



**State of Tennessee**  
**Department of Children's Services**

**Administrative Policies and Procedures: 20.59**

<b>Subject:</b>	<b>Medication Error Guidelines</b>
<b>Authority:</b>	TCA 37-5-105; 37-5-106
<b>Standards:</b>	None
<b>Application:</b>	To All Department of Children's Services Employees, Contract Providers, and Resource Parents

**Policy Statement:**

Medication errors must be reported to the Department of Children's Services in accordance with the reporting of incidents (see DCS Policy [1.4, Incident Reporting](#)) to promote continuous quality improvement and best practice for children/youth in DCS custody.

**Purpose:**

Reporting, managing and tracking medication errors are necessary to: identify causes of errors, provide prompt and thorough healthcare after errors occur, evaluate the severity of errors and to take corrective action to prevent further occurrences.

**Procedures:**

<b>A. Classification of harm</b>	<ol style="list-style-type: none"><li>1. A medication error is when a medication is not administered according to the prescribing provider and according to DCS policy and procedure.</li><li>2. In order to track and quantify medication errors, they will be reported according to severity as described below.<ol style="list-style-type: none"><li>a) <b>Level I (No harm):</b> Incidents would include errors in which there has been verification from a prescribing provider that no harm has resulted to the child/youth.</li><li>b) <b>Level II (Low Severity):</b> Incidents would include errors in which a prescribing provider determines that the child/youth needs increased monitoring as a result of the error and no harm resulted.</li><li>c) <b>Level III (High Severity):</b> Incidents in which medical treatment/intervention or hospitalization is needed due to the potential for harm from the error. If harm is caused from the error, it is of a temporary nature.</li></ol></li></ol>
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	<p><b>d) Level IV (Life Threatening):</b> Incidents in which errors result in the child/youth suffering permanent harm, near-death (e.g., anaphylaxis, cardiac arrest, etc.), and/or death.</p>
<b>B. Categories of medication errors</b>	<p>DCS will use the following categories to define types of medication errors.</p> <p><b>1. Medication Not Administered</b></p> <ul style="list-style-type: none"> <li>◆ Medication unavailable</li> <li>◆ Failed to administer medication</li> <li>◆ Child/youth refused medication</li> <li>◆ Child/youth hid (cheeked) medication</li> </ul> <p><b>2. Medication Administered</b></p> <ul style="list-style-type: none"> <li>◆ Wrong Dose: administration of a dose that is greater than or less than the amount ordered by the prescribing provider (or manufacturer's recommendation for over the counter medications).</li> <li>◆ Wrong Medication: medication that is contraindicated (e.g., known allergy, harmful interaction with existing medications) or an incorrect medication is given to a child/youth.</li> <li>◆ Wrong Time: administration of medication more than one (1) hour before or more than one (1) hour after the prescribed administration time.</li> <li>◆ Expired Medication: administration of a medication that has expired.</li> <li>◆ No Informed Consent: administration of a psychotropic medication without proper informed consent (see DCS Policy <a href="#">20.24, Informed Consent</a>).</li> </ul>
<b>C. Reporting medication errors</b>	<ol style="list-style-type: none"> <li>1. Medication errors must be reported to the Department of Children's Services in accordance with the reporting of incidents (see DCS Policy <a href="#">1.4, Incident Reporting</a>).</li> <li>2. Medication errors should be reported as close to the time of the incident as possible, but no later than 24 hours after the incident.</li> <li>3. Medication errors also must be reported within a facility to appropriate staff.</li> </ol>
<b>D. Monitoring of medication errors</b>	<ol style="list-style-type: none"> <li>1. DCS Regional Nurses monitor medication errors classified as Level III (High Severity) or Level IV (Life-Threatening).</li> <li>2. The DCS Health Services Coordinator monitors medication errors that occur at a Youth Development Center.</li> <li>3. The DCS Division of Evaluation and Monitoring reviews all incidents, including medication errors, for trending and aggregate reporting.</li> </ol>

<b>Forms:</b>	<a href="#"><u>CS-0311 Facility Incident Report</u></a> <a href="#"><u>CS-0496, Incident Report</u></a>
<b>Collateral Documents:</b>	<a href="#"><u>Dept. of Children's Services "Standards of Professional Practice For Serving Children and Families: A Model of Practice"</u></a> <a href="#"><u>Incident Reporting Review Manual</u></a> <a href="#"><u>Critical Incident Reporting Web-Based Application (YDC)</u></a> <a href="#"><u>Serious Incident Reporting Web-Based Application</u></a>