PPNO List Serv Query Summary: **Medications Administered in Error**

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| Contact for further information: | Marika Bishop, BSc., ILCO, ITIL  Manager, Policy Development and Special Projects | Professional Practice Office  Centre for Addiction and Mental Health Tel: (416) 535-8501 ext. 30597 | Ema: [marika.bishop@camh.ca](mailto:marika.bishop@camh.ca) |
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| Date of Summary | August 17, 2020 |
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| Abbreviated Question (as it will appear on search results page) | * Where are medications administered in error (medications that have not been ordered such as wrong dose, time, medication, route or patient) documented in the health record in your organization? |
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| Keyword(s) Check 1 or 2. Required for website archiving | Policy/Procedure  Practice  Program Info  Committee Structure info  Role  Students  Model/Structure  Care Delivery  Collaboration  Pt. Safety  Regulation/Legislation  Quality/Outcome/Indicator  PP Culture/Leadership  Other: |

Responses: Please cut and paste responses from emails into the table, save and send summary table to PPNO List Serv. Allow 3 weeks for responses to filter in before sending final

| **Responder Info** | **Comments** | **Attachment(s)\*** |
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| Corinne Savignac, R.N., BScN  Nurse Clinician General Internal Medicine **Health Sciences North | Horizon Santé-Nord** Tel: (705) 523-7100 ext. 3315 [csavignac@hsnsudbury.ca](mailto:csavignac@hsnsudbury.ca) [www.hsnsudbury.ca](http://www.hsnsudbury.ca) | The nurses would document this in the narrative portion (progress notes) of the patient’s chart (an incident report would also be completed through our online reporting system). |  |
| Glen-mary Christopher Policy Specialist, Corporate and Clinical Policy –Swift Current  **Saskatchewan Health Authority**  Cel: (306) 316-5298 [Glen-Mary.Christopher@saskhealthauthority.ca](mailto:Glen-Mary.Christopher@saskhealthauthority.ca) [www.saskhealthauthority.ca](http://www.saskhealthauthority.ca) | In Saskatchewan, patient safety incidents (which would include medication errors) are documented on patient safety reports, which are privileged and confidential internal documents for quality improvement purposes; AND the facts of the incident are documented in the patient’s health care record, including assessment, follow-up care and monitoring, etc. |  |
| Susan MacNeil RN, MN Advanced Practice Nurse – Clinical Nurse Specialist for Gerontology | Professional Practice **Providence Care Hospital** Tel: (613) 544-4900 ext. 53394 [macneis4@providencecare.ca](mailto:macneis4@providencecare.ca) [www.providencecare.ca](http://www.providencecare.ca) | We use an electronic patient record so the medication could not be administered unless ordered by the physician and checked by the nurse electronically and even then it would have to be transferred to the drug cabinet profile. If it was ordered in error the physician would have to discontinue the order in ePR. A progress note indicating that the error occurred and the follow up and disclosure with the patient would occur by either the nurse or the physician depending on who made the error and a Safe report would be filled out.  Previously I worked in a paper system and if a transcription error and administration error occurred, the medication would be crossed off as “ERROR - Wrong Patient “ and crossed off, a progress note made indicating the follow-up and disclosure with the patient and a SAFE report completed. The medication would have to be signed off even if the error was made either on transcription or ordering but then cancelled with reference to reason for cancelling it e.g. see progress note. Potential reasons for the error were not documented in the chart just the SAFE report for quality review. |  |
| Grace Sutherland, RN, BScN, MN Informatics Coordinator/Clinical Educator **Almonte General Hospital**  Tel: (613) 256-2500 ext. 2507 [gsutherland@agh-fvm.com](mailto:gsutherland@agh-fvm.com) [www.agh-fvm.com](http://www.agh-fvm.com) | We use Cerner as our EMR. If someone has charted a medication in error, it is a simple right click on the medication administered and the nurse can choose “Modify” or “Unchart”. Modifications are allowed with no justification; however, the nurse can always enter a comment if they want. The chart shows the time as modified. When uncharting, a box pops up that allows free text to indicate why you are uncharting the medication. I have entered an example from our ‘train’ environment.  cid:image002.png@01D661C8.56C7DAA0 |  |
| Talitha Brush Policy Coordinator  **Sunnybrook Health Sciences Centre** Tel: (416) 480 6100 ext. 7693 [talitha.brush@sunnybrook.ca](mailto:talitha.brush@sunnybrook.ca) [www.sunnybrook.ca](http://www.sunnybrook.ca) | See Section 12. |  |
| Sara Leblond, RN, MScN, IIWCC Clinical Manager  Med/Surg/ECU, Rehabilitation, Discharge Planning, Complex Care and Clinical Nutrition **Winchester District Memorial Hospital / Hôpital Winchester District Memorial Hospital** Tel: (613) 774-2422 ext. 6339 [sleblond@wdmh.on.ca](mailto:sleblond@wdmh.on.ca) [www.wdmh.on.ca](http://www.wdmh.on.ca) | Depends on the error and impact on the patient. Most usually in a variance note.  Then PRN as needed depending on the error. |  |
| Lorraine Bird, RN, MScN Interim Clinical Educator Collingwood General and Marine Hospital Tel: (705) 445-2550 [birdl@cgmh.on.ca](mailto:birdl@cgmh.on.ca) [www.cgmh.on.ca](http://www.cgmh.on.ca) | We have an electronic meditech risk reporting system where it would go. Not sure we have a specific policy on where it must be documented in the patient chart. |  |
| Trent Fookes, RPh, BSP  Director, Pharmacy Grey Bruce Health Services │ Owen Sound  Tel: (519) 376-2121 ext. 2101 Cel: (519) 374-5568 [tfookes@gbhs.on.ca](mailto:tfookes@gbhs.on.ca) [www.gbhs.on.ca](http://www.gbhs.on.ca) | Not completely consistent here at GBHS – of course, any medication errors are identified in our Risk Reporting system, and if appropriate, external registers such as NSIR.  For wrong dose and wrong time errors, we encouraged documentation in our health record on our electronic MAR (eMAR) to provide the information in a consistent manner for the care team.  For wrong drug errors, we don’t record these on the eMAR, as there would be an increased risk of error if we were to enter the incorrect drug into the patient profile so that it could be recorded on the eMAR. There are other types that are also problematic to enter into the eMAR, such as self-administration of unknown drugs or quantities. These should all be recorded in our clinical notes sections so the care team has the information at hand. |  |

\*Imbedding Attachments: When in a document, with the cursor in the place where you wish to insert another document as an icon, Go to Insert, choose "Object" (not 'file') choose "Create from File" browse for the file name from your directory, once found, check off "Display as Icon" select "OK” The document Icon now appears in this document where your cursor was positioned. Save the document you are working in and the imbedded icon with the document they relate to attached will also be saved to this document.