

Facility:
Date:
Surveyor:

Drug Pass Observation
Intermediate Care Facility/Individuals with Intellectual Disabilities

Directions: Follow these steps to detect medication errors:

1. Identify the drug product. Determine what drugs, in what strength and dosage forms, etc., staff members are administering. There are two principle ways of doing this. In most cases, staff members use these methods in combination.
 - A. Identify the product by its size, shape, and color. Many products have a distinctive size, shape, or color. However, this technique can be problematic because not all products are distinctive.
 - B. Identify the product by observing the label. When the punch card or unit dose system is used, you can usually observe the label and adequately identify the drug product. When the vial system is used, observing the label is sometimes difficult. Ask the person administering medications to identify the drug product.
2. Observe the administration of drugs. Record your observations in your notes. Follow the person administering medications and observe the individuals receiving drugs. Be as neutral and as unobtrusive as possible during this process.

Watch 8 drug doses administered to the individuals residing in the facility, or observe a 100 percent sample of the clients in the facility, whichever is smaller. For example, in a four-bed facility with each individual taking two morning doses, you would watch a 100 percent sample of the individuals since staff members would only administer eight doses. In an eight-bed facility with each individual taking four morning doses, you would observe a sample of 16 doses administered.

It is usually preferable to watch the morning pass because more doses per individual are administered at that time; however, you may observe the pass at any time. Observe more than one staff member administering drugs, at two passes. You may observe the drugs being administered in the individual's living quarters or in the day program if the day program is operated by the ICF/IID on its grounds (i.e., the day program is not a separately certified entity).

If there are individuals in the facility who self-administer medications, attempt to observe the self-administration. Respect the individual's right to privacy by verbally asking the individual for permission to observe.

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Note every detail about drug administration in your notes. For example, “eye drops administered to both eyes,” or “nurse took pulse,” or “all crushed drugs administered in applesauce.”

1. Record in your notes the most current physician’s orders for those individuals who were observed receiving medications. The latest recapitulation (recap) of drug orders is sufficient to determine whether a valid order exists, provided the physician has signed the recap. The signed recap and subsequent orders constitute legal authorization to administer the drug. You should now have a complete record of what you observed, and what should have occurred according to the physician orders.
2. Reconcile your record of observation with the physician’s orders. Compare your record of observation to the most current signed orders for drugs.
 - For each drug on your list: Was it administered according to the physician’s order? For example, in the correct strength, by the correct route? Was there a valid order for the drug?
 - For drugs not on your list: Are there orders for drugs that staff members should administer, but did not? Such circumstances represent omitted doses, which is one of the most frequent types of errors.
3. Determine the number of errors by adding the errors for each individual. Before concluding that an error has occurred, discuss the apparent error with the person who administered the drug. There may be a logical explanation, such as a more recent physician order which you have not seen.
4. Timing errors: If the facility orders a drug before meals (AC) and administers the drug after meals (PC) or vice versa, always count this as an error. If staff members administer the drug more than 60 minutes later or earlier than its scheduled administration time, count this as an error only if that wrong time error can cause the individual discomfort or jeopardize the resident’s health and safety. Counting a drug with a long half-life (beyond 24 hours) as a wrong error when it is 15 minutes late is improper because there is no significant impact on the individual. To determine the scheduled administration time, examine the facility’s policy relative to dosing schedules.

