


LAPEER COUNTY COMMUNITY MENTAL HEALTH

Date Issued 11/19/2009  
Date Revised 03/16/12; 07/14/21

<b>CHAPTER</b> Health/Medical	<b>CHAPTER</b> 03	<b>SECTION</b> 001	<b>SUBJECT</b> 15
<b>SECTION</b> Drugs and Medication		<b>DESCRIPTION</b> Medication Errors	
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**APPLICATION:**

<input checked="" type="checkbox"/> CMH Staff	<input type="checkbox"/> Board Members	<input checked="" type="checkbox"/> Provider Network	<input checked="" type="checkbox"/> Employment Services Providers
<input checked="" type="checkbox"/> Employment Services Provider Agencies	<input checked="" type="checkbox"/> Independent Contractors	<input checked="" type="checkbox"/> Students	<input checked="" type="checkbox"/> Interns
<input type="checkbox"/> Volunteers	<input type="checkbox"/> Persons Served		

**POLICY:**

Lapeer County Community Mental Health ensures the health and well-being of persons served related to the management and follow-up of medication-related errors.

**STANDARDS:**

- A. LCCMH will monitor areas of risk management involving medication errors.
- B. The health and safety of persons served will be addressed immediately related to any medication errors.
- C. Medication errors will be reported via Incident Reports in OASIS to appropriate supervisor and Recipient Rights Office.
- D. Medication errors will be appropriately documented in the electronic health record.

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- E. Medication errors will be reviewed quarterly for identification of possible training needs and quality improvement opportunities for staff.

**PROCEDURES:**

- A. When a medication error occurs, staff complete the following steps immediately:
1. When a person served has ingested medication in error, advise appropriate medical staff and supervisor, assess risk to person served and respond accordingly.
  2. Report medication error to a nurse or a supervisor.
  3. Notify prescriber as necessary and follow directives. If needed, call Poison Control (1-800-222-1222). Phone number is posted where CPR / choking posters are displayed.
  4. Notify guardian and/or home staff as necessary.
  5. Complete an incident report in OASIS.
  6. Route Incident Report to Supervisor and Recipient Rights Office.
- B. The LCCMH Clinical Case Review Committee will review medication error-related incident reports for trends related to training needs or quality improvement opportunities each quarter. This review will be forwarded to the Quality Council Committee for approval.
- C. The following are not considered medication errors, but they do need to be attended to and reported following the same procedures as for reporting medication errors:
1. Any and all adverse reactions to medications observed by staff.
  2. The incorrect dispensing of medication by a pharmacy, which would include the incorrect medication and/or incorrect dosage.

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**DEFINITIONS:**

A medication error is defined as any of the following:

- Medications discovered on the floor, counter, medicine tray, or anywhere left unattended.
- Mistakes having been made in any of the following areas: person served, time, medication, dosage, and/or route.
- Medication cupboard left open and unattended, or key left in door or out in clear sight.
- Medications given by untrained staff.
- Administering medications not properly labeled or identifiable.
- Failure to initial medication sheet when meds are given.

TC:mgr

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This policy supersedes  
#11/09047 dated 11/19/2009.  
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