MEDICATION ERROR PROCEDURE

Disclaimer: NASN's model procedures and/or language are intended as examples that may serve as a tool for those responsible for drafting policies that meet the needs of a local school or district. These examples are not authoritarian, nor should they be viewed as complying with any requirements specific or unique to any school or district. Model procedures and language should not substitute or replace the advice of legal counsel and/or research on applicable federal or local laws, regulations or ordinances.

Definitions:

1. **Licensed prescriber:** A licensed health care provider with the authority to prescribe medication. Licensed prescribers may vary by state and may include physicians, advanced practice nurses, physician's assistants, dentists, podiatrists, and optometrists.
2. **Medication error:** Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use. (NCCMERP, 2021). Medication errors include incorrect person, incorrect medication, incorrect dose, incorrect time, incorrect route, incorrect or missing documentation, missing dose, wrong weight.
3. **Parent:** "Parent" is used to collectively refer to whoever has guardianship over the child.
4. **School Nurse:** Registered nurses who works in the school setting.
5. **Six rights of safe medication administration:** The right person, right medication, right dose, right route, right time, and right documentation.
6. **UAP:** Unlicensed assistive personnel. UAPs include certified nursing assistants (CNAs), health aides, health techs, secretaries, clerks, teachers, principals, and other personnel without a health care license.

Unlicensed Assistive Personnel Responsibilities (UAP)

When a medication error occurs, follow these guidelines:

1. Keep the student in the health room (or room where medication was administered).
2. If the student has already returned to class, have someone accompany the student back to the room where medication was administered.
3. Observe the student's status and document what you observe.
4. Remain calm and do not alarm the student.
5. Identify the incorrect dose or type of medication taken by the student.

6. Notify the principal and school nurse immediately if non-licensed personnel gave medication. (The school nurse or principal/school administrator will contact the parents of the student and/or licensed prescriber.)
7. If contacting the Poison Control Center for instructions:
   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.
8. ollow 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.
9. Complete a Medication Administration Incident Report form.
   a. Carefully record all circumstances and actions taken, including instructions from the Poison Control Center or the student's health care provider, and the student's status.
   b. All reports are to be filed and kept according to district policy.
10. Give completed Medication Administration Incident Report form to the school nurse and administrator within 24 hours of the incident.

[For districts using paper MAR] Errors made in recording medications on the Medication Administration Record should have a line drawn though it and marked "error," or "mistaken entry" initialed and dated. Whiteout may not be used.

[For districts using EHR] Errors made in recording medications in the electronic health record should [ENTER DISTRICT/SOFTWARE SPECIFIC INSTRUCTIONS].

School Nurse Responsibilities

1. Upon notification of a medication error, contact the parents of the student and licensed prescriber, if warranted.
2. Review the Medication Administration Incident Report form immediately.
3. Follow up with the employee(s) who was involved in the medication error.
   a. In collaboration with the principal/school administrator:
      i. Console the employee involved in the medication error.
      ii. Determine what category of human behavior (simple human error, at-risk behavior, reckless behavior) contributed to the error.
      iii. Based on findings:
         1. Evaluate the root cause/contributing factor(s) of the error, consider changes to the process that led to the error.
         2. Provide additional education to employee(s) who was involved in the medication error.
         3. Provide coaching to employee(s) involved in the medication error.
         4. Consider remedial action and/or disciplinary action.
4. Ensure competency of the employee who was involved in the medication error.
5. If appropriate, identify someone else to assume responsibility of medication administration.
6. In conjunction with the principal or school administrator, review all the completed Medication Administration Incident Report forms at least quarterly to understand the factors that contribute to errors and identify if the errors are related to systems and/or process issues.

7. Identify 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 student attached to the medication administration form to assist with proper identification (if not already doing so).
   c. Providing more frequent medication administration education refreshers.

Principal/School Administrator Responsibilities

1. If the school nurse has not already done so, upon notification of the medication error, contact the parents of the student and licensed prescriber, if warranted.
2. Review the Medication Administration Incident Report form immediately.
3. In conjunction with school nurse, review all the completed Medication Administration Incident Report forms at least quarterly to understand the factors that contribute to errors and identify if the errors are related to systems and/or process issues.

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