SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section Pharmacy	**Effective:** 10/10/2018
Sub-section	**Version:** 1.0
Policy Pharmacy Medication Errors	**Last Revised:** New Policy
Policy # 17.016	

Director's Approval _____ Alice Gleghorn, PhD **Date** 10/22/18

Pharmacist-in-Charge Approval _____ Morgan Peterson, PharmD **Date** 10/22/18

Audit Date: 10/10/2021

Supersedes: New policy

1. PURPOSE/SCOPE

1.1. To establish a quality assessment program to document and assess medication errors that occur at the Santa Barbara County Mental Health Services Pharmacy (hereafter the "Pharmacy").

2. DEFINITIONS

2.1. **Medication error** – any variation from a prescription or medication order not authorized by the prescriber. Medication errors do not include any variation that is corrected prior to furnishing the medication to the patient.

3. POLICY

3.1. The Pharmacy shall establish a quality assessment program to determine medication error causes and contributing factors. This program shall also identify and implement corrective action to improve the quality of Pharmacy services and prevent medication errors in the future. [16 CCR §1711(a)]

4. MEDICATION ERROR PROCEDURE

4.1. A pharmacist will identify if a medication error has potentially occurred wholly or in part as a result of actions taken by Pharmacy personnel. This includes, but is not limited to, wrong medication dispensed, wrong strength, wrong quantity, wrong directions, wrong patient, or clinically significant delay in therapy.

4.2. When a pharmacist determines that a medication error has occurred, a pharmacist shall as soon as possible:

a. Communicate to the program's team lead the fact that a medication error has occurred and the steps required to avoid injury or mitigate the error.

b. Communicate to the prescriber the fact that a medication error has occurred. [16 CCR §1711(c)(2)(A-B)]

4.3. The communication requirement shall only apply to medication errors if the medication was administered to the patient, or if the medication error resulted in a clinically significant delay in therapy. [16 CCR §1711(c)(3)]

4.4. An investigation of each medication error shall commence as soon as is reasonably possible, but no later than two (2) business days from the date the medication error is discovered. All medication errors discovered shall be subject to a quality assessment review. [16 CCR §1711(d)]

4.5. The quality assessment review will analyze, individually and collectively, investigative and other pertinent data collected in response to a medication error to assess the cause and any contributing factors such as system or process failures. A record of the quality assessment review shall be immediately retrievable in the Pharmacy. The record shall contain at least the following information:

a. Date, location, and participants in the quality assessment review;

b. Pertinent data and other information relating to the medication error(s) reviewed and documentation of any contact with the program's team lead and prescriber as required;

c. Findings and determinations generated by the quality assessment review; and,

d. Recommended changes to Pharmacy policy, procedure, systems, or processes, if any. [16 CCR §1711(e)(1-4)]

4.6. The Pharmacy shall inform Pharmacy personnel of changes to Pharmacy policy, procedure, systems, or processes made as a result of recommendations generated in the quality assessment review. [16 CCR §1711(e)]

4.7. The record of the quality assessment review shall be immediately retrievable in the Pharmacy for at least one (1) year from the date the record was created. [16 CCR §1711(f)]

5. UNUSUAL OCCURRENCE INCIDENT REPORTING

5.1. All Pharmacy medication errors that were not corrected prior to the medication being administered to the patient or result in a clinically significant delay in therapy must be reported in accordance with the Department of Behavioral Wellness Unusual Occurrence Reporting policy. An incident report is required regardless of whether or not the medication error resulted in an adverse outcome.

a. **Psychiatric Health Facility (PHF) Unusual Occurrence Reporting.** Significant medication errors resulting in serious adverse outcomes is a listed incident category on the DHCS PHF 24-Hour Unusual Occurrence Report. [22 CCR §77036] A significant medication error that occurs at the PHF resulting in a serious adverse outcome (e.g., toxicity, serious allergic reaction, emergency room transfer, death) shall be reported to the Department of Health Care Services (DHCS) within 24 hours of the incident in accordance with the PHF's Unusual Occurrence Reporting policy.

6. BOARD OF PHARMACY COMPLIANCE

6.1. The Pharmacy's compliance with this policy will be considered by the California State Board of Pharmacy as a mitigating factor in the investigation and evaluation of a medication error. [16 CCR §1711(g)]

ASSISTANCE

Morgan Peterson, PharmD, Pharmacist-in-Charge

RELATED POLICIES

Pharmacy Quality Assessment Program

Unusual Occurrence Incident Reporting

PHF only - Unusual Occurrence Reporting

REFERENCE

California Code of Regulations – California State Board of Pharmacy
Title 16, Division 17, Section 1711

California Code of Regulations – Social Security
Title 22, Division 5, Section 77036

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION

Culturally and Linguistically Competent Policies
The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).