GEORGIA DEPARTMENT OF CORRECTIONS

Standard Operating Procedures

Policy Name: Medication Errors		
Policy Number: 507.04.46	**Effective Date:** 01/25/2022	**Page Number:** 1 of 4
Authority: Commissioner	**Originating Division:** Health Services Division (Physical Health)	**Access Listing:** Level I: All Access

I. Introduction and Summary:

The purpose of this policy is to ensure Medication Errors will be documented, thoroughly investigated, and reported. Appropriate corrective actions will be taken as indicated. This procedure is applicable to all facilities that house Georgia Department of Corrections (GDC) offenders including private and county prisons where medications are administered.

II. Authority:

A. GDC Standard Operating Procedures (SOPs): 507.04.47 Intravenous Therapy, 507.04.76 Incident Reporting, and 507.04.78 Pharmacy and Therapeutics Committee;

B. NCCHC 2018 Adult Standards: P-D-01 and P-D-02; and

C. ACA Standard: 5-ACI-6A-43 (ref. 4-4378).

III. Definitions:

A. **Medication Errors** - A medication error is broadly defined as a dose of medication that deviates from the physician's order as written in the patient's chart or from standard policy and procedure. The incorrect medication dose must actually reach the patient. A Wrong Dose that is detected and corrected before administration to the patient is not a medication error.

B. **Serious Adverse Event** - An event after medical treatment that results in hospitalization, disability, and death.

C. **Category of Medication Error** - May encompass any of the following:

1. **Omission:** The failure to administer an ordered dose.

2. **Unauthorized Drug:** Administration to the patient of a medication dose not authorized for the patient such as: a dose given to the wrong patient, duplicate

doses, administration of an unordered drug, and a dose given outside a stated set of clinical parameters.

3. **Wrong Dose:** Any dose that is the wrong number of pre-formed units or any dose above or below the ordered dose by a predetermined amount.

4. **Wrong Route:** Administration of a drug by a route other than that ordered by the prescriber. Doses given via the correct route but the wrong site (e.g., left eye instead of right) are also included.

5. **Wrong Rate:** Administration of a drug at the Wrong Rate of administration, not by the physician's order or as established by policy.

6. **Wrong Dosage Form:** Administration of a drug by the correct route but in a different dosage form than that specified by the prescriber.

7. **Wrong Time:** Administration of a dose of drug greater than plus/minus one (1) hour from its scheduled administration time.

8. **Wrong Preparation of a Dose:** Incorrect preparation of the medication dose such as:

    a. Incorrect dilution or reconstitution;

    b. Not shaking a suspension;

    c. Using an expired drug;

    d. Not keeping a light-sensitive drug protected from the light; and/or

    e. Mixing drugs that are physically/chemically incompatible.

9. **Incorrect Administration Technique**: Situations when the drug is given via the correct route, site, and so forth, but improper technique is used.

10. **Pharmacy Filling Error.**

IV. Statement of Policy and Applicable Procedures:

A. Identification of Medication Errors:

1. When a medication error is discovered, an MD, NP, PA will be notified and provided information regarding the type of error and any adverse effects experienced by the patient. The provider will determine what treatment, if any, is appropriate. Once the error is identified, an assessment of the patient and a plan of care will be documented in the progress note. The patient must be referred to a provider for follow-up.

2. An approved medication incident/error report will be completed for all Medication Errors and sent to the nursing and medical authority.

3. Incident reports will be documented, investigated, the Category of Medication Error identified, and any necessary corrective action taken.

4. Incident reports will be placed in a confidential file in the medical unit. This report is **not** part of the offender's health record and will **not** be referenced in the progress note.

5. Any Serious Adverse Event, as the result of a medication error, will be documented in the health record and reported to the Statewide Medical Director, Statewide Clinical Services Supervisor, the Warden of the facility, and the Department's General Counsel within twenty-four (24) hours of event discovery.

6. Serious Adverse Events will be reported to the Statewide Pharmacy and Therapeutics Committee and the GDC General Counsel.

Note: The clinical update associated with this SOP may be found on the GDC Intranet at Captiva/Resources/Health Services Documents/02 Physical Health/Clinical Updates/P-33-0004-01, Medication Incident/Error Report.

V. **Attachments:** None.

VI. **Record Retention of Forms Relevant to this Policy:** None.