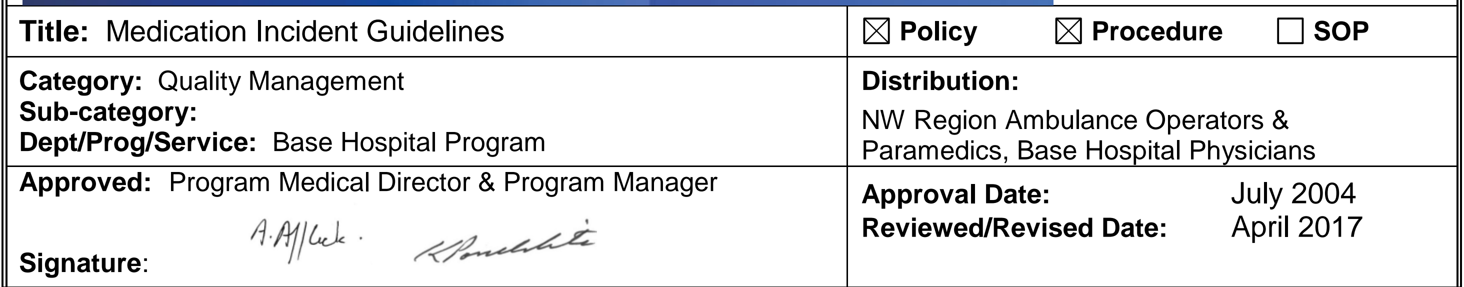
Thunder Bay Regional Health Sciences Centre

Policies, Procedures, Standard Operating Practices

No. QM 500



Title: Medication Incident Guidelines	☒ **Policy** ☒ **Procedure** ☐ **SOP**
Category: Quality Management **Sub-category:** **Dept/Prog/Service:** Base Hospital Program	**Distribution:** NW Region Ambulance Operators & Paramedics, Base Hospital Physicians
Approved: Program Medical Director & Program Manager **Signature:**	**Approval Date:** July 2004 **Reviewed/Revised Date:** April 2017

CROSS REFERENCES: *Quality of Care Review- Quality of Care Information Protection Act (QCIPA) Protected (QM-80); Quality of Care Review- Not covered under QCIPA (QM-81; Mandatory Disclosure of Harm-Critical incidents (QM 70); Medication Incident Reporting Procedures (QM 500A)*

1. PURPOSE

This policy will provide paramedics guidelines for reporting medication incidents. Policy outlines:

i. The Rights of Medication Administration
ii. Patient & Family Centered Care Values & Tips
iii. Glossary of Terms
iv. Three Types of Medication Incidents
    a. Patient Involved
    b. Non Patient Involved
    c. Controlled Substances
v. Criteria for Medication Incidents
vi. Reporting

2. POLICY STATEMENT

All Paramedics must ensure the five rights of medication administration are considered when administering medication to any patient.

5 Rights of Medication Administration

1) Right patient
2) Right drug
3) Right dose
4) Right route
5) Right time

The updated list also now includes:

a. Right to know information about the drug
b. Right to refuse the drug
c. Right documentation

Paramedics must:

- Ensure use of the “rights” of medication administration.
- Avoid medical/medication jargon and acronyms when speaking with patients and families.
- Ask patients to repeat information to ensure full understanding of the treatment or care you are proposing.
- Uses a variety of tools to share information and receive medication history e.g. show the patient the pill or pill bottle you are referring to.

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- Acknowledge patient and families as the experts of their own experience, with information that needs to be heard and acted upon.

3. SCOPE

Primary Care Paramedics (PCP) and Advanced Care Paramedics (ACP).

4. DEFINITIONS

MEDICATION is synonymous with drug and means any substance or mixture of substances used in:

a) the diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical state, or the symptoms thereof;
b) restoring, correcting or modifying organic functions.

Medication therefore includes **symptom relief medication**, diagnostic agents (e.g., radiographic contrast media), **oxygen**, medicated irrigation, **intravenous solutions**, blood products, distillates, etc, in addition to those substances usually considered to be drugs.

MEDICATION INCIDENT is the prescribing, dispensing and/or administration of the wrong medication or dose of medication to the wrong patient, or at the wrong time, or the failure to administer such agents at the specific time or in the manner prescribed or normally considered as accepted practice or according to Medical Directives (i.e. in transport or on-scene) or Hospital policy (i.e. during CME).

MEDICATION INCIDENT (Patient Involvement) involves the actual erroneous administration or omission of a drug to a specific patient.

MEDICATION INCIDENT or Medication Discrepancy (Non-Patient Involvement) A medication incident which does not involve the actual administration of a drug to a patient, where an error in the medication process has been detected and corrected before reaching the patient, (i.e. questionable order given by Base Hospital Physician and therefore not followed), but *excludes* mistakes that were detected and corrected by departmental quality control procedures (i.e. incorrect medication found in supply cupboard).

ON DUTY speaks to medication incidents that might occur while the Paramedic is "**on duty"**. On duty refers to work as a paramedic in the ambulance and during a Base Hospital approved CME. For example, you are on duty when treating a patient on-scene or en-route to a call, or when counting or procuring pharmacy supplies, or when treating a patient in the Hospital setting during a required CME.

5. PROCEDURE

A. Patient Involved Medication Incident

Incident Criteria:
The following criteria should be used for further defining patient-involved medication incidents:

I. Wrong Patient**:** Administration of medication to the wrong patient has occurred.

II. Wrong Dose: Administration of the *wrong dose* is an incident if the dose differs from the ordered dose, *by any* measurable *amount.*

III. Wrong Rate**:** Administration of a drug (e.g. IV solution, oxygen, etc.) at the *wrong rate* is an incident if the rate differs from the ordered rate.

IV. Omission**:** An incident has occurred when a dose has not been administered to a patient; unless the dose was refused or withheld for a documented, justifiable reason (i.e. BHP order, arrival time to ED

is imminent, during CME the RN in care of the patient advises you not to). *Note: Documentation to justify the reason for the omission must be on the ACR and/or nursing notes for any refused and/or withheld medication(s).*

V. Unordered Drug: Administration of an unordered drug to a patient is always considered an incident, except where medical directives permit the administration of such medication(s).

VI. Wrong Drug**:** An incident has occurred when the wrong drug was given. A “wrong drug” may also indicate an “unordered drug” incident and/or an “omission.”

VII. Wrong Route/Wrong Site**:** An incident has occurred when a drug has been administered:

a. By a route or at a site other than that prescribed; or
b. By a route or at a site other than that normally considered acceptable for that drug; or
c. By a route or at a site other than that as indicated in the standing order or protocol.

VIII. Wrong Dosage Form**:** An incident has occurred when a non-prescribed dosage form has been administered per standing order or protocol.

IX. Incorrect Dosage Preparation**:** An incident has occurred when a dose has been prepared contrary to standing order or protocol, then administered to a patient, e.g., incorrect reconstitution of , parenteral crushing of enteric coated tablets, etc

X. Outdated Drugs**:** An incident has occurred when a medication which is older than its labeled expiry date has been given to a patient.

XI. Allergy**:** An incident has occurred when a patient has been given a drug to which he or she has a known allergy; as documented on his or her chart or is observed on their medic alert bracelet or if the patient or their guardian verbally advises you.

XII. Other: Patient-involved medication incidents, which do not fall into any of the foregoing categories, may be classified as “other”. For example; an incident has occurred when a drug has been administered by an unapproved technique (e.g. giving a medication by direct IV injection when not trained to do so or not as indicated by medical directive, such as IM vs. SQ, or not preparing morphine as required).

B. Non-Patient Involved Medication Incident

Incident Criteria
The following criteria should be used for further defining non-patient-involved medication incidents:

I. Prescribing Incidents

Non-patient-involved prescribing incidents are those where an error in a prescription is detected and corrected before any dose(s) reach the patient; otherwise the error is classified as a “patient involved medication incident”. Paramedics will most often run into prescribing incidents when receiving an order from the Base Hospital Physician (BHP).

Under these circumstances, the following examples could be considered prescribing incidents:

a) Prescribing for the wrong patient - writing an order on the wrong chart;
b) Prescribing the wrong drug - the prescribed drug is clearly not indicated for the patient and/or there is a contraindication;
c) Prescribing the wrong dose - a decimal point is misplaced, resulting in an ordered overdose or under dose.

d) Prescribing a drug to which the patient has a documented allergy, using an unacceptable or misleading abbreviation, illegible handwriting and any other prescribing which has a significant potential for patient inconvenience and/or harm.

It should be noted that a prescribing incident is often a matter of opinion and therefore; judgment and discretion must be applied. What is not considered to be accepted practice by one party may be the usual practice of the attending physician when treating patients under these circumstances. Paramedics are responsible to bring their concerns to the attention of the BHP when they feel a prescribing incident has occurred.

II. Dispensing Incidents: Examples

a) An outdated product.
b) The wrong drug.
c) An unordered drug.
d) The wrong strength or dose.
e) The wrong dosage form.
f) An incorrect quantity or wrong number of doses.
g) An incorrectly prepared product (e.g., reconstituted parenteral).
h) An incorrectly labeled product.
i) A drug to which the patient has a documented allergy.

III. Significant Other Incidents: Examples

Incidents which have a significant potential to become patient-involved incidents and to cause patient inconvenience or harm will be considered during audits or call review. Feedback and/or follow up will provided/requested when necessary. For example, incorrect transcriptions and the failure to note an allergy invite a significant patient-involved incident. Similarly, incomplete / illegible orders and use of unapproved abbreviations as well as apothecary terminology can all predispose an order being misinterpreted and a significant error being made.

C. Controlled Substance Medication Incident: Patient & Non Patient Involved

Paramedics must be aware that the distribution, administration, care and control of controlled substances such as, but not limited to, Morphine and Valium, are routinely audited by the Designated Delivery Agent, the Base Hospital, TBRHSC Pharmacy, and the RCMP. Discrepancies in supply and demand or non-compliance with medical directive or policies such as reporting of wastage, breakage, theft, will result in a review by the Base Hospital and possible disciplinary action by the Medical Director if necessary (i.e. written or verbal counsel, education, employee assistance, de-activation or decertification) or, in some cases, criminal charges.

Incident Criteria
The following criteria should be used for further defining controlled substance medication incidents:

a) Any patient involved or non patient involved incident criteria (as per information above);
b) Any call audit, care & control audit, or on-person spot audit that reveals a discrepancy;
c) Any breach in the Controlled Drugs and Substances Act of Canada
d) Any breach in the Medical Directive
e) Any breach in any Base Hospital, Employer or Hospital controlled substance related policies (i.e drug wastage or breakage, medication incident reporting)

Reporting a Medication Incident

Paramedics are encouraged to report all incidents and any concerns involving medication (storage, concentration, care and control, etc) to maintain safe practice. To report a medication incident or concerns refer to *Base Hospital Policy QM 500A Medication Incident Reporting Procedures*.

5. RELATED PRACTICES AND/OR LEGISLATIONS

i. *Ambulance Act* (Ontario) and *Ontario Regulation 257/00*
ii. *Health Canada Controlled Drugs and Substances Act* (CDSA)

6. REFERENCES

i. *BLS & ALS Patient Care Standards*
ii. *Superior North EMS Narcotic & Controlled Substance Policies*
iii. *Base Hospital Program Event Report*