NHS
Lincolnshire Community Health Services
NHS Trust

Management of Medication Errors Policy

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Lincolnshire Community Health Services NHS Trust

Management of Medication Errors Policy

Version Control Sheet

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/Amended by
1		New Policy	November 2013	Petra Clarke
	6.5	HR responsibility to support staff through medicines errors	January 2014	Petra Clarke
	3 (page 7)	Definition of Medicines errors	February 2014	Petra Clarke / Karen Leggett
2	Throughout Section 5	References updated Inclusion of duty of candour	February 2016	Lorna Adlington
	Appendices	Marking criteria removed		
3	Page 5	Expanded scope. Added Nurse associates.	May 2018	Helen Oliver
	Page 6	Clarified individual responsibilities.		
	Page 8	Added incidents / errors associated with PGDs. Added supply of medicines.		
	Page 9	Use of environmental walkthrough as a tool to support RCA. Updated medicines competencies.		
	Page 10	Timescales updated and clarified.		
	Throughout document	Process updated with associated timescales and roles. Roles / titles updated. References updated throughout.		
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Lincolnshire Community Health Services NHS Trust
Management of Medication Errors Policy

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Lincolnshire Community Health Services NHS Trust

Management of Medication Errors Policy

Policy Statement

Background

Lincolnshire Community Health Services encourage a sensitive response to medication errors through a comprehensive assessment taking full account of the context and circumstances surrounding the incident.

This policy details the immediate, medium and long term actions to be taken following the discovery of a Medication Error to ensure patient safety and to support staff. Root Cause Analysis checklists have been developed to help identify how the error occurred and a Critical Incident Reflective Exercise for Medication Errors is included for staff to complete with the line manager as a formal process of learning from incidents that they have been involved in.

Statement

This policy has been developed to ensure that there is consistency in practice and aims to:
- Strengthen the organisations just and fair blame culture in response to adverse healthcare events
- Facilitate organisation learning through the findings of thorough and careful investigation at local level
- Provide a framework for practitioners to improve practice
- Ensure appropriate actions are taken by managers and applied consistently across the Trust

Responsibilities

This policy applies to all healthcare staff/ medical workforce (including Doctors, Nurses, Nurse Associates (NA) HCSW. Pharmacy Associated staff and Paramedics) , including bank and agency involved in any medication processes. It also sets out guidance on the definitions of medication errors and categorises them into prescribing errors, dispensing errors, preparation and administration errors and monitoring errors

Training

All members of staff involved within management of medicines will be introduced to the organisation's procedures for handling medicines errors.

Dissemination

Website/Team Brief/E-mail

Resource implication

1. Introduction and Background

1.1 This document sets out the organisations' policy on the management of medication errors. It aims to:

- Strengthen the organisations' just and fair blame culture in response to adverse healthcare events

- Facilitate organisational learning through the findings of thorough and careful investigation at local level

- Provide a framework for practitioners to improve practice

- Ensure appropriate actions are taken by managers and applied consistently across the organisation

1.2 The organisation encourages a sensitive response to medication errors through a comprehensive assessment taking full account of the context and circumstances surrounding the incident

2. Policy Scope

2.1 This policy applies to all healthcare staff/ workforce , including bank and agency involved in any medication processes including (not a definitive list)

- Nursing staff including registered Nursing associates (NA)
- Medical staff
- Emergency Care Practitioners
- Pharmacy Associated staff
- Allied Health Care Professionals

2.2 This policy also applies to Pre-registration Healthcare Professional Students (e.g Medical, Nursing, NA or Allied Health Care Professionals) who may be involved in any medication process under direct supervision. If a student is involved in / makes an error their University must also be involved

2.3 All staff involved in the prescribing, dispensing or administration of medicines must be able to demonstrate understanding and compliance with relevant professional guidance and LCHS Policies and procedures.

2.4 It is the individual staff's responsibility to ensure they have the relevant knowledge, skills competences and confidence concerning the prescribing, supplying/dispensing or administration of medicines. Training issues should be highlighted and supported by the line manager prior to any issues regarding medicine errors. Staff should decline prescribing, supplying/ dispensing and administrating medicines if they feel incompetent to do so.

2.5 Training and competences should reflect national standards and frameworks for medicine management such as those developed by the Royal Pharmaceutical Society, any local competences should be agreed and authorised for use by the Trust.

2.5 Staff who promptly report in relation to a medication error will not be subject to disciplinary action except under the following circumstances:

• Where the member of staff acted in a criminal, deliberate or malicious manner

• Where the member of staff concerned is guilty of gross carelessness with the potential for serious consequences and where they can reasonably be expected to appreciate the direct consequences of his / her behaviour

• Where an adverse event follows other incidents of a similar nature and where the organisation has provided all necessary training, counselling and supervision to prevent a reoccurrence

2.6 In the above cases. The LCHS policy Your Behaviour Matters – Disciplinary Policy and Procedure Incorporating Investigation Process (P_HR_06) will apply.

3. Definitions of Medication Errors and Incidents

For the purpose of this document:

1. **Errors resulting in harm** is an error or omission arising during clinical care causing physical or psychological injury to a patient.

2. **Errors with significant potential to harm** is an error or omission arising during clinical care with the potential to cause significant physical or psychological injury to a patient.

3. **Errors with potential to harm** is an error or omission arising during clinical care with the potential to cause physical or psychological injury to a patient.

4. **Incidents with potential to harm** is a medication incident that will not have caused harm but will be judged to have the potential to cause harm (near miss).

5. **Incidents with no potential to harm** is an incident during the process of procuring, dispensing, preparing, administering or monitoring which was prevented and would not have the potential to cause harm.

6. **Incidents resulting in harm** is an incident during the process of procuring, dispensing, preparing, administering or monitoring which was not prevented and resulted in harm

NB All medication omissions will be reported as an error and categorised as points 1, 2 or 3.

The following list gives examples of scenarios where medication errors can occur. Near misses in any of the sections below should also be considered. The definitions have been divided into sections according to the National Patient Safety Agency (NPSA) Safety in doses: medication safety incidences in the NHS (2007).

This is not a definitive list and as such clinicians, managers, and Clinical Governance Managers must exercise professional judgment prior to progression of the issue.

3.1 Prescribing Errors
• Patient prescribed the wrong medication / dose / route / rate

• Medication prescribed to the wrong patient

• Transcription errors

- Prescribing without taking into account the patients clinical condition
- Prescribing without taking into account patients clinical parameters e.g. weight
- Prescription not signed
- Deviation from LCHS Medicines Management and Non Medical Prescribing Policy or crieteria within the Patient Group Direction

3.2 Dispensing / Supply Errors

- Patient dispensed / supplied the wrong medication / dose / route
- Medication dispensed / supplied to the wrong patient
- Patient dispensed / supplied an out of date medicine
- Medication is labelled incorrectly
- Deviation from LCHS Medicines Management and Non Medical Prescribing Policy or criteria within the Patient Group Direction.

3.3 Preparation and Administration Errors

- Patient administered the wrong medication / dose / route
- Patient administered an out of date medicine
- Medication administered to the wrong patient
- Medication omitted without a clinical rationale
- Medication incorrectly prepared
- Incorrect infusion rate
- Medication administered late / early*

*(LCHS recognises this is a complex issue and the full context of late/early administration should be taken into account, however where it would have a significantly detrimental effect on patient care, this would constitute an error)
Deviation from LCHS Medicines Management and Non Medical Prescribing Policy or Patient Group Direction criteria

3.4 Monitoring Errors

- Patient allergic/sensitive to medication but the medication was prescribed and/or dispensed and/or administered
- Failure to provide the patient with correct information regarding their medication e.g. when to take, what it is for, side effects and drug interactions
- Failure to monitor therapeutic levels
- Failure to undertake appropriate review
- Failure to monitor patient / carer who is undertaking self-medication.

• Deviation from LCHS Medicines Management and Non Medical Prescribing Policy or Patient Group Direction criteria

4. Actions to be taken following the discovery of a Medication Error

4.1 Immediate Actions to be completed within 24 hrs

4.1.1 Assess the patient's condition and take necessary actions to maintain patient stability

4.1.2 The error must be reported immediately to the Manager / person in charge and the clinicians in charge of the patient/s care

4.1.3 Seek advice from Pharmacist / prescriber regarding the possible outcomes of medication error

4.1.4 In the instance of a dispensing error, inform the pharmacy and make arrangements for re-dispensing

4.1.5 Complete an incident report form (Datix) and obtain statements from the staff involved. Ensure the incident is documented in the patient's record

4.1.6 The line manager will ensure the incident report is completed and escalated as appropriate e.g. to the Matron / Head of Clinical Services/ Quality. It is essential this is carried out expediently to allow for a timely investigation in the event of a more serious event. In the event of an incident occurring out of hours the Duty Manager on call should be informed

4.1.7 Inform the patient as appropriate (see section 5)

4.2 Medium Term Actions to be completed within 7 days by Line Manager/ Matron / Medical Director

4.2.1 A systematic review of the root causes for the error must take place with the staff involved using the most appropriate Root Cause Analysis checklist (Appendix One) as soon as possible. Ideally carrying out an environmental walkthrough assessment; to determine any additional locality, system, personal or procedure errors/ causes. For errors resulting in harm or significant potential to harm, the Head of Clinical Services/ Quality will involve the Integrated care team staff as appropriate.

4.2.2 Following initial Root Cause Analysis and using the NPSA incident decision tree the line manager may feel it is appropriate to withdraw the member of staff from undertaking medication prescribing, dispensing or administration until a critical incident reflective exercise has been undertaken. In these cases the line manager must consult with the Matron / Head of Clinical Services / Quality (or duty manager if out of hours) before any decision is reached. The LCHS policy Your Behaviour Matters – Disciplinary Policy and Procedure Incorporating Investigation Process (P_HR_06) should be followed.

4.2.2 If the member of staff has been involved in other errors in the past three months a Reflective Exercise including evidence of references (Appendix 2) must be undertaken within a period of 7 days and sent to the staff members line manager

and attached to the Datix for review by the Medicine Management Team and practitioner performance manager . An agreed action plan highlighting areas for review of competences, actions and timeframe to be achieved will be developed in conjunction with the staff members Line Manager for implementation

4.2.3 There may be occasions where staff wish to withdraw themselves from prescribing, supply/dispensing or administration and have the opportunity to review their competencies. This decision should be respected and addressed within the critical incident reflective exercise. Any formal decision will be in consultation with the Matron / Head of Clinical Services/ Quality (or duty manager if out of hours) and the Medicine Management Officer.

4.2.4 The Matron supported by the MM team (as required), will undertake a critical incident reflective exercise with the member of staff (see Appendix Two). This will be undertaken within 7 days of reporting the error.

4.2.5 A copy of the agreed actions as identified within the critical incident reflective exercise is kept on the member of staff's personal record and reviewed in line with the appraisal process confirming positive change.

4.3 Long Term Actions

4.3.1 Individual healthcare practitioners (involved in medicine errors) performance will be reviewed at One to One (review of objectives) and through the Appraisal system. Clinical Supervision must be offered.

4.3.2 Completion of annual medicine competences and mandatory updates will ensure ongoing support and early recognition of further potential errors/ incidents

4.3.3 Lessons learnt / future learning for teams should be cascaded in an appropriate way to maintain anonymominity

4.3.4 The Head of Clinical Services / Quality, service matron's and the Medicines Management Officer must have clear processes in place to review information on medication errors from Datix to identify any themes and trends. Concerns regarding medication errors must be highlighted and escalated to the Deputy Director of Nursing and Medical Director as appropriate.

4.3.5 A Copy of the Root Cause Analysis Checklists must be sent to the appropriate Matron, Head of Clinical Services/ Quality and a copy attached to the Datix incident. The results will be analysed and reviewed by the Medicine Management Officer to identify any themes and trends. These results will be reported to the Service quality and risk groups and Safeguarding and Patient Safety group on a monthly basis

5. Informing the Patient

5.1 The organisation acknowledges that when things go wrong, open and honest (Duty of Candour) communication with the patient and / or relatives is fundamental to the ongoing partnership between them, those providing their care and the organisation. LCHS Open and Honest Policy (incorporating Duty of Candour) provides a framework for all staff to ensure appropriate management.

5.2 The patient should be informed by the healthcare professional in charge / Manager/ Medical Director and /or the Clinicians in charge of the patient's care. If appropriate an apology should be given, acknowledging that an apology is not an admission of liability

5.3 The patient's consent must be sought prior to informing other family members; if the patient is unable to provide this consent then the most appropriate family member may be informed.

5.4 Where the Clinicians or Nursing staff considers there are compelling clinical reasons not to discuss the event with the patient / relative(s) a clear record should be made of this in the patient's records. In such circumstances further advice may be sought from the Matron/Head of Clinical Services/ Quality /On Call Manager

5.5 If appropriate, following the investigation, a meeting should be offered to the patient and/or relatives with the relevant practitioner(s) / personnel. The purpose of such a meeting would be to discuss the findings of the investigation, share the lessons learned and outline the recommendations put into place to reduce the risk of a similar incident re-occurring in the future

6. Suspensions in Practice and Addressing Concerns of Competency

6.1 The line manager may feel it is in the patients and member of staff's best interests to stop them from undertaking medication prescribing, supply/dispensing or administration until a critical incident reflective exercise has been undertaken (within one week of the error). In these cases the line manager must consult with the Matron / Head of Clinical Services/ Quality and Medicine Management Officer before any decisions are made / actions taken.

6.2 The member of staff themselves may decide to stop their practice due to concerns regarding their own practice or a loss of confidence. This should be discussed and agreed with their line manager/ Head of Clinical Services/ Quality as it may have implications for staffing levels / allocation. They must also undertake a critical incident reflective exercise with their line manager, supported by the MM team within one week of the error.

6.3 If the critical incident reflective exercise highlights an issue with competency relating to medication prescribing, supply /dispensing or administration, the individual should undertake a period of re-assessment planned in collaboration with their line manager and the Service Matron/ Practitioner Performance Manager and facilitated by the Medicine Management (MM) team . Specific action plan and timescales must be set, agreed and regularly reviewed and monitored by line managers and reported by to the Medicines Management team for assurance.

6.4 If, after the period of education, training and re-assessment the member of staff's competence is still in doubt they should be managed in accordance with the Your Performance Matters Policy (P_HR_68)

6.5 Where an individual member of staff has made subsequent errors in the past three month period, the process as described in Section 4 will be undertaken by their line manager, supported by the MM team and comprehensive assessment made of the practitioners competence level, timescale and context. The Medicine Management team should be notified so immediate remedial support can be given to the practitioner. HR Colleagues within the Workforce and Transformation team will assume responsibility in ensuring adequate support is given to these individuals.

7. Support for Staff

7.1 Support for staff throughout the medication error process is available from (not a definitive list):

- Line Manager
- Medicine Management Team
- Organisational Development Staff
- Staff Side
- Service Matron/Head of Clinical Services / Quality
- Occupational Health
- Professional Bodies
- HR Colleagues within the Workforce and Transformation team

7.2 Line Managers can gain advice and support in managing staff that have made a medication error from:

- Service Matron / Head of Clinical Services/ Quality
- Organisational Development Teams
- Pharmacists
- Medicines Management Officer and Medicine Management Skills Facilitator
- Occupational Health
- HR Colleagues

8. Legal Liability

The organisation will generally assume vicarious liability for the acts of its staff. However, it is incumbent on staff to ensure that they:-

• Have undergone any suitable training and assessment of competence identified as necessary under the terms of this policy or otherwise.

• Have been fully authorised by their line manager and their Neighbourhood Team to undertake the activity.

• Fully comply with the terms of any relevant organisational policies and/or procedures at all times.

• Only depart from any relevant organisational guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery of such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable – such decision to be fully recorded in the patient's notes.

Staff are recommended to have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the organisation does not automatically assume vicarious liability and where support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies.

9. Audit and Review

9.1 This policy has been developed by the Medicines Management team

9.2 Compliance with this policy will be monitored through the incident reporting system using medication error as a search term.

9.3 The service quality and risk groups and Safeguarding and Patient Safety group will receive a monthly report of incident reports and Root Cause Analysis data where lessons learnt and best practice identified will be shared across the organisation and concerns will be flagged to Trust Board via the Quality and Risk Committee.

10. Related National Documents, LCHS Policies and References

- GMC Good Medical Practice Guidelines (2013) [online] Available at:www.gmc-uk.org [accessed 14.05.18]
- Kolbs Learning Cycle (1984)[online] Available at: https:/skillsfor learning.leedsbeckett.ac.uk/preview/content/models/02.shtml [accessed 14.05.18]
- LCHS Policies available at: https://www.lincolnshirecommunityhealthservices.nhs.uk/policies
1. Your Behaviour Matters – Disciplinary Policy and Procedure Incorporating Investigation Process (P_HR_06)
2. Open and Honest Care, (Including Duty of Candour) Policy (P_CIG_16)
3. Your Performance Matters (P-HR-68)
4. Performance Appraisal and Development Review (P-HR-59)
5. Policy for the development and control of patient group directions (PGDs) (P-CIG-13)
6. Management of Controlled Drugs Policy (P-CIG-18)
7. Safe and Secure Handling of Medicines policy (P-CIG-20)

- NICE (2017) Competency framework for people authorising PGDs [online] Available at:www.nice.org.uk/guidance/mpg2/rescources [accessed 14.05.18]
- NICE (20137 Competency framework for health professionals using PGDs PGDs [online] Available at:www.nice.org.uk/guidance/mpg2/rescources [accessed 14.05.18]
- NPSA (2004) Incident Decision Tree
- NMC Standards for Medicines Management (2007) [online] Available at: https://www.nmc.org.uk/standards/additional-standards/standards-for-medicines-management/ [accessed 13.04.18]
- NMC The Code, Nursing and Midwifery Council (2015) The Code. Professional Standards of practice and behaviour for nurses and midwives [online] Available at: https://www.nmc.org.uk/standards/code/ [accessed 13.04.18]
- NMC Standards and proficiency for nurse and midwife prescribers[online] Available at: https://www.nmc.org.uk/standards/additional-standards/standards-for-medicines-management/ [accessed on 13.04.18]

- Royal Pharmaceutical Society (2016) A Competency Framework for all Prescribers [online[Available at: www.rpharms.com [accessed 14.05.18]
- Royal Pharmaceutical Society Medicines, Ethics and Practice (2016) [online] Available at: www.rpharms.com/rescources/publications/medcines-ethics-and-practice-mep [accessed 14.05.18]

Flow Chart to show process of Medication Error

Training and completion of RPS Framework and relevant LCHS medicine competences, ensuring practitioner is competent, confident, knowledgeable and safe to supply and administer medication

Error Occurs

| Prescribing | Preparation/ Supplying Dispensing | Administration | Monitoring |

Immediate Actions
(complete within 24 hrs of error)

Patient
Rectify
Advice
Inform Patient

Inform Line Manager
Datix- IR1

Practitioner has had subsequent medication errors in past three months

Reflective Practice, using Appendix 2

Discuss with Medicine Management team and work to develop action plan to ensure any identified gaps in knowledge and competences are met within agreed timeframe

Medium Term Actions
(complete within 7 days of error)

An environmental walkthrough assessment in the relevant workplace whilst using the Analysis Checklists-(Appendix 1) will ensure all area/s of error are recognised at an early stage of investigation

Datix IR2
Immediate Fact Finding,
Root Cause Action
Incident Decision Tree
Refer to LCHS policies
1   P_HR_06
2   P-HR-68

Suspensions in Practice and/or concerns of competency by individual practitioner or investigator

Work with line managers and Practitioner Performance in a timely manner ensuring LCHS policies (P-HR-06 & P-HR- 68 are adhered to

Long Term Actions

Final approval of Datix with all relevant attachments.
Line Manger and MM to collate themes, reporting, monitoring and action plans to appropriate Quality Group & DTC.
Cascade lessons learnt / future learning

Individual to ensure;
Clinical Supervision
One to One
Appraisals
Completion of medicine competences

Chair:
f Exec

Appendix One

Use this checklist to undertake a systematic review of the error. It will help pinpoint where things went wrong and identify areas for action/improvement

Was the prescription written in accordance with medicines code?

No

Which was incorrect?

Capitals ☐

Generic ☐

Abbreviations ☐

Units ☐

Illegible ☐

Quality ☐

Signature(s) ☐

Transcribed and Dated ☐

Were all the patient details recorded and correct ?

No

Was the data missing ? ☐

Was the data inaccurate ? ☐

What was missing/ inaccurate ?

Allergy status ☐

Medication history ☐

Weight ☐

Blood results ☐

Other ☐

Why did it happen ?

Communication :
Verbal ☐

Written ☐

Transcription ☐

Wrong pt ☐

Were the prescribed medication details correct?

No

Were the prescribed medication details correct?

What was incorrect ?

Medication Name ☐

Dose ☐

Frequency ☐

Route ☐

Start/Stop ☐

Did the prescriber have sufficient prescribing information ?

No

Did the prescriber have sufficient prescribing information ?

Yes

Are there any guidelines? ☐

Guidelines :

Unclear ☐

Not followed ☐

Incomplete ☐

Was the prescriber's knowledge/ competence inadequate?

YES

Other Root Causes Identified:

Chair: Elaine Baylis QPM
Chief Executive: Andrew Morgan

Completed by : (Print name and Job title)		BU/Service	Date :	Datix Ref No :

Preparation /Dispensing Errors Root Cause Analysis Checklist

Use this checklist to undertake a systematic review of the error. It will help pinpoint where things went wrong and identify areas for action/improvement

Ward Level ☐
Service Level ☐
Pharmacy ☐

Dispensed incorrectly

Was it a problem with storage of the medication?

Were there packaging issues?

Was there a Manipulation error?

Due to an individual?

Any environmental issues?

Yes

Yes

Yes

Yes

Yes

Yes

Incorrect Medication ☐

Incorrect strength ☐

labelling ☐

Expired medication ☐

Other Root Causes Identified

Removed from package ☐

Space issues ☐

Next to similar Medication/ confused names ☐
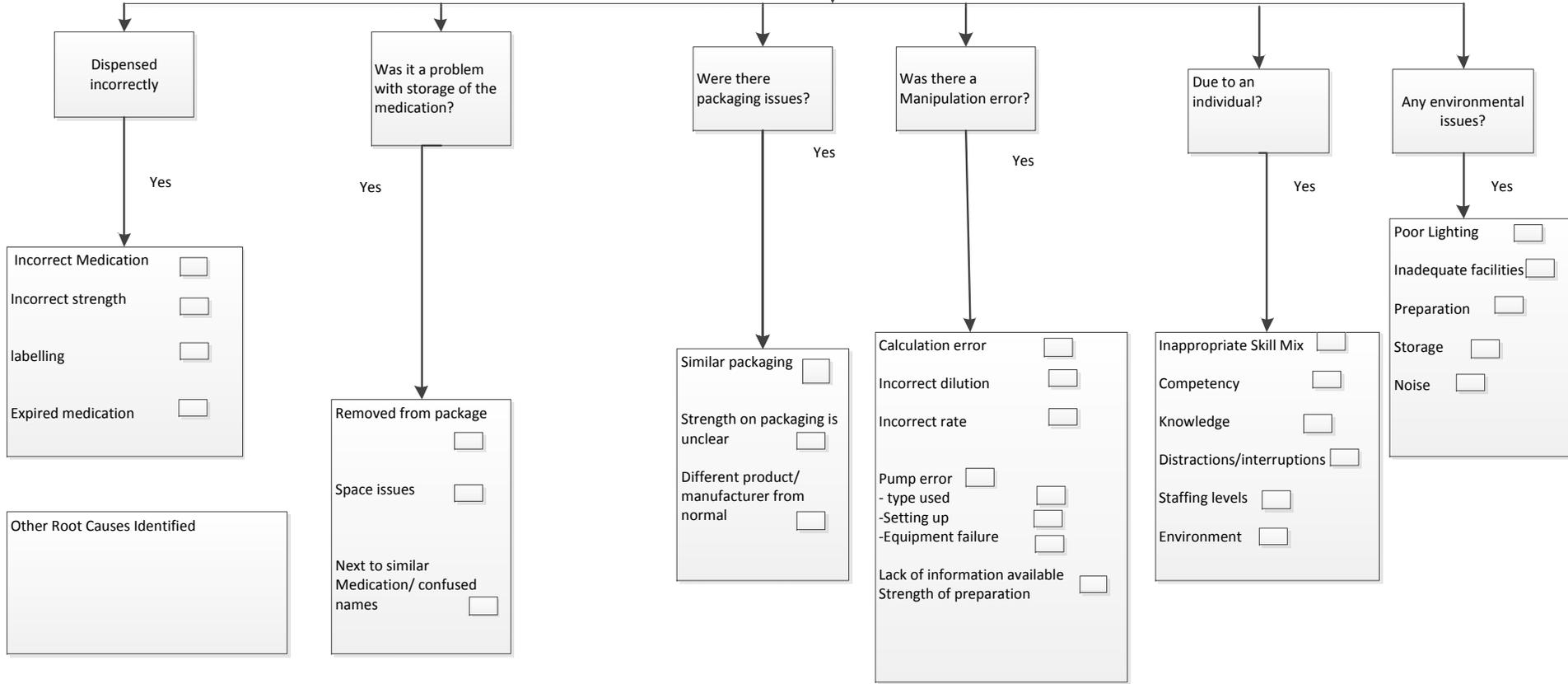
Similar packaging ☐

Strength on packaging is unclear ☐

Different product/ manufacturer from normal ☐

Calculation error ☐

Incorrect dilution ☐

Incorrect rate ☐

Pump error ☐
- type used ☐
-Setting up ☐
-Equipment failure ☐

Lack of information available
Strength of preparation ☐

Inappropriate Skill Mix ☐

Competency ☐

Knowledge ☐

Distractions/interruptions ☐

Staffing levels ☐

Environment ☐

Poor Lighting ☐

Inadequate facilities ☐

Preparation ☐

Storage ☐

Noise ☐

Completed by : (Print name and Job title)		BU/Service	Date :	Datix Ref No :

Administration Errors Root Cause Analysis Checklist

Use this checklist to undertake a systematic review of the error. It will help pinpoint where things went wrong and identify areas for action/improvement
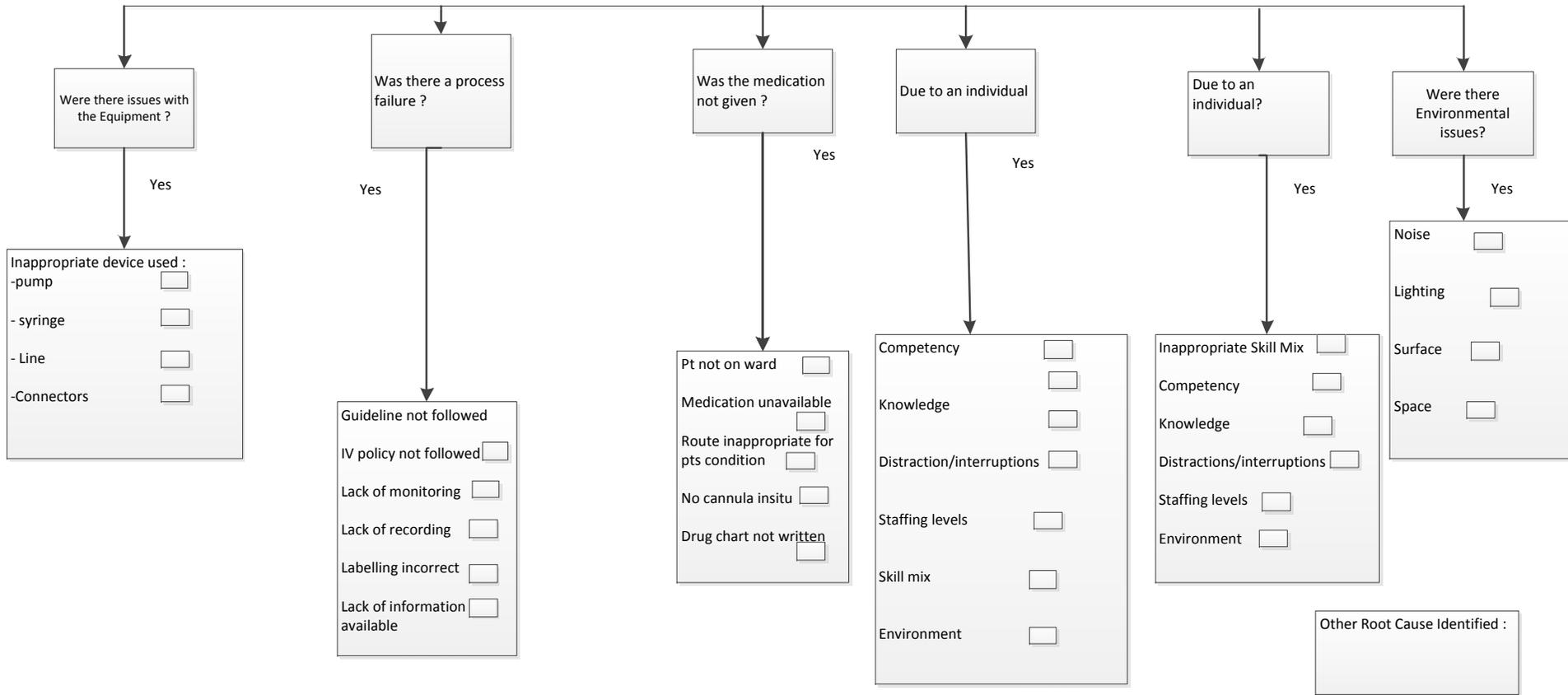
Were there issues with the Equipment ?	Was there a process failure ?	Was the medication not given ?	Due to an individual	Due to an individual?	Were there Environmental issues?

Yes   Yes   Yes   Yes   Yes   Yes

Inappropriate device used :
-pump ☐

- syringe ☐

- Line ☐

-Connectors ☐

Guideline not followed

IV policy not followed ☐

Lack of monitoring ☐

Lack of recording ☐

Labelling incorrect ☐

Lack of information available ☐

Pt not on ward ☐

Medication unavailable ☐

Route inappropriate for pts condition ☐

No cannula insitu ☐

Drug chart not written

Competency ☐

☐

Knowledge ☐

Distraction/interruptions ☐

Staffing levels ☐

Skill mix ☐

Environment ☐

Inappropriate Skill Mix ☐

Competency ☐

Knowledge ☐

Distractions/interruptions ☐

Staffing levels ☐

Environment ☐

Noise ☐

Lighting ☐

Surface ☐

Space ☐

Other Root Cause Identified :

Completed by : (Print name and Job title)		BU/Service	Date :	Datix Ref No :

Monitoring Errors Root Cause Analysis Checklist

Use this checklist to undertake a systematic review of the error. It will help pinpoint where things went wrong and identify areas for action/improvement
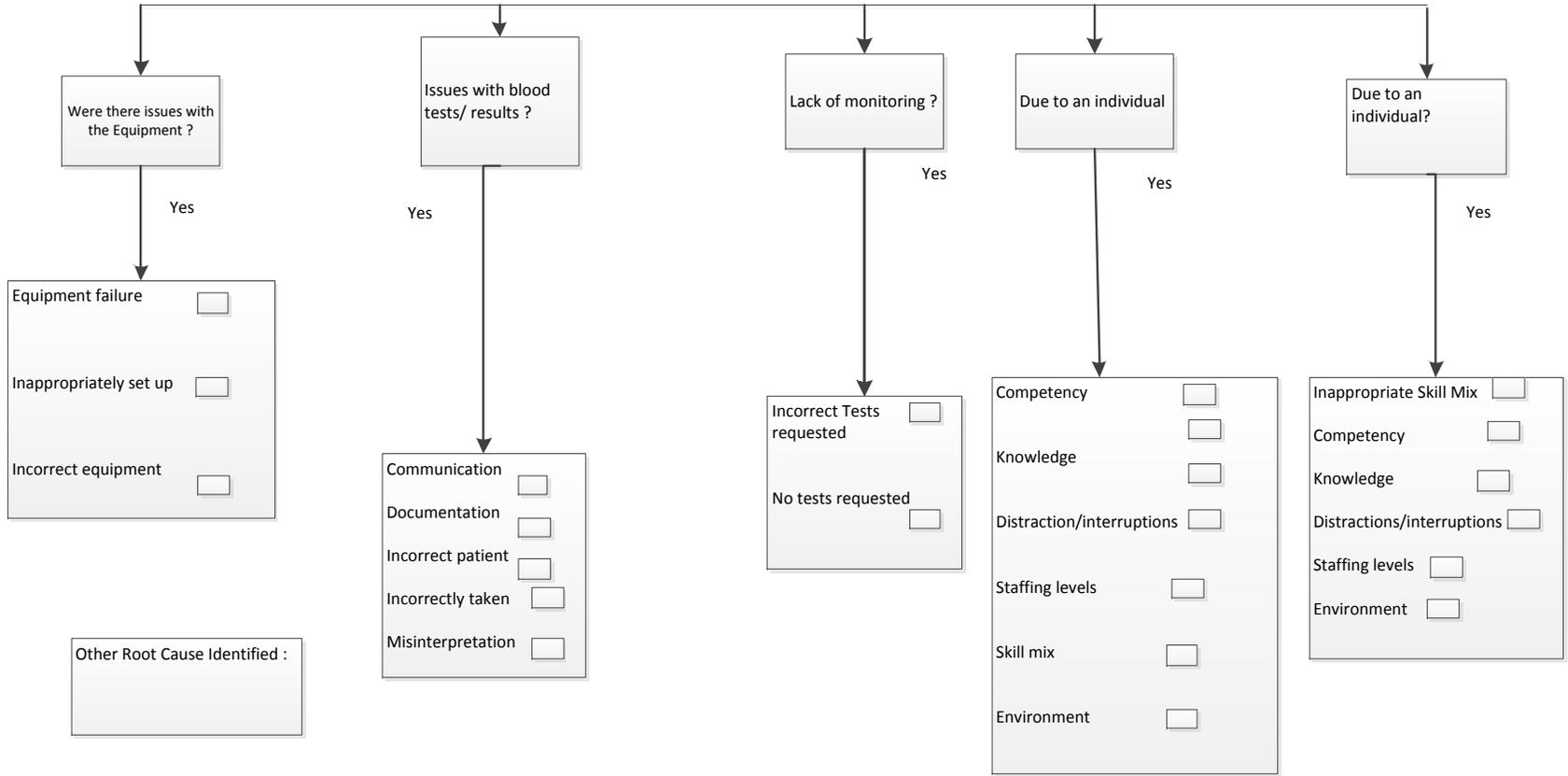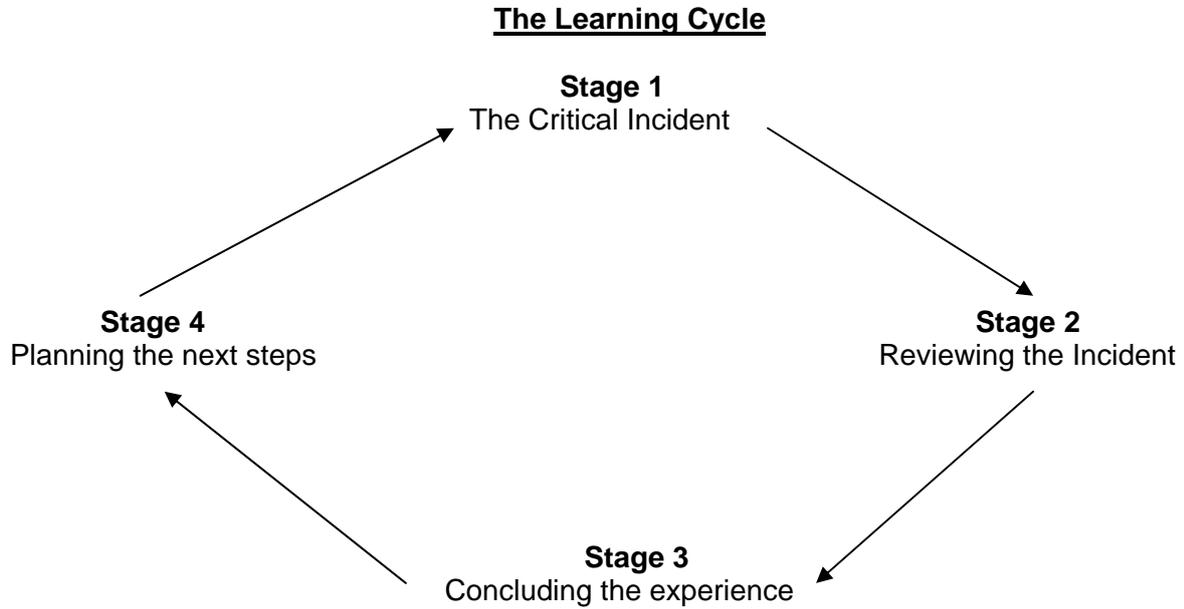
Were there issues with the Equipment ?

Issues with blood tests/ results ?

Lack of monitoring ?

Due to an individual

Due to an individual?

Yes

Yes

Yes

Yes

Yes

Equipment failure ☐

Inappropriately set up ☐

Incorrect equipment ☐

Communication ☐

Documentation ☐

Incorrect patient ☐

Incorrectly taken ☐

Misinterpretation ☐

Incorrect Tests requested ☐

No tests requested ☐

Competency ☐

☐

Knowledge ☐

Distraction/interruptions ☐

Staffing levels ☐

Skill mix ☐

Environment ☐

Inappropriate Skill Mix ☐

Competency ☐

Knowledge ☐

Distractions/interruptions ☐

Staffing levels ☐

Environment ☐

Other Root Cause Identified :

Completed by : (Print name and Job title)		BU/Service	Date :	Datix Ref No :

~~Critical~~ Incident Reflective Exercise for Medication Errors

This document has been developed to enable all practitioners to have a formal process of learning from incidences that they have been involved in. You must complete this form in conjunction with the Medcie Management team and your line manager. You will keep the original form; your manager will keep a copy.

The Learning Cycle

Stage 1
The Critical Incident

Stage 4
Planning the next steps

Stage 2
Reviewing the Incident

Stage 3
Concluding the experience

The Incident Reflective Exercise is in three parts:

Part A: You write a factual statement about the incident. This will be kept by your manager with the relevant incident form

Part B: Is a formal learning exercise for you to reflect on the incident and to discuss issues with the service lead / service Matron and the Medicine Management team. It should be completed using the Reflective Exercise cycle above and in such a manner that demonstrates your knowledge of associated standards and policies.

Part C: Is an action plan that arises from the incident and will be kept as part of your appraisal documentation to be reviewed as appropriate

There are several hints and suggestions in each part of the document to assist you in completing it; these do not have to be followed exactly as set out

Part A: Formal Statement of the incident

Write a detailed account of what happened before, during and after the incident.				
Returning to the situation: • What exactly occurred in your words? • What did you see? • What did you do? • What were the immediate consequences of your actions for yourself, the patient, visitors, your colleagues? • What did other people do? (e.g. colleagues, patient, visitors)				
Write your statement here (Continue on another sheet if necessary)				
Name of person completing the form:		**Signature:**		**Date:**
Name of person receiving the form: *(attach to relevant Datix)*		**Signature:**		**Date:**

Part B: Reflection on the Incident (To be completed within **one week** of the incident, to be kept by the individual practitioner and discussed with Medicine Management team and their line manager)

Write a reflective account of the events leading up to, during and after the incident

Reflecting on the incident:
- What was I trying to achieve? Why did I act as I did?
- What internal/external factors influenced my decision making or actions?
- What sources of knowledge (reference LCHS policies and NMC Code and RPS Competencies) did or should have influenced my decision making actions? What were my feelings at the time?
- What are my feelings now? Are there differences? Why?
- What were the effects of what I did or did not do?
- What 'good' emerged from the situation e.g. self/others?
- What troubles me now (if anything)?
- What would I have done differently/better?

(Write your reflection here)

Date you completed the reflection…………………………………………………………………………

Date discussed with your Line Manager……………………………………………………………….

Date discussed with Medicine Management team …………………………………………………….

(Continue on another sheet if necessary)   *File as part of your revalidation evidence*

Part C: Action Plan arising out of the Incident (to be kept by the manager with appraisal documentation)

List your learning points from the incident, with an action plan of what you need to concentrate on or do differently as a result

Looking to the future:
- What needs to happen to alter the situation?
- What are you going to do about the situation?
- What happens if you decide not to alter anything?
- What information do you need to face a similar situation again?
- What are your best ways of getting further information about the situation should it arise again?
- Have I taken effective action to support myself and others as a result of this experience?
- Identify anything that may hinder your action plans and how you can tackle these?

(Write your Learning/ Future learning points here)

Learning Need	Actions to address Learning Needs	Progress and review date

Name of person completing the form: *MM Team*		Signature:		Date:
Name of person reviewing the form: *Line Manager*		Signature:		Date:

INCIDENT DECISION TREE
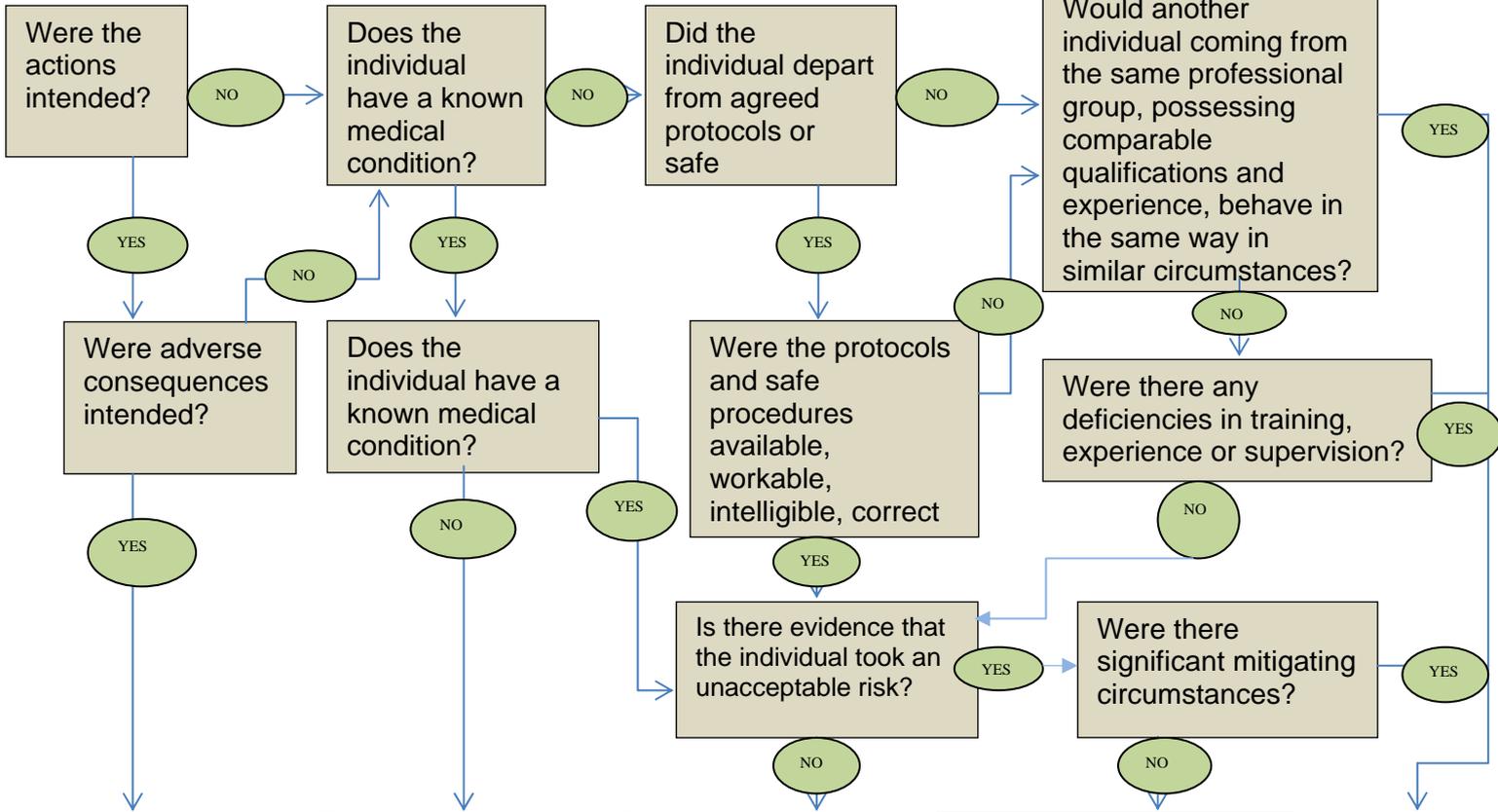Work through the tree separately for each individual involved

Start here

Deliberate Harm Test

Incapacity Test

Foresight Test

Substitution Test

Were the actions intended? → NO →

Does the individual have a known medical condition? → NO →

Did the individual depart from agreed protocols or safe → NO →

Would another individual coming from the same professional group, possessing comparable qualifications and experience, behave in the same way in similar circumstances? → YES →

YES ↓

YES ↓

YES ↓

NO

NO ↓

Were adverse consequences intended?

Does the individual have a known medical condition?

Were the protocols and safe procedures available, workable, intelligible, correct

Were there any deficiencies in training, experience or supervision? → YES →

YES ↓

NO

YES

YES ↓

NO

Is there evidence that the individual took an unacceptable risk? → YES →

Were there significant mitigating circumstances? → YES →

NO ↓

NO ↓

Consult NCAA or relevant regulatory body
Advise individual to consult Trade Union Representative
Consider:

- Suspension
- Referral to police and disciplinary/regulatory body
- Occupational Health referral

Highlight any System Failures identified

Consult NCAA or relevant regulatory body
Advise individual to consult Trade Union Representative
Consider:

- Occupational Health referral
- Reasonable adjustment to duties
- Sick Leave

Highlight any System Failures identified

Advise individual to consult Trade Union Representative
Consider:

- Corrective training
- Improved supervision
- Occupational Health referral
- Reasonable adjustment to duties

Highlight any System Failures identified

Consult NCAA or relevant regulatory body
Advise individual to consult Trade Union Representative
Consider:

- Referral to disciplinary/regulatory body proved supervision
- Reasonable adjustment to duties
- Occupational Health referral
- Suspension

Highlight any System Failures identified

SYSTEM FAILURE
Review System

Equality Analysis

<u>Appendix Four</u>

Name of Policy/Procedure/Function*	

Management of Medication Errors Policy

Equality Analysis Carried out by: Helen Oliver
Date: March 2018
Equality & Human rights Lead: Rachel Higgins

Director\General Manager:

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*In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	This policy has been developed to ensure that there is consistency in practice and aims to: • Strengthen the organisations just and fair blame culture in response to adverse healthcare events • Facilitate organisation learning through the findings of thorough and careful investigation at local level • Provide a framework for practitioners to improve practice • Ensure appropriate actions are taken by managers and applied consistently across the Trust This policy applies to all healthcare staff, (untrained and registered staff including Nurse Associates (NA)) including bank and agency involved in any medication processes. It also sets out guidance on the definitions of medication errors and categorises them into prescribing errors, dispensing errors, preparation ad administration errors and monitoring errors
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	This policy applies to all healthcare staff, (untrained and registered staff including NA) including bank and agency involved in any medication processes including (not a definitive list) • Nursing staff including registered NA • Medical staff • Emergency Care Practitioners • Pharmacy associated staff • Allied Health Care Professionals
C.	Is there is any evidence that the policy\service relates to an area with known inequalities?	No.

			Yes	No	
		Please give details			
D.		Will/Does the implementation of the policy\service result in different impacts for protected characteristics?			
			Yes	No	
		Disability		X	
		Sexual Orientation		X	
		Sex		X	
		Gender Reassignment		X	
		Race		X	
		Marriage/Civil Partnership		X	
		Maternity/Pregnancy		X	
		Age		X	
		Religion or Belief		X	
		Carers		X	
		If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
		The above named policy has been considered and does not require a full equality analysis			
Equality Analysis Carried out by:			Helen Oliver		
Date:			March 2018		