LAPEER COUNTY COMMUNITY MENTAL HEALTH **Date Issued** 11/19/2009
**Date Revised** 03/16/12; 07/14/21; 12/16/25

| **CHAPTER** Health/Medical | **CHAPTER** 03 | **SECTION** 001 | **SUBJECT** 15 |
|---|---|---|---|
| **SECTION** Drugs and Medication | **DESCRIPTION** Medication Errors | | |
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**APPLICATION:**

| | | | |
|---|---|---|---|
| ☒CMH Staff | ☐Board Members | ☒Provider Network | ☒Employment Services Providers |
| ☒Employment Services Provider Agencies | ☒Independent Contractors | ☒Students | ☒Interns |
| ☐Volunteers | ☐Persons Served | | |

**POLICY:**

Lapeer County Community Mental Health (LCCMH) ensures the health and well-being of persons served related to the management and follow-up of medication-related errors.

**STANDARDS:**

A. LCCMH monitors areas of risk management involving medication errors.

B. The health and safety of persons served are addressed immediately in relation to any medication errors.

C. Medication errors are appropriately documented and reported via Incident Reports in the electronic health record (EHR) to the appropriate supervisor and the Recipient Rights Office.

D. Medication errors are reviewed quarterly in the critical event report for identification of possible training needs and quality improvement opportunities for staff.

E. All medication errors and near misses are reported within 24 hours of occurrence or discovery.

**PROCEDURES**:

A. When a medication error occurs, staff complete the following steps immediately:

1. When a person served has ingested medication in error, advise appropriate medical staff and supervisor, assess risk to the person served, and respond accordingly. If needed, call Poison Control (1-800-222-1222).

2. Notify the guardian and/or home staff, as necessary.

3. Complete an Incident Report in the EHR and route Incident Report to supervisor and Recipient Rights Office within 24 hours.

B. The LCCMH Clinical Case Review Committee reviews medication error-related incident reports for trends related to training needs or quality improvement opportunities each quarter. This review is forwarded to the Quality Council Committee for approval.

C. The following are not considered medication errors, but they do need to be attended to and reported following the same procedures for reporting medication errors:

1. All adverse reactions to medications are observed by staff.

2. The incorrect dispensing of medication by a pharmacy, which may include the incorrect medication and/or incorrect dosage.

**DEFINITIONS:**

**Medication Error:** includes any of the following:

1. Medications discovered on the floor, counter, medicine tray, or anywhere left unattended.

2. Mistakes have been made in any of the following areas: person served, time, medication, dosage, and/or route.

3. Medication cupboard left open and unattended, or key left in the door or out in clear sight.

4. Medications given by untrained staff.

5. Administering medications not properly labeled or identifiable.

6. Failure to initial medication sheet when medication is given.

**Near Misses:** medication-related events that could have led to patient harm but was intercepted before reaching the patient.

JS & LJ

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