



<b>VOLUME 5: NURSING SERVICES</b>	Effective Date: 07/2015
<b>CHAPTER 18</b>	Revision Date:
<b>5.18 NURSING MEDICATION ERROR REPORTING PROGRAM POLICY</b>	Attachments: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

**I. POLICY**

California Correctional Health Care Services (CCHCS) Nursing Services shall maintain a Nursing Medication Error Reporting Program that ensures a standardized statewide system of reporting nursing related medication errors. Errors shall be reported via the standardized statewide health incident reporting system that provides for error reporting within 24 hours of discovery, and is a process for fact-finding and analysis of every medication error.

**II. PURPOSE**

To improve patient safety and promote positive patient outcomes through medication error identification, reporting, analysis, and process improvements and to assist institutions statewide in understanding context of errors to inform changes in nursing policy, curriculum, and education.

**III. DEFINITIONS**

**Medication Error:** Any preventable event that may cause or lead to inappropriate medication use or patient harm as a result of professional practice, health care products, procedures, and systems. Errors may occur in prescribing, order communication, product labeling, packaging, nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

**Medication Error Severity:** A standardized system of assigning numerical value (category) by severity (description) to assist in defining and prioritizing medication errors, patient care intervention and mitigation, and action planning.

Category	Medication Error Severity
0	Error not reaching the patient
1	Error reached the patient but did not result in harm
2	Error resulted in increased monitoring but no change in vital signs and no harm
3	Error resulted in increased monitoring and change in vital signs but no harm
4	Error resulted in need for treatment or hospitalization
5	Error resulted in permanent patient harm
6	Error caused death

**Near Miss:** A medication error that did not reach the patient either by chance or through timely intervention. A near miss shall be reported as a medication error.

# CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

**Nursing Medication Error:** Medication errors directly attributable to nursing actions or inactions in the nursing activities associated with medications.

**Six (6) Rights of Medication Administration:** A globally accepted standard for safe medication administration. Right Patient, Right Route, Right Dose, Right Medication, Right Time, and Right Documentation.

## IV. RESPONSIBILITIES

- A. The Statewide Chief Nurse Executive (CNE) has overall responsibility for oversight of the statewide program and shall set the standard of a culture of safety for reporting medication errors for nurses.
- B. The Nursing Professional Practice Council shall:
  1. Ensure statewide tracking, trending, and reporting of nursing related medication errors.
  2. Generate statewide reports on a regular basis, but not less than annually, that shall:
    - a. Identify best practices and statewide opportunities for improvement for safe medication administration.
    - b. Inform policy, curriculums, competencies, and educational offerings specific to nursing practice and medication administration.
- C. The institution CNE shall ensure:
  1. A local process is established for monitoring medication administration areas to ensure barriers to safe medication administration are identified and mitigated.
  2. All licensed nursing staff receive education and demonstrates competency in medication administration (e.g., Six (6) rights of medication administration), pharmacology and nursing implications, and medication error reporting in all medication administration areas within the institution as outlined in Volume 5, Chapter 4, Nursing Competency Policy.
  3. Medication error reporting forms are readily available at the point of service.
  4. Medication errors are reported via the standardized sentinel event reporting system within 24 hours of discovery.
  5. Medication errors are analyzed in a process that is inclusive of the reporting staff to determine root causes and breaks in the medication administration process and identify barriers to providing safe medication administration.
  6. Utilization of nursing supervisor meetings, nursing staff meetings, the Quality Management Committee, and other forums to promote process improvements.

## V. REFERENCES

- 2014 National Coordinating Council for Medication Error Reporting and Prevention
- Inmate Medical Services Policies and Procedures, Volume 4, Chapter 4A, Primary Care Model Policy and Procedure
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures Volume 5, Chapter 4, Nursing Competency Policy
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures Volume 5, Chapter 17.1, Nursing Professional Practice Council Policy  
California Correctional Health Care Services, Inmate Medical Services Policies and Procedures Volume 9, Chapter 27, Reporting of Medication Errors and Adverse Drug Reactions