1.0 PURPOSE

The purpose of this policy is to reduce risk and harm to patients through a safety system focused on strategies that improve clinical practice.

2.0 REFERENCES AND DEFINITIONS

.1 References

a. Hawaii Revised Statutes, Section 26-14.6, Department of Public Safety; and Section 353C-2, Director of Public Safety, Powers and Duties.


.2 Definitions

a. Adverse Clinical Event: injury or death caused by medical management rather than by the patient’s underlying disease or condition.

b. Error Reporting System: includes policies and procedures that outline how health care staff voluntarily identify and report all clinical errors, whether the error occurs by omission or commission.

c. Near Miss Clinical Event: an error in clinical activity without a consequential adverse patient outcome.

d. Patient Safety Systems: practices and/or interventions designed to prevent adverse or near miss-clinical events.

3.0 POLICY

.1 The Health Care Division shall in conjunction with the facility Clinical Section Administrators proactively implement patient safety systems to prevent adverse and near miss clinical events.

.2 The Health Care Division in conjunction with the facility Clinical Section Administrators shall implement an error reporting system for health staff to voluntarily report, in a non-punitive environment, errors that affect patient safety.
4.0 PROCEDURES

.1 All newly hired nursing staff shall undergo a thorough orientation including the successful passing of a medication administration skills test, a complete review of all nursing procedures, departmental policies and procedures per the orientation policy.

.2 All nursing staff shall undergo an initial and then annual review of Core Competency skills necessary to perform within a correctional setting.

.3 All nursing and provider staff shall receive education on the use and completion of the Clinical Event and Medication Error reports (Attachment 1 & 2).

.4 All errors and near misses shall be confidentially reported to the responsible health authority (RHA). The RHA shall review each event analyzing what happened during the event and any contributory factors to determine causation. The RHA shall submit a narrative report indicating the results of their analysis and actions or initiatives under taken to address the incident. This data shall be used for event trending, identifying the need for retraining, and formulation of quality improvement initiatives.

   a. Incidents involving all other aspects of clinical care including but not limited to nursing, medical records, and dental services shall be routed to the Clinical Services Branch Administrator for review, identification of needed system-wide organizational structure and function improvements, trending and reporting to the QI Committee.

   b. Incidents involving mental health staff shall be routed to the Mental Health Branch Administrator for review, identification of needed system-wide organizational structure and function improvements, trending and reporting to the QI Committee.

   c. Incidents involving provider practice shall be routed to the Medical Director for review, identification of needed system-wide organizational structure and function improvements, trending and reporting to the QI Committee.

.5 All errors and near misses shall be reported in a non-punitive, supportive environment. Data is used to evaluate for trends, review current practice patterns and ultimately improve patient practice through incorporation into the facility CQI process.

NOT-CONFIDENTIAL
.6 All patients shall present either a picture or picture ID wrist which shall be used for patient identification during medication administration to decrease medication administration errors.

5.0 **SCOPE**

This policy and procedures applies to all correctional facilities and their assigned personnel.

**APPROVAL RECOMMENDED:**

![Signature]

**Acting Medical Director**

**Date**

**Health Care Division Administrator**

**Date**

**Deputy Director for Corrections**

**Date**

**APPROVED:**

![Signature]

**Director**

**Date**

**NOT-CONFIDENTIAL**
STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

MEDICATION ERROR REPORT

Date:________

I. GENERAL INFORMATION (please complete below)

Name of Patient: _____________________________

Date of Birth: ____________ Diagnosis of Patient: _____________________________

Date and Time of medication error: _____________________________

Name(s) of individual(s) involved with medication error:

_____________________________________________________

_____________________________________________________

Date and Time of discovery of medication error: ____________

Name(s) of individual(s) who discovered medication error:

_____________________________________________________

II. INFORMATION REGARDING MEDICATION INVOLVED (please complete below)

Name of medication involved in error: _____________________________

Medication Dose (please write dosage): Ordered_________________ Given_________________

Medication Route (please circle): Ordered - PO IM IV SQ SL Given - PO IM IV SQ SL

Medication Administration Order (please circle): Drug ordered and given

Drug ordered and not given

Drug not ordered and given

III. OBJECTIVE NARRATIVE DESCRIPTION OF MEDICATION ERROR:

_____________________________________________________

_____________________________________________________

_____________________________________________________

IV. CAUSE(S) OF MEDICATION ERROR (please check below)

A. Failure to Follow Procedure

___ Patient not identified correctly

___ Comparison of medication container label and/or medication administration record with physician medication

Order is not consistent

___ Administration route of medication not checked correctly

___ Patient not observed taking medication

___ Timely charting of medication administration not done
B. Failure to Communicate

___ Physician medication order not written correctly
___ Physician medication order not transcribed correctly
___ Transcribed physician medication order not read correctly

C. Other

___ Pharmacy Dispensing Error: __________________________ (Pharmacy Name and Location, if approp.)
___ Medication not available
___ Other (please describe) ______________________________

V. TYPE(S) OF MEDICATION ERROR (please check below)

___ Wrong patient
___ Wrong dose
___ Wrong time
___ Wrong date
___ Medication given when not ordered
___ Other (please describe) ______________________________

___ Wrong route
___ Transcription error
___ Wrong medication
___ Medication not given

V. PATIENT OUTCOME (please complete below)

Patient seen by physician (please circle): Yes No

If "No" please explain __________________________

Date and Time patient seen by physician __________________________

Intervention(s) implemented for patient __________________________

Physician's statement of assessment/intervention and signature __________________________

VI. REVIEWING SIGNATURES (please sign and date below, as applicable)

Individual(s) who made error: __________________________

Individual(s) who discovered error: __________________________

Individual who completed this report: __________________________

Clinical Section Administrator: __________________________

Prescribing Physician: __________________________

Clinical Services Branch Administrator: __________________________

Comments/Remedial Actions Taken: __________________________