# 7.2.24 MEDICATION ERRORS

Issue Date: 04/08/2013

Revision History: 05/26/2026

References: Not Applicable

Policy Owner: Behavioral Health Division, Quality Assessment and Performance Improvement (QAPI), Quality Assurance Manager

Director Signature: **Signature on File**

## I. Policy Statement

To document the procedures for the multi-disciplinary review of sentinel events to allow appropriate follow-up and the implementation of corrective actions for the prevention and/or reduction of Medication Errors.

## II. Scope

This policy applies to all Department of Health Services, Behavioral Health Division (DHS-BHD) Covered Persons including employees (full-time, part-time, extra-help), unpaid interns, paid interns, temporary agency workers, registered volunteers, and all individual providers contractually designated as covered persons. Covered Persons do not include Community Based Organization (CBO) staff.

## III. Definitions

Not Applicable

## IV. Policy

All Sonoma County Behavioral Health (SCBH) staff members are required to report all Medication Errors in accordance with DHS-BHD Policy No. 7.1.16, *Unusual Occurrences and Sentinel Event Reporting*. Sentinel Event reports are evaluated by the Sentinel Event Reporting Sub-committee of the Quality Improvement Steering Committee (QIS). Recommendations for action or follow-up are made as appropriate.

## V. Procedures

A Medication Error is any event that may cause or lead to inappropriate medication use. Such events include, but are not limited to: ordering, transcription, labeling, packaging, dispensing, administration, and monitoring. Use the built in template formatting styles in this template, as follows.

A. Medication Errors – Types and Examples

1. Order Error – Types and Examples

    a. Inappropriate medication selected.

    b. Inappropriate dose.

    c. Illegible order.

    d. Duplicate order.

    e. Order not dated/timed (time applies to Psychiatric Emergency Services (PES) and Jail documentation only).

    f. Wrong client/wrong chart.

    g. Verbal order written incorrectly, or verbal order not written in the chart.

    h. Wrong frequency, route, therapy duration, or use of nonstandard nomenclature or abbreviations.

2. Transcription Error – Transcription involves both the orders that are manually transcribed into a paper record and those electronically transcribed into computer systems (e.g., electronic health record, pharmacy computer system). Types of transcription errors include:

    a. Wrong medication, time, dose, frequency, or duration.

    b. Misunderstanding, or verbal orders not entered correctly.

    c. Order not manually transcribed correctly.

    d. Wrong pharmacy order entry.

3. Administration Error – Administration Errors include:

    a. Wrong client.

    b. Correct client but wrong dose, time, medication, route, omission, or unauthorized dose given.

c. Preparation/Dispensing Error - inaccurate labeling, wrong quantity, medication, wrong dose, expired medication, refill error, or med box filled incorrectly.

d. Significant delay in medication delivery.

4. Review and Trending of Medication Errors

   a. The Quality Improvement (QI) Coordinator and the Medical Director, in collaboration with the Sentinel Event Review Committee and other appropriate personnel, shall review all Medication Errors and assign the appropriate severity level.

   b. On a periodic basis, Medication Error data are trended based on severity levels for continued analysis.

5. Case Conferences for Medication Errors

   A case conference is convened for significant Medication Errors to conduct a root cause analysis. The case conference may include the Medical Director, QI Coordinator, Program Manager, and other appropriate staff. The focus of the case conference is on system improvement rather than employee discipline. Review and documentation of the event shall include:

   a. Immediate corrective action(s) taken; including any staff training for personnel involved in the incident.

   b. The outcome and/or consequences of the error.

   c. Details of any systemic corrective action plans to prevent reoccurrence.

   d. The date, location, and participants in the case conference.

## B. Category and Severity Level Definitions

**Medication errors shall be assigned a severity level by the Sentinel Event Sub-Committee based on the following criteria:**

**No Harm:** Error was identified and corrected before client could suffer harm.

**Temporary Harm:** Error required increased monitoring, medical treatment, intervention, or hospitalization due to the medication error. Harm caused is of a temporary nature.

**Permanent Harm:** Error resulted in the client suffering permanent harm, near-death (e.g., anaphylaxis, cardiac arrest, etc.), and/or death.

**Categories:**

1. Categories 1: Reported incident was by pharmacy staff:
    1. A. No harm to client
    1. B. Temporary harm to client
    1. C. Permanent harm to client
2. Category 2: Reported incident was by California Forensic Medical Group (CFMG)/jail medical staff:
    2. A. No harm to client
    2. B. Temporary harm to client
    2. C. Permanent harm to client
3. Category 3: Reported incident was by Behavioral Health (BH) staff:
    3. A. No harm to client
    3. B. Temporary harm to client
    3. C. Permanent harm to client
4. Category 4: Reported incident was by contract provider staff:
    4. A. No harm to client
    4. B. Temporary harm to client
    4. C. Permanent harm to client

## VI. Forms

None

## VII. Attachments

None