PREVENTION
OF
MEDICATION ERRORS

Med Administration:

Prescribe
Dispense
Transcribe
Administer
Monitor

Medication Error

WRONG MED
DOSE
ROUTE
REASON OTHER THAN AS PRESCRIBED
TIME
CLIENT
FAILURE TO DOCUMENT ON MAR
FILL WITHIN 24 HOURS
COUNT CONTROLLED MEDICATIONS
MISSED DOSE
EXPIRED MEDICATION ADMINISTERED
MAR DOES NOT REFLECT CORRECT ORDER
MOST COMMON ERRORS

52% MEDS NOT GIVEN
11% GIVEN BUT NOT DOCUMENTED
10% MAR INCORRECT
10% DOCUMENTED BUT NOT GIVEN
 8% WRONG CLIENT
 6% CONTROL COUNT ERRORS
 3% OTHER

MEDICATION NOT GIVEN

Distraction
No reason
“Found” on floor, in drawer
Left on nightstand
Late from ADT or outing
Not delivered by pharmacy
Staff unaware of noon med pass
“Forgot”

MEDICATION NOT GIVEN

REFUSAL
TIMING
TASTE
TOO BIG TO SWALLOW
HOW MED MAKES CLIENT FEEL
DOESN’T FEEL NEEDS IT

COLLABORATE WITH PHYSICIAN RE:
VARIABLES – CHANGE AS NEED SEE IF
MAKES A DIFFRENCE
PAM LASSITER  RN
813 233 4361

GIVEN NOT DOCUMENTED
Bubblepack initiated and dated but MAR blank

MAR INCORRECT
Physician orders change never entered on MAR

DOCUMENTED BUT NOT GIVEN
Bubblepack or count reveals med not given

WRONG CLIENT
Distraction

CONTROL COUNT ERRORS

OTHER
Wrong dose
Wrong time
Wrong med
New med not given w/i 24 hours
Family error
PREVENTION

- RESPONSIBILITY
- STAFF MUST KNOW THEIR CLIENTS
- ELIMINATE DISTRACTIONS
- FOLLOW POLICY AND PROCEDURE
- MAR AUDITS
- SIX RIGHTS

The 6 Rights of Medication Administration

- Right Drug
- Right Person
- Right Route
- Right Time
- Right Dosage
- Right Documentation

CHECK RX
**RIGHT DOCUMENTATION**
IMMEDIATELY document on MAR

If new or changed medication documentation of monitoring client for 20 min for first 3 doses is entered on reverse of MAR in same area as documenting the results of PRN medication and documenting reason when meds not given.

**MISCELLANEOUS INFORMATION**
- Have a back up pharmacy
- Ask physician to enter diagnosis or reason on Rx
- When med discontinued immediately remove it from the client's med box, store separately till destroyed or sent back to pharmacy and IMMEDIATELY make correction to the MAR
- Two staff to check all entries on MAR for new or changed medication orders
- NEVER pass meds without using current MAR
- When meds arrive check label against MAR, check to be sure all bubbles filled, note if any refills left
- Creams and ointments need to be check twice a month to be sure not running low
- Use X to mark out days not to give for meds not given daily
- When appropriate change times to meet need

**ERROR REPORTING**
- Notify any supervisory personnel
- In case of wrong med or dose:
  - Observe client closely for 20 minutes
  - Report to prescribing physician
  - Follow up as directed by physician
- Notify client’s prescribing physician of error, any orders given will then need to be faxed
- Fully document event, observations and contacts on Medication Error Report - APD form 65G-7-05
  - Submit to APD within 24 hours
- Staff take responsibility seriously
- Follow the rules
- Appropriate staff on duty to meet need
- Give meds in quiet area
- Using the MAR triple check performed
- Immediately chart
- MAR audits

Questions Comments Ideas

727 639 2145

Jill_Chase@apd.state.fl.us

“... and, with the proper medication, they lived happily ever after.”
Medication Clarification/Verification

We have received a medication from our pharmacy (__________________________) which was filled pursuant to a phone order to said pharmacy. In order for our medication assistance providers to administer/supervise self-administration of this medication a written verification that this is a current and correct order is required.

The information provided on that pharmacy label is listed below. Please verify that all of the information is correct. If any information is incorrect please make corrections in the space provided. Please sign and date this form and include your license number in the space provided.

Thank you for your assistance in helping us comply with Fl. Rule 65G-7.

Order as it appears on the Pharmacy Label:

Date Ordered: __________________________
Consumer Name: __________________________
Drug Name and strength: __________________________
Dose and __________________________
Directions for Use: __________________________

Quantity and # of Refills: __________________________

Information Needed: __________________________
Or Clarification __________________________

Signature of Physician: __________________________
Date of Signature: __________________________
Physician’s License #: __________________________
NEW or CHANGED MEDICATION ORDER

Client: ___________________________  Date: ______________

Medication Order: ______________________________________

_______________________________________________________

_______________________________________________________

_______________________________________________________

☐ Faxed to pharmacy

☐ Medication received IF NOT RECEIVED IN 24H MUST NOTIFY PHARMACY AND MANAGER and MUST DOCUMENT info on reverse of MAR

☐ Order entered on MAR - must match exactly the Prescription as written by physician and the label from pharmacy - if not manager MUST be notified All PRN Meds must include When Physician to be Notified

☐ **If dose change be sure to DC the old order on MAR**

☐ Side effects/adverse reaction sheets placed in MAR file

☐ First dose given. Documented on reverse of MAR

☐ Second dose given. Documented on reverse of MAR

☐ Third dose given. Documented on reverse of MAR

☐ Physician notified of any side effects or adverse reaction

10/15/09
PRN MEDICATION INSTRUCTIONS SHEET
(In accordance with the Florida 65G-7 Policy)

Name: ________________________________                       DOB: __________________________

Medication Name:__________________________________Dose:_____________________________
Take______ Tablet(s)/Capsule(s)by mouth every__________________ for______________________
(No variable interval)                     (indication)
Maximum_______________ in 24 hours
Notify health care provider for:________________________________________________________

Medication Name:__________________________________Dose:_____________________________
Take______ Tablet(s)/Capsule(s)by mouth every__________________ for______________________
(No variable interval)                     (indication)
Maximum_______________ in 24 hours
Notify health care provider for:________________________________________________________

Medication Name:__________________________________Dose:_____________________________
Apply______ ___________ to __________Every__________________ for______________________
(No variable interval)                     (indication)
Maximum_______________ in 24 hours
Notify health care provider for:________________________________________________________

Coments:_____________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________  

Physician’s Signature:___________________________                       Date:_________________________
Non licensed staff for Agency for Persons with Disabilities clients must follow this list of requirements before they may administer/supervise medications. Thank you for your assistance.

65G-7.005 Medication Administration Procedures. (6) The medication assistance provider may not assist with PRN medications, including OTC medications, unless a health care practitioner has provided written directions for the medication. The provider must attach to the client’s MAR a copy of the prescription or order legibly displaying the following information: (a) The name of the medication; (b) The prescription number, if applicable; (c) The prescribed dosage; and (d) Specific directions for use, including the medical basis for the medication, the time intervals for administration, the maximum number of doses, the maximum number of days that the medication should be administered, and conditions under which the health care practitioner should be notified.

To: __________________________________________________________

From: _____________________________________ Date: ____________________

Phone number: _________________________ Fax Number: __________________________

Consumer Name: ____________________________________

Why Requested/Needed:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Name and strength of medication: ____________________________________________

Specific dose of medication: _______________________________

Specific reason(s) this medication may be given______________________________________
____________________________________________________________________________________

May administer/supervise every ____________ hours

Maximum of ____________ doses in a 24 hour period

“If _________________________________ or symptoms persist greater than
_________________________________________________________Call the physician.”

________________________________________________________

Signature:_________________________________________ Date:________________________

Revised 4/10