Department of Juvenile Justice
Health Services Operating Procedure

HSOP VOL IV – 4.3 – 3.10	**Statutory Authority:** Title 66 of the Code of Virginia
Subject: **Medication Incidents**	**Regulations:** 6VAC35-71-1070 **Board Policy:** 12-001; 12-004; 12-005
	ACA # 4-JCF-4C-05; 4-JCF-4C-06; 4-JCF-4C-07; 4-JCF-4C-32; 4-JCF-4C-49 **NCCHC #** Y-B-03; Y-D-02

3.10-1.0 PURPOSE

To ensure medication incidents and errors are documented, reported, and reviewed to reduce future incidents and to promote resident health and safety.

3.10 -2.0 SCOPE

These procedures apply to all Juvenile Correctional Center (JCC) employees and staff assigned to the JCCs by other units, agencies, or departments.

3.10-3.0 DEFINITIONS

5 Rights +2 – The verification of the right resident, medication, dose, time, route, documentation and allergies.

Health Services Staff – The staff at the JCC consisting of Licensed Practical Nurses, Registered Nurses, dental assistants, and providers who provide health services to residents.

Local Health Authority – The designated Registered Nurse (RN) (e.g., head nurse) who has been delegated the responsibility: for the management of all health services in the facility; including medical nursing, and dental; and for ensuring the quality and accessibility of all health care services provided to residents. Final medical judgments shall be the sole province of the Chief Physician.

Medical Department – The location at which the health services staff are located in the JCCs to provide health services to residents. The medical department may include nursing stations, examination rooms, infirmary, and dental office.

Medication Incident - An error made in administering or in failing to administer a medication to a resident including the following: a resident is given incorrect medication; medication is administered to the incorrect resident; an incorrect dosage is administered; medication is administered at a wrong time or not at all; and the medication is administered through an improper method. A medication incident does not include a resident's refusal of appropriately offered medication.

Provider – The Physician, Nurse Practitioner, Physician's Assistant, or Dentist providing health services to residents.

3.10-4.0 PROCEDURES

The Medication Incident Report is an evaluation tool to identify factors leading to medication errors, identify trends, determine preventability and implement corrective actions. A Medication Incident Report shall be completed on every error or incident involving medication storage and medication administration (errors of commission and omission), including any violation of the 5 rights +2.

3.10-4.1 Medication Incidents

1. In the event of a medication incident or an adverse drug reaction, first aid shall be administered, if indicated.

2. The nurse involved in a medication incident or the nurse who discovers a medication incident, if different than the nurse who was responsible for the incident, shall complete the Medication Incident Report.

3. The nurse shall immediately notify the nursing supervisor, Local Health Authority, and the provider of the medication incident.

4. The supervising nurse who is notified shall ensure that the incident report is completed prior to the end of the shift, immediately following the shift where the medication error was identified.

5. If there is an adverse reaction or potential for an adverse drug reaction, the nurse shall notify the shift commander and complete an Institutional Incident Report in accordance with SOP VOL IV-4.1-1.01 (Incident Reports).

    a. A copy of the IIR shall be forwarded to the Local Health Authority.

    b. The original IIR shall be forwarded to the Shift Commander.

    c. If it is determined that the resident cannot return to general population and he/she shall remain in the infirmary for observation, a Serious Incident Report (SIR) shall be completed by the Shift Commander or designee.

    d. The nurse shall share information relating to the ER diagnosis with the Shift Commander or designee only when it is relevant for the incident report or as it relates to security.

6. The nurse shall receive orders from the provider regarding follow-up care for the resident involved in the medication incident. Depending on the side effects, the resident:

    a. May be monitored in the housing unit;

    b. May require admission to the infirmary; or

    c. May require referral to the Emergency Room (ER).

7. The Medication Incident Report shall be forwarded to the Local Health Authority. The Local Health Authority shall send a copy of the Medication Incident Report to the Chief Nurse.

8. The nurse shall document the medication incident in the resident's medical record.

9. The Local Health Authority and/or nurse supervisor shall determine the circumstances resulting in the medication incident, including, what happened, the cause of the error, and how to avoid the error in the future. The Local Health Authority and/or nurse supervisor shall review his/her findings with the nurse responsible for the incident. A copy of the Medication Incident Report form shall be forwarded to the Chief Nurse and Health Services Administrator.

3.10-5.0 RESPONSIBILITY

The Local Health Authority and Superintendent shall be responsible for implementing this procedure.

3.10-6.0 INTERPRETATION

The Health Services Administrator and Deputy Director of Operations shall be responsible for the interpretation and the exception approval to this procedure.

3.10-7.0 REVIEW DATE

This procedure shall remain in effect until rescinded or otherwise modified by the appropriate authority.

Approved by Director:	**Date:** 9/10/2014
Approved by Health Administrator:	**Date:** 9/5/14
Approved by Chief Physician:	**Date:** 9/5/14
Effective Date: October 13, 2014	**Office of Primary Responsibility:** Health Services; Division of Operations
Supersedes: July 8, 2013	**Forms:** Medication Incident Report