MEDICATION ERROR AND INCIDENTS PROCEDURE

A medication error is defined as “a medication administered that deviates from the instructions of the medical provider and parent” (WI Department of Public Instruction, 2022). A medication error occurs when one of the “five rights of medication administration” has been violated. Examples include:

1. administering the wrong medication
2. administering the wrong dose
3. administering medication at the wrong time
4. administering medication in the wrong way (e.g. ear drops administered in the eye)
5. administering medication to the wrong student
6. not administering a dose of medication (omission)
7. Medication count discrepancy

In addition, circumstances that may require additional follow up would be administering the medication for the wrong reason and administering the medication without proper documentation.

Situations that are not considered medication errors include: students who refuse to consume or are unable to tolerate the medication, lack of supply of the medication from the parent, and a medication held by the parent. Careful notation of these situations should be made in the medication log and parent/guardian will be notified.

Staff Guidelines to Follow when a Medication Error Occurs:

1. Identify the incorrect dose or type of medication taken or not taken by the student.
2. If the error was made by someone other than the school nurse, consult with the school nurse either in person or by phone, and if he or she is not available, call the designee (back-up nurse or health service lead team member), as soon as the error is recognized. Early intervention is the key to avoiding complications if an error is made.
3. Contact Poison Control Center upon the school nurse or designee recommendations:
    a. give the name and dose of the medication taken in error.
    b. give the student’s age and approximate weight, if possible.
    c. give the name and dose of any other medication the student receives, if possible.
4. Follow instructions from the Poison Control Center, if possible. If unable to follow their instructions, explain the problem to the Poison Control Center to determine if the student should be transported for emergency care. Notify the school nurse or designee after contact with Poison Control Center.
5. Staff member who commits the error notifies the principal and the school nurse or Nursing Assistant notifies a member of the health service lead team via phone call.
6. The school nurse, upon notification of the medication error, contacts parents of the student, and the health care provider. If a medication diversion occurred, the school

nurse should make sure that the healthcare provider is informed that the diversion happened while the medications were in possession of the school. In addition, when the school nurse or designee calls the parent, clarify with them if they want the afterschool day care provider notified.

7. If there are concerns for diversion of medication, a lead team nurse will do an investigation in partnership with the building based school nurse. After the investigation, if the cause for the missing medication cannot be determined, the lead team nurse will contact the Office of School Safety and Assistant Director of Health Services to determine next steps which may include filling a report with the Madison City Police Department.
8. Staff member who makes the error completes the top portion of the Medication Incident Form, carefully recording all circumstances and actions taken. Completed Medication Incident Form is sent to the health services director within 24 hours of the incident.
9. School nurse or nurse's assistant record the error on the Medication Administration Log by drawing a line drawn through it and marking "error," or "mistaken entry," then initialing and dating. Whiteout may not be used.
10. School nurse records the incident in Health Notes section of electronic student health record.
11. School nurse follows up with the employee who was involved in the medication error, providing additional education to employee if needed. If competency issues arise, school nurse notifies principal and/or health services director.
12. School nurse identifies process changes that may need to occur to improve medication administration procedures:
    a. Reducing distractions when/where the medications are being given.
    b. Having photos of the students available to assist with proper administration.
    c. Providing more frequent medication administration education refreshers.
13. Health Services Director along with nurse leadership team reviews all the completed Medication Incident Forms at least quarterly to understand the factors that contribute to errors and identify if errors are related to systems and/or process issues.

References

Wisconsin Department of Public Instruction (2022, April). Administration of Medications in Wisconsin Schools. Retrieved July 23, 2023, from https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/Administration_of_Medications_in_Wisconsin_Schools.pdf