

Medication Errors

General Discussion:

With the increased needs of individuals in assisted living facilities, facilities must have the ability to manage complex medication regimens. Although medications can improve the functional status and quality of life for residents, improperly managed medications can also cause serious adverse consequences. The frequency of preventable medication errors is cause for concern.

Medication errors can include mistakes involving prescription drugs, over-the-counter products, vitamins, minerals, or herbal supplements. Medication errors can occur in a fraction of a minute, and the results can be devastating. Some points to consider in the reduction of medication errors are:

- Question practitioner's orders that are unclear or appear to be incorrect
- Ensure all staff fully understand orders before administering medications
- Avoid unnecessary distractions while administering medications
- Provide adequate staff levels and sufficient staff time for uninterrupted medication administration
- Ensure all staff understand and follow proper medication procedures
- Do not allow inexperienced, untrained staff to administer medications
- Provide accessible medication resources (i.e. drug books, pharmacy drug information)
- Teach residents about their medications and listen to residents who question a medication
- Don't take shortcuts
- If a medication error is made, never cover it up

The Wisconsin Bureau of Assisted Living's Medication Management Initiative Workgroup defines a medication error as follows: A medication error is a preventable event resulting in the incorrect administration of a medication, or harm or potential harm to a resident. The practitioner's written order identifies the prescribed medication, dose, time and route of administration for the resident. An error occurs when the resident does not receive a medication as prescribed/ordered by the practitioner.

The definition of harm is a temporary or permanent impairment of physical or mental function which requires intervention. Intervention may include monitoring the resident's condition, acute medical treatment or a change in the practitioner's orders.

Medication errors include:

- Wrong medication – occurs when a medication is given that is not prescribed or has been discontinued or the medication label is incorrect
- Wrong dose – occurs when a resident receives a medication in a dosage other than what was prescribed by the practitioner
- Wrong time/omission – occurs when a resident does not receive medication at the time prescribed by the practitioner
- Wrong route – occurs when a resident receives a medication via a route other than what was prescribed by the practitioner
- Wrong technique – occurs when a medication is altered by crushing but should not be crushed, not given with or without food as prescribed, incorrect timing between doses of eye drops, ear drops, nose drops, inhalers, etc.

Relevant Regulations:

ADC: Although there is no specific regulation related to medication errors, you should consider best practices for the prevention and reporting of medication errors to protect the health, safety and welfare of your residents.

FAMILY ADC: Although there is no specific regulation related to medication errors, you should consider best practices for the prevention and reporting of medication errors to protect the health, safety and welfare of your residents.

AFH:

DHS 88.07(3)(e)1. The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by licensee shall be kept in a locked place.

DHS 88.10(3) Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have all of the following rights:

DHS 88.10(3)(q) To receive all prescribed medications in the dosage and the intervals prescribed by the resident's physician and to refuse medication unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency.

RCAC:

DHS 89.13(21) "Medication administration" means giving or assisting tenants in taking prescription and nonprescription medications in the correct dosage, at the proper time and in the specified manner.

DHS 89.13(22) "Medication management" means oversight by a nurse, pharmacist or other health care professional to minimize risks associated with use of medications. Medication management includes proper storage of medications; preparation of a medication organization or reminder system; assessment of the effectiveness of medications; monitoring for side effects, negative reactions and drug interactions; and delegation and supervision of medication administration.

DHS 89.34(16) Except as provided for in the service agreement or risk agreement, to have the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician and to refuse a medication unless there is a court order.

CBRF:

In addition to the rights under s. [50.09](#), Stats., each resident shall have all of the following rights:

DHS 83.32(3)(h) Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.

DHS 83.37(1)(k)1. The CBRF shall document in the resident's record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication.

DHS 83.37(1)(k)2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days.

Relevant DQA Memos:

[BQA Memo 04-006 Medication Setup in Assisted Living - REVISED](#)

Other Resources:

[Division of Quality Assurance \(DQA\) Safety in Healthcare](#)

[DQA Pharmacy NewsCapsule](#)

Do Not Crush List - Institute for Safe Medication Practices (ISMP)

“Mistake-Proofing the Design of Health Care Processes”,
Agency for Healthcare Research and Quality (AHRQ)

National Coordinating Council for Medication Error Reporting & Prevention

Institute for Safe Medication Practices Website

ISMP “Eliminating Error-prone Abbreviations, Symbols & Dose Designations”

Institute for Safe Medication Practices – High Alert Medications

DQA List of High Alert Medications

Eyedrop Administration Procedure (Med-Pass, Inc.)

Eardrop Administration Procedure (Med-Pass, Inc.)

Nasal Medications Administration Procedure (Med-Pass, Inc.)

Eye Ointment Administration Procedure (Med-Pass, Inc.)

Inhaled Medicine Administration Procedure (Med-Pass, Inc.)

Best Practice, Tools & Forms:

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