☐ADMINISTRATE POLICY & PROCEDURE (APP)	✔INSTITUTIONAL POLICY & PROCEDURE (IPP) ✔INTERDEPARTMENTAL ☐ INTERNAL

TITLE		POLICY NUMBER/V#
Medication Errors Reporting		MMC – MED – 11 (01)
INITIATED DATE	**EFFECTIVE DATE**	**REVISED DATE**
02/08/2025	**01/09/2025**	**01/08/2028**
REPLACES NUMBER		**NO. OF PAGES**
N/A		**04**

APPLIES TO	RESPONSIBILITY
All Healthcare Professionals	Pharmacy, Nursing, Procurement

1. PURPOSE:

1.1 To improve the process for monitoring, identifying, and reporting Medication Errors, near miss and initiating appropriate corrective measures.

1.2 To prevent and/or control potential and actual medication errors to enhance patient care and improve patient safety.

2. DEFINITION:

2.1Medication Error: Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems, including prescribing, dispensing, distribution, administration, education, monitoring and use.

2.2 Significant Medication Error: Any medication error that if not prevented may cause significant harm to the patient (i.e. permanent harm or death).

2.3 Near- Miss: An event or situation that could have resulted in an adverse event that caused patient harm but that did not, either by chance or through timely intervention.

2.4 Look-Alike and Sound-Alike Medications (LASA): Medications with generic or proprietary names that look or sound like other medications.

2.5 Patient Safety: Freedom from accidental during the course of medical care; activities to avoid, prevent, or correct adverse outcomes that may result from the delivery of healthcare.

2.6 Harm: An unexpected or normally avoidable outcome that negatively affects a patient's health and/or quality of life and that occurs or has occurred during the course of receiving healthcare or services.

2.7 Sentinel Event: An event that, when noted, requires intensive assessment and prompt response. An unexpected occurrence involving death, serious physical or psychological injury, or the risk thereof, and any event that might cause
embarrassment or risk to the healthcare organization, with potential legal ramifications and/or media inquiries or coverage. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a
significant chance of a serious adverse outcome. Such events are called "Sentinel "because they signal the need for immediate investigation and response.

2.8 Root Cause: The ultimate reason for an event/condition.

2.9Root Cause Analysis: A collective term used to describe a wide range of approaches, tools and techniques used to uncover causes of problems.

3. POLICY:

3.1 Medication error reporting is a multidisciplinary process that involves all healthcare professionals at ****.

3.2 Patients or staff wishing to report any medication error may do so through a healthcare professional in the clinic.

3.3 Improvement in medication processes and staff training are used to prevent error in the future.

3.4 Reporting of medication error is done by filling "Occurrence/Variance Report (OVR)" through the OVR form. (Refer to OVR policy)

3.5 Medication error reporting is a non-punitive and strongly encouraged process that can be done anonymously.

3.6 The person responsible for reporting medication error is the one who first discovers it.

3.7 Report submission for the person involved should be made within the same shift or duty period of the occurrence.

3.8 The organization uses medication errors and near misses reporting information to improve medication use processes.

3.9 The Quality Coordinator will report to the medical director and head of pharmacy a compiled Medication Error Report on quarterly basis.

3.10 Any sentinel event involving medication will be immediately brought to the attention of the administration to conduct multidisciplinary Root-Analysis for further investigation.

4. PROCEDURE:

4.1 Once identified, medication error must be reported immediately to the attending physician and/ or head nurse/ charge nurse, as appropriate for patient safety purposes (especially when a serious or potentially serious event occurs). Stabilize you patient first; patient safety is our main goal.

4.2 Completion of the report should be done within the same shift or duty period by first person encountering the incident

4.3 Report the medication error using the OVR Form.

4.4 The direct supervisor carries out the required investigation and takes corrective action as needed.

4.5 If a Medication Error meets the criteria of Sentinel Event as per definition, OVR form will be completed, then (Refer to Sentinel Event Policy).

4 **4.6** Any sentinel event involving medication will be immediately brought to the attention of relevant authorities for further investigation. (Refer to Sentinel Event Policy)

4.7 An intensive root cause analysis will be conducted for significant and potentially significant medication errors.

4.8 All medication error / near miss statistical reports will be discussed during the Medical Committee On quarterly basis for further action.

5. RESOURCES:

a. N/A

6. CROSS REFERENCE:

6.1 Incident management Policy

6.2 Sentinel Event Policy

7. REFERENCES:

7.1 CBAHI National Standards for Ambulatory Care Centers, Effective Jan,2020.

7.2 The Joint Commission International (JCI), 7th Edition, Effective Jan 2021.

8. FORMS & ATTACHMENT:

8.1 OVR Form

9. approved

APPROVALS & REVIEWS:			
Prepared By	**Title**	**Date**	**Signature**
Ms. Mentalla Alaa Fouad	**Head of Nurse**	**02-08-2025**	
Reviewed By			
Dr. Mostafa Mohammed Osman	**Quality Director**	**02-08-2025**	
Approved By			
Dr. Abdulmajeed Abdullah Saleh	**Medical Director**	**02-08-2025**	
Eng. Meshaal Hussein Alghamdi	**Executive Director**	**02-08-2025**	