



Reporting a Serious Incident as a Medication Error

Office of Licensing Standards

Purpose: This document is intended to offer Providers clarification as to their role of reporting serious incidents/events that are the result of a medication error to the Office of Licensing.

Definitions:

- (1) "Medication error" means an error in administering a medication to an individual and includes when any of the following occur:
 - (i) the wrong medication is given to an individual,
 - (ii) the wrong individual is given the medication,
 - (iii) the wrong dosage is given to an individual,
 - (iv) medication is given to an individual at the wrong time or not at all, or
 - (v) the wrong method is used to give the medication to the individual.

- (2) "Serious incident" means any incident or injury resulting in bodily damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner while the individual is supervised by or involved in services, such as attempted suicides, medication overdoses, or reactions from medications administered or prescribed by the service.

- (3) "Medications" (*adapted from CMS & Licensing Regulations*): Medications refers to all prescription and over-the-counter medications taken by the resident, including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident. This information must be in the resident's clinical record.

Recording and Reporting Requirements:

All medication errors should be recorded and dealt with through the provider's administrative processes. Refer to 12VAC35-105-780, for additional regulatory requirements. Providers should remember that the state's incident reporting system is not designed to be used to capture all staff inaccuracies or all behaviors of persons receiving services. There are more appropriate methods of doing this.

Current DBHDS Licensing standards indicate that medication errors should only be reported to licensing when it results in adverse outcomes, which is defined as a serious incident in the licensing regulations.

Licensing requires that a serious incident is reported within 24-hrs. Medication Errors become serious incidents when they lead to adverse reactions or outcomes.

Reference to DBHDS Standards:

12VAC35-105-160. Reviews by the department; requests for information. Each instance of death or serious injury shall be reported in writing to the department's assigned licensing specialist within 24 hours of discovery and by phone to the individual's authorized representative within 24 hours. Reported information shall include the following: the date and



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place of the individual's death or serious injury; the nature of the individual's injuries and the treatment received; and the circumstances of the death or serious injury. Deaths that occur in a hospital as a result of illness or injury occurring when the individual was in a licensed service shall be reported.

(General Steps Regarding Medication Errors)

12VAC35-105-780. Medication errors and drug reactions.

1. First aid shall be administered if indicated.
2. Employees or contractors shall promptly contact a poison control center, pharmacist, nurse or physician and shall take actions as directed.
3. The individual's physician shall be notified as soon as possible unless the situation is addressed in standing orders.
4. Actions taken by employees or contractors shall be documented.
5. The provider shall review medication errors at least quarterly as part of the quality assurance in 12VAC35-105-620.
6. Medication errors and adverse drug reactions shall be recorded in the individual's medication log.