Nebraska Medicine **POLICIES AND PROCEDURES MANUAL** ☒ System ☐ Department **Supersedes:** UH Med Staff - PT-10 Portions of CH Med Staff Rules and Regs. MS 04 Medication Error & Incident Reporting, BMC – Medication Error and Incident Reporting, QMS 01_006; UNMCP- QM09	Section: Leadership (LD) Subject: **Medication Error & SOS Reporting** Number: LD11 Attachments: Attachment A- Incident File Management Date Effective: 05/05/98 Date Reviewed: 08/01/03, 10/1/05, 11/19/07, 2/10, 5/13, 3/16, 4/18

MEDICATION ERROR & INCIDENT REPORTING

POLICY

It is the intent of this policy and procedure that safety event reports are created specifically for exclusive use by a peer review committee pursuant to Neb. Rev. Stat. Section 71-7904 through7913. It is the further intent of this policy and procedure that all information, interviews, statements, memoranda or any other data collected or furnished is privileged communication and not subject to discovery or disclosure as set forth in Neb. Rev. Stat. Section 71-7912.

Healthcare workers involved in patient care, medication and or equipment use are required to participate in the detection and reporting of adverse events or near misses involving patients, contracted services or visitors. A Shout Out for Safety (SOS) report should be completed even if a staff member is in doubt as to whether a report has been completed or whether the event should be reported.

- Completion of an SOS report does not replace documentation of the event in the medical record or other required reporting, as applicable.
- The responsibility for initiating an SOS report rests with the healthcare worker or physician who witnesses, discovers, or has direct knowledge of the event.
- All personnel who have knowledge of the occurrence will provide information prior to the end of their shift or before leaving the facility.
- Individuals involved in safety events or having knowledge of safety events will avoid making any statements alluding to or regarding liability.

Managers and/or designees assigned to receive notification of SOS reports are responsible for reviewing them on a regular basis.

- To facilitate communication and ensure timely response to the events, files will be reviewed, thoroughly investigated, and communication will occur between multidisciplinary team members if applicable.
- SOS report files should be opened and investigation initiated within three days.
- Completion of investigation and closing of SOS report files should normally occur within 14 days from report file date.
- Failure to complete timely review and completion of SOS reports may result in escalation through the Quality & Patient Safety committee structure and the appropriate area supervisor.

DEFINITIONS:

- Patient Safety Event: An event, incident, or condition that could have resulted or did result in harm to a patient.

- Medication errors are classified as safety events. A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm. While the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use." (definition is from the National Coordinating Council for Medication Error Reporting and Prevention, retrieved 1/7/16 from http://www.nccmerp.org/about-medication-errors)

NOTE: Adverse drug reactions, transfusion reactions and employee incidents are NOT subject to this policy. Such events should be reported according to hospital policies MS03, MS18, and HR 42 respectively.

Event Location: If a safety event involves a patient or visitor, the event location is the area where the patient or visitor impacted by the event was located when the event occurred.

PURPOSE

Describe the process for identification, documentation and aggregation of occurrences and to provide timely and accurate flow of quality and risk information to appropriate patient care units, departments, risk management, and hospital administration.

The goal of reporting actual and near miss (potential) events is to learn about their causes, enhance patient care delivery systems, and reduce the likelihood of future occurrences thus providing a safe environment of patient care.

PROCEDURE

A. **Immediate actions by person who discovers event:**
   1. Implement nursing or other professional actions and clinical procedures or treatments.
   2. For cases that involve serious harm, notify by phone or in person manager or lead nurse and document in the SOS reporting system (RL Solutions) as soon as reasonably possible.
   3. Document in the medical record:
      - Statement of the event as it relates to the patient. Only ACTUAL FACTS will be recorded.

      NOTE: DO NOT make a note in the Medical Record that an SOS Report was completed.

   4. If event involves equipment/medical device or disposable products, remove the product from service, tag appropriately and sequester for further investigation. Save all materials, disposables, packaging, etc. that were associated with the event.

B. Manager/Designated Reviewer receiving report will complete file management actions (See Attachment A – SOS Report File Management).

C. Patient Safety and Medication Safety staff will:
   1. Review SOS reports.
   2. Contact manager or appropriate medical staff to obtain more detailed analysis of the event as necessary.
   3. Determine if specific events or trends need further investigation through the root cause analysis or a formal peer review process.
   4. Assist management with the development of monthly trend reports for their units.
   5. Review and analyze event reports for organizational trends.
   6. Provide roll up reports to committees who have requested trending of data.

Related Policies and Procedures
Adverse Drug Reaction (ADR) Reporting, MS 03
Root Cause Analysis, PI 01
Sentinel Events, LD 07

Reviewed By: Core Event Review Team 04/2018

STAFF ACCOUNTABILITY:
Risk Council 04/2018
Nebraska Medicine Quality & Patient Safety Steering Committee 04/2018

Department Approval		**Administrative Approval**	
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