possible and notify the physician of the error made in detail.
 2. Follow any instructions given by the physician, which may include monitoring vital signs, holding off the administering of other medications, giving other medications, monitoring for adverse reactions, or possibly referring to the emergency room, if necessary.
 3. Complete hand written Incident Report and notify the Health Authority or Nursing Coordinator as soon as possible. The Health Authority will determine if the resident's parent/legal guardian needs to be notified. The Health Authority will notify the Facility Administrator as soon as possible.

4. Document error and necessary follow-up in a nursing progress note and report it to the next shift nurse.
5. Notify the resident's parent/legal guardian if so directed.

III. **Medication Error Defined**

- A. A medication error is defined as any of the following:
 1. Any medication given to the wrong resident. Example: give to Resident B Resident A's antibiotic, instead of Resident B's Ritalin.
 2. Wrong dosage given to resident. Example: give Clonidine .1 mg instead of .05 mg.
 3. Medication given to resident at the wrong time. Examples: (a) give hour-of-sleep (HS) dose of 50mg Depakote at noon instead of the noon dose of 250 mg; (b) give HS dose of Trazadone at noon instead of the noon dose of Ritalin. (It is acceptable to give medication one-half hour on either side of the designated time. Medication may also be given late if resident is physically not available *in the building* at the time dosage was ordered. Further doses for that day may need to be adjusted accordingly.)
 4. Any medication given twice (this is usually due to a documentation and/or communication error). Example: noon dose given by day nurse, but not documented; then night nurse gives same dose at 1 PM thinking it was not done.
 5. Transcribing error that results in a medication being administered incorrectly.

IV. **Documentation and Requirement to Report**

- A. Nurses responsible for medication errors are responsible for documenting and following up said errors. However, if the error is detected by another nurse at a later time, the discovering nurse is responsible for implementing the required steps of documentation and notifying the physician and Health Authority. Any failure to report a medication error may result in disciplinary action by the New Hampshire Board of Nursing (Administrative Rules: Part Nur 215, 215.01 (b). 10, 11, 12).

V. **Overdose Reactions**

- A. Nurses shall be knowledgeable of adverse and overdose reactions of all medications they administer.

VI. **Medication Incidents**

- A. Medication incidents, such as a resident hoarding their medications or giving their medications to another resident, shall be documented when discovered on an Incident Tracking report and the resident's progress note, and residential staff shall be notified. In most cases the physician shall be notified and the offending resident closely monitored.