Medication Minute …

Brought to you by the Medication Committee

MEDICATION ERRORS

Medication errors are among the most common health threatening mistakes that affect client care. A medication error occurs when a staff member fails to follow correct procedures and/or the 7 rights. Today we will be focusing on documentation errors which is one of the most common errors we see in our Agency.

<u>Documentation Errors</u>

Staff are accountable for ensuring timely, accurate documentation of all medication they administer. Documentation is the proof that supports your actions. Remember: **if you did not write it down, it did not happen!**

For example, a staff member forgetting to document a PRN medication may result in another dosage being administered by another staff member since no documentation denoting previous administration exists.

<u>How to Prevent Documentation Errors:</u>

- Work together as a team and pre-plan how you are going to ensure that the medication process including documentation can be done smoothly.
- Always ensure that you have the right MAR sheet for the correct client, month and year.
- Make sure you doc **right after** it has been administered.
- Document only what you have administered—never document medications given by another person.
- If the medication is PRN, record the symptoms the client was experiencing, dose, time and effectiveness.
- Ensure all documentation is completed (ie: MAR sheet, log notes, communication book, etc).
- Document any medication errors or incidents on an incident report form.
- Always document in ink (pencil can be easily erased by someone) and never use white-out to correct mistakes.
- Use only accepted abbreviations.