

# Management of Medication Errors Policy

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**Lincolnshire Community Health Services NHS Trust**

**Management of Medication Errors Policy**

**Version Control Sheet**

<b>Version</b>	<b>Section/Para/ Appendix</b>	<b>Version/Description of Amendments</b>	<b>Date</b>	<b>Author/Amended by</b>
1	6.5  3 (page 7)	New Policy HR responsibility to support staff through medicines errors Definition of Medicines errors	November 2013 January 2014 February 2014	Petra Clarke Petra Clarke Petra Clarke / Karen Leggett
2	Throughout Section 5  Appendices	References updated Inclusion of duty of candour Marking criteria removed	February 2016	Lorna Adlington
3	Page 5  Page 6  Page 8  Page 9  Page 10  Throughout document	Expanded scope. Added Nurse associates. Clarified individual responsibilities. Added incidents / errors associated with PGDs. Added supply of medicines. Use of environmental walkthrough as a tool to support RCA. Updated medicines competencies. Timescales updated and clarified. Process updated with associated timescales and roles. Roles / titles updated. References updated throughout.	May 2018	Helen Oliver
4	Page 5  Page 7 Page 8  Pages 9 – 10  Page 10	Revised policy statement "Statement" section. Revised Section 1 Revised Section 2.5: Staff Involved In a medication error. Revised the last bullet point in Sections 31, 3.2 and 3.4. Introduced CAS/OOH in 4.1.3.	March 2020	Sue Kinder/ Kim Todd

	Page 11	Revised 4.2.2 to introduce and agreed action plan and timeframe.		
	Page 11	Revised 4.3.1 to explain procedure		
	Page 14	Revised 4.3.2 to include prescribing competencies.		
	Page 14	Revised 7.2 to include Clinical Practice Educator Team.		
	Page 13	Revised reference at 10.1		
	Page 5	Update to sentence 6.5		
	Page 12	Third paragraph on background		
		5.2 removal of "if appropriate" at the start of the sentence.		
5				

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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 Just Culture response to medication errors through a comprehensive reporting system. In the event of a medication error an assessment taking full account of the context and circumstances surrounding the incident is conducted to learn lessons. These lessons are then disseminated to improve collective knowledge and understanding.

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 updating any processes as part of any lessons learned during the investigation.

A Medication Errors Reflection Exercise 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 organisation's just culture 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 shall 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 Culture 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 its Just Culture.

1.3 It expects staff to report errors openly, honestly and promptly through the reporting system(s).

1.4 Whenever an error is reported a comprehensive assessment shall take place. It shall consider in full the context and circumstances surrounding the incident. Lessons learned will be disseminated to improve the knowledge base of colleagues and improve practice.

## **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 Professionals

2.2 This policy also applies to Pre-registration Healthcare Professional Students (e.g Medical, Nursing, NA or Allied Health 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.

Where staff consider that they have had insufficient training, or where they identify gaps in their knowledge base or skill set that they cannot self-rectify, they should refer these to their

training facilitator and/or their line manager. Staff will be supported with further training or guidance to overcome these deficiencies.

Finally, staff should decline prescribing, supplying/ dispensing and administering medicines if they consider themselves not competent to do so.

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

2.5 Staff involved in a medication error shall not be subject to disciplinary action unless:

- The member of staff has not reported the error and not taken the actions required following the discovery of a Medication Error (See Section 4).
- The member of staff acted in a criminal, deliberate or malicious manner
- 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 their behaviour
- 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

In these cases the LCHS policy Your Behaviour Matters – Disciplinary Policy and Procedure Incorporating Investigation Process (P\_HR\_06) shall 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 shall 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 shall 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 shall 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 Independent and Supplementary Prescribing Policy or criteria 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 Independent and Supplementary 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. *NB: 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 Independent and Supplementary 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 Independent and Supplementary 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 / CAS/ OOH Team 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 shall 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 shall involve the Integrated Care Team staff as appropriate.

4.2.2 Following the initial Root Cause Analysis and using the Just Culture Guide 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 member's 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 member's Line Manager for implementation within a further 7 days.

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), shall undertake a critical incident reflective exercise with the member of staff (see Appendix Two). This shall 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**

Where a practitioner has been involved in a medication error, their practice requires close monitoring to ensure that lessons have been learnt and that there have been no further errors. Any discussion should be formally documented.

Where there have been repeated errors and an apparent failure to remediate, then formal disciplinary action should be considered in line with LCHS HR policy and procedure. A referral to the practitioner's relevant regulatory body should also be considered, especially if there are concerns in regards to future patient's safety.

4.3.2 Completion of annual medicine / prescribing 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 anonymity

4.3.4 The Head of Clinical Services / Quality, service matrons 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 shall 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. 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 shall 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. This should be undertaken with involvement of HR Colleagues to ensure that correct process is followed and the staff member receives the appropriate support.

## **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
- NHS Improvement.
  
- 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:

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

## 8. Legal Liability

The organisation will generally assume vicarious liability for the acts of its staff. However, staff shall 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.

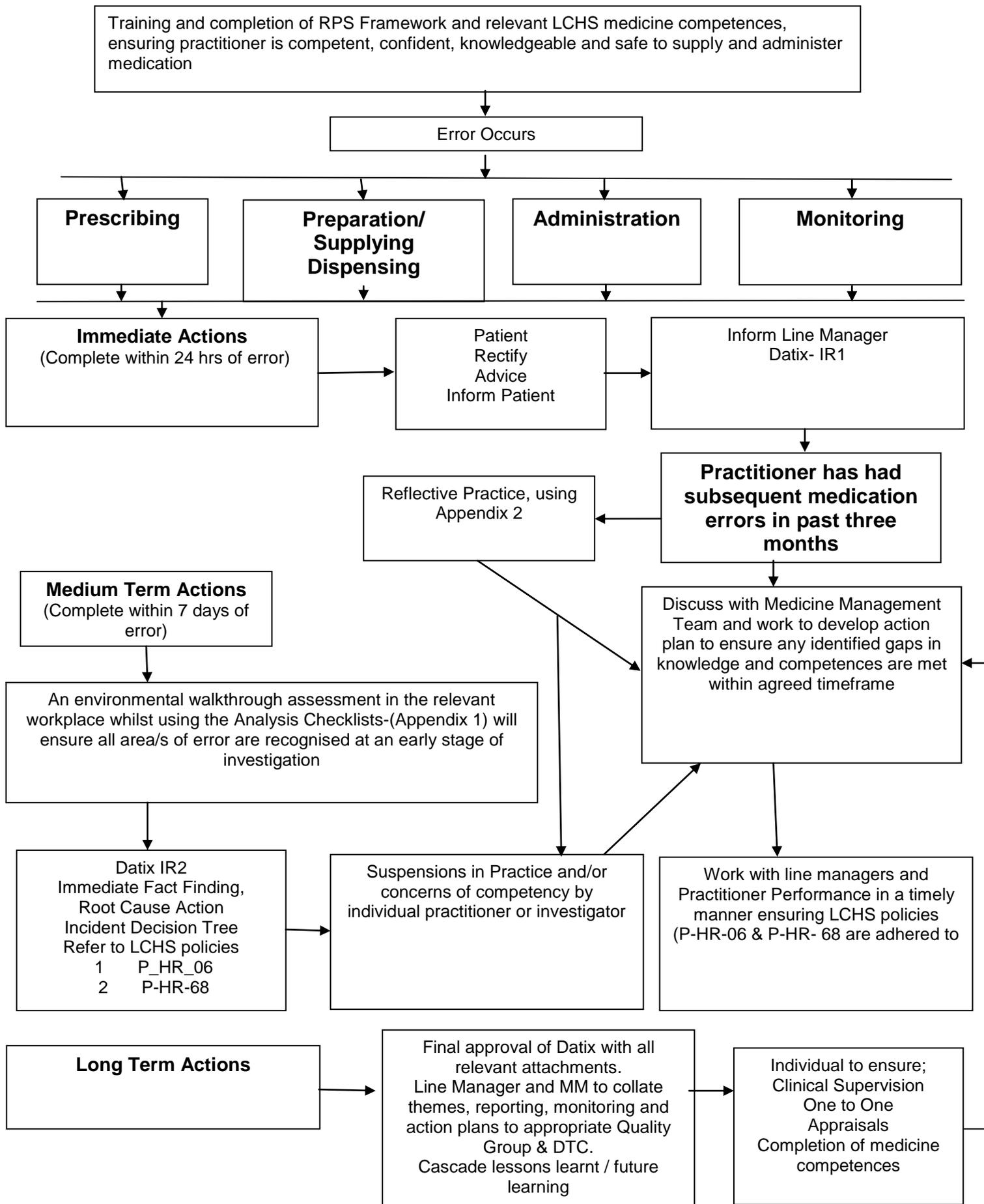
9.3 The service quality and risk groups and Safeguarding and Patient Safety group will receive a monthly report of incident reports and Root Cause Analysis data where lessons learnt and best practice identified shall be shared across the organisation and concerns shall be flagged to Trust Board via the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

## 10. Related National Documents, LCHS Policies and References

1. GMC Good Medical Practice Guidelines (2013 and updated 29.04.19) [online]  
Available at: [www.gmc-uk.org/guidance](http://www.gmc-uk.org/guidance) [accessed 17.03.20]
2. LCHS Policies available at:  
<https://www.lincolnshirecommunityhealthservices.nhs.uk/policies>
3. NHS – A Just Culture Guide at: <https://improvement.nhs.uk/resources/just-culture-guide/> [this is not something which should be routinely. It should be used if; there is a suspicion that the staff member needs support or management to work safely, as part of a practitioner performance case or staff investigation.]

- a. and the Just Culture Poster at [https://improvement.nhs.uk/documents/2490/NHS\\_0932\\_JC\\_Poster\\_A3.pdf](https://improvement.nhs.uk/documents/2490/NHS_0932_JC_Poster_A3.pdf) [both last updated on 14.12.2018 and accessed on 25.03.2020]
4. Your Behaviour Matters – Disciplinary Policy and Procedure Incorporating Investigation Process (P\_HR\_06)
5. Open and Honest Care, (Including Duty of Candour) Policy (P\_CIG\_16)
6. Your Performance Matters (P-HR-68)
7. Performance Appraisal and Development Review (P-HR-59)
8. Policy for the development and control of patient group directions (PGDs) (P-CIG-13)
9. Management of Controlled Drugs Policy (P-CIG-18)
10. Safe and Secure Handling of Medicines policy (P-CIG-20)
11. NICE (2017) Competency framework for people authorising PGDs [online] Available at: [www.nice.org.uk/guidance/mpg2/resources](http://www.nice.org.uk/guidance/mpg2/resources) [accessed 14.05.18]
12. NICE (20137 Competency framework for health professionals using PGDs PGDs [online] Available at: [www.nice.org.uk/guidance/mpg2/resources](http://www.nice.org.uk/guidance/mpg2/resources) [accessed 14.05.18]
13. Royal Pharmaceutical Guidance ( January 2019) Professional Guidance on the Administration of Medications in Healthcare settings. <https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567> [accessed 05.05.20]
14. NMC The Code, Nursing and Midwifery Council (October 2018) The Code. Professional Standards of practice and behaviour for nurses midwives and nurse associates [online] Available at: <https://www.nmc.org.uk/standards/code/> [accessed 05.05.20]
15. NMC Standards and proficiency for nurse and midwife prescribers (October 2018) [online] Available at: <https://www.nmc.org.uk/standards/additional-standards/standards-for-medicines-management/>
16. Royal Pharmaceutical Society ( 2016) A Competency Framework for all Prescribers [online] Available at: [www.rpharms.com](http://www.rpharms.com) [accessed 14.05.18]

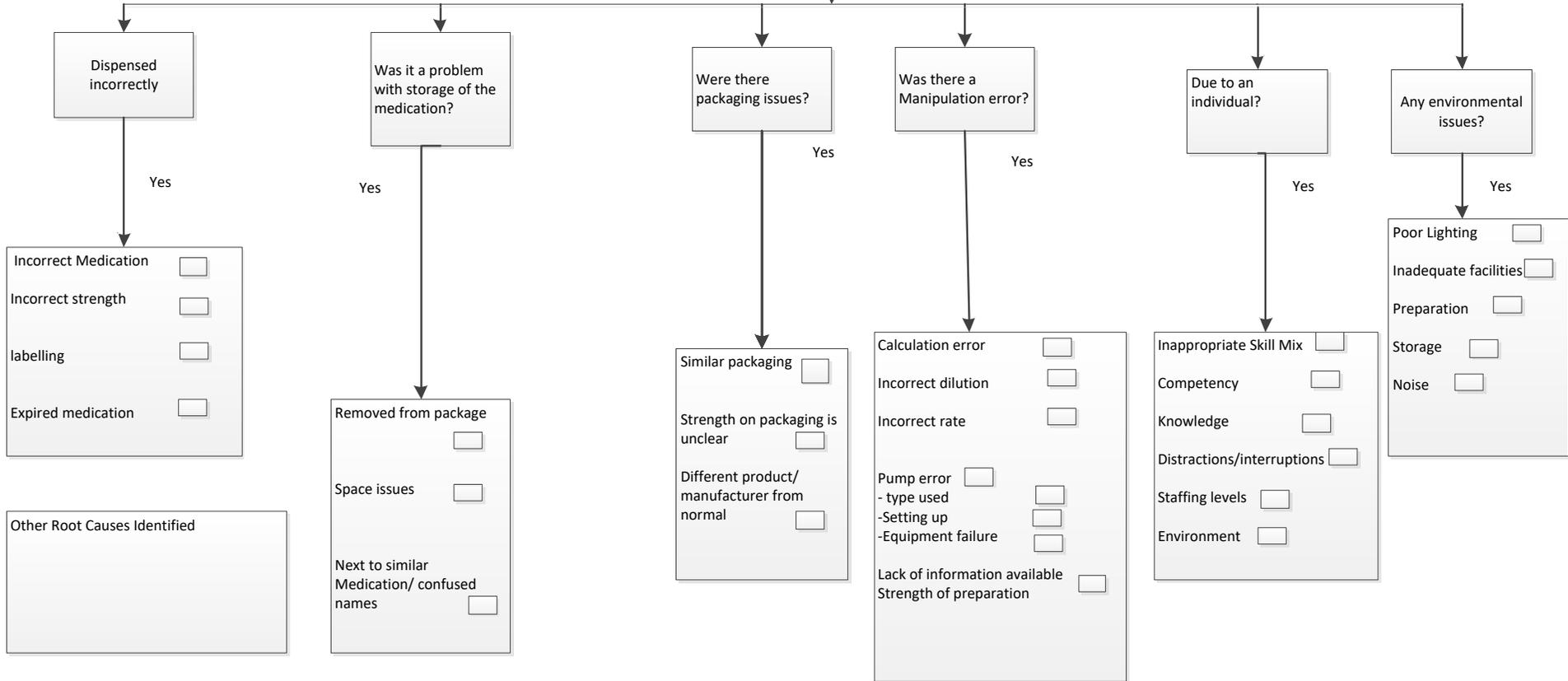
## Flow Chart to show process of Medication Error



### 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	<input type="checkbox"/>
Service Level	<input type="checkbox"/>
Pharmacy	<input type="checkbox"/>

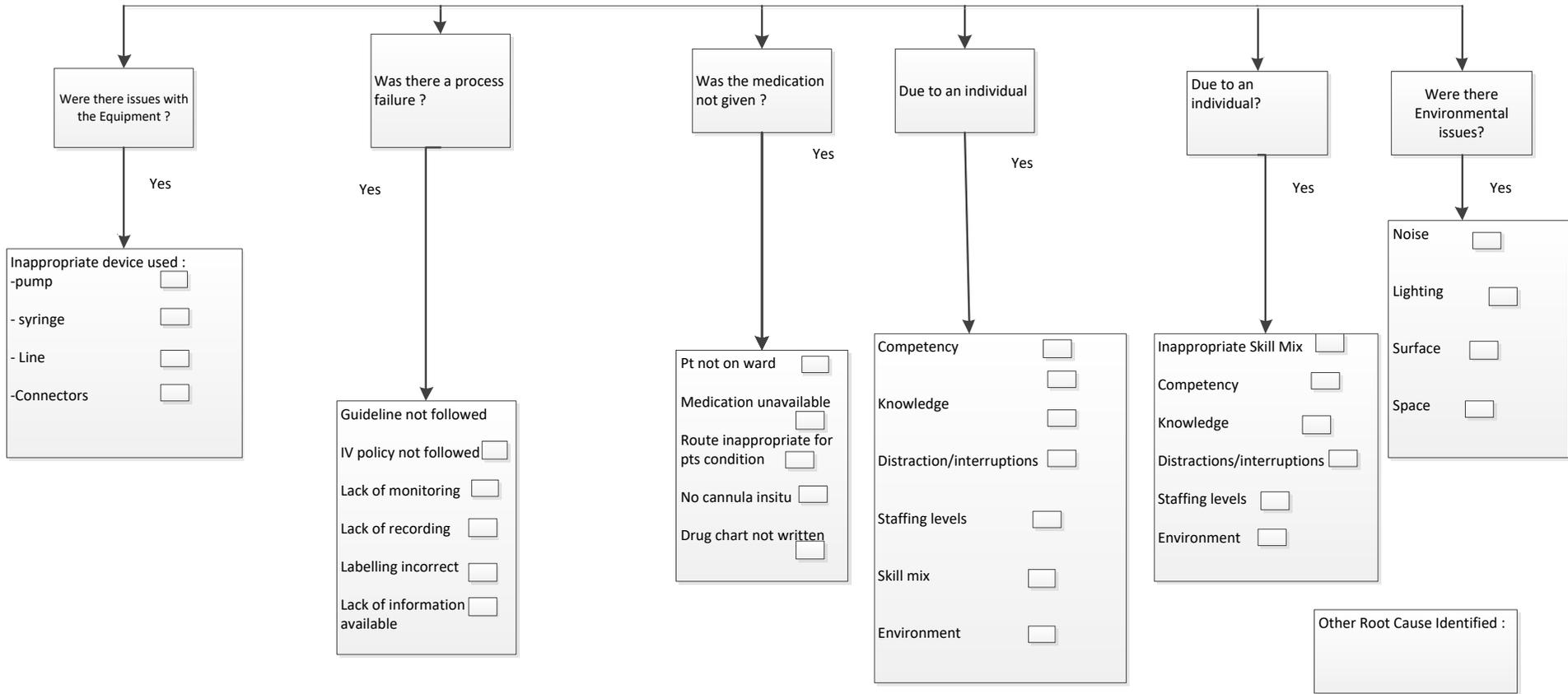


Other Root Causes Identified

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

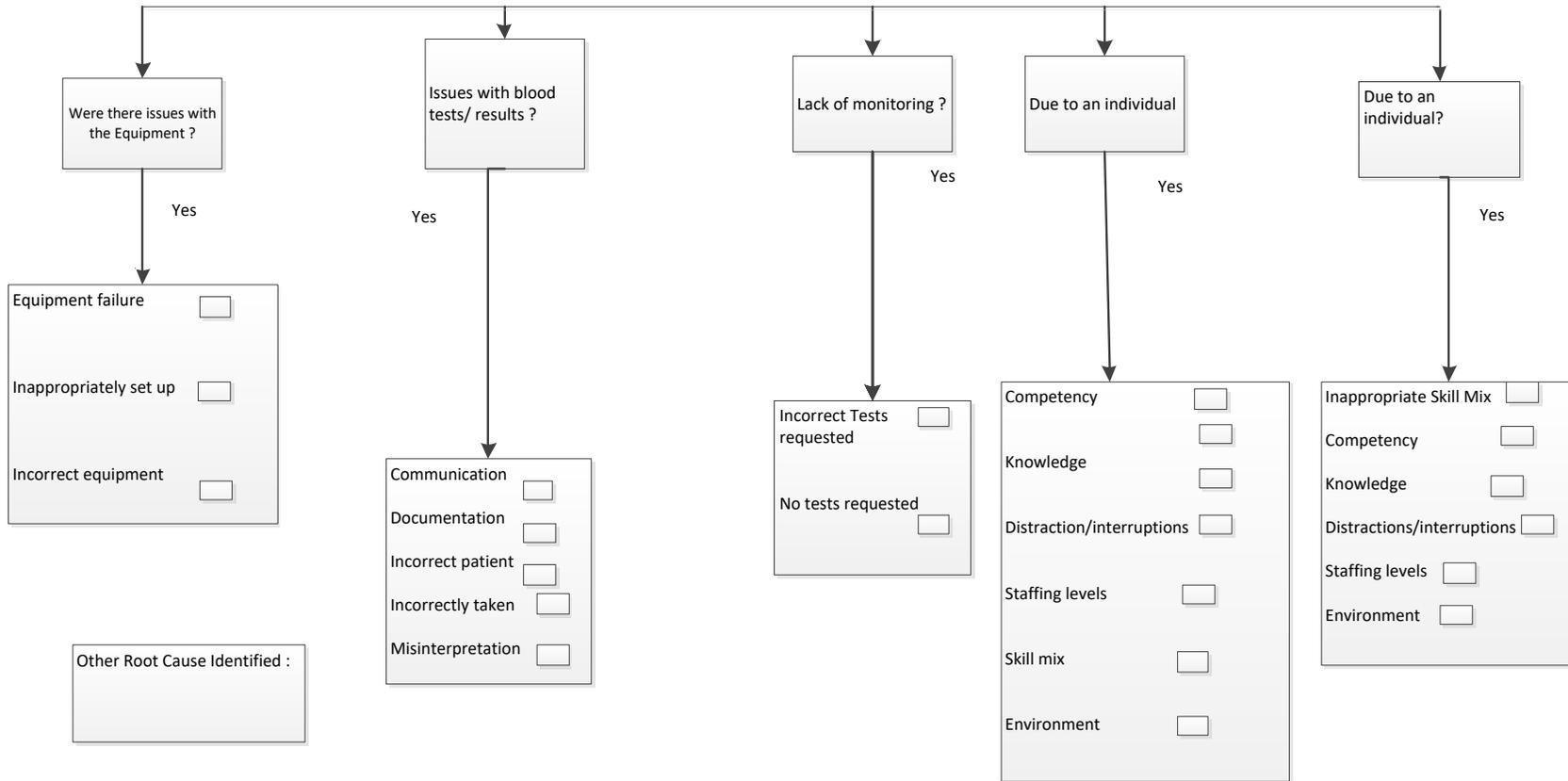


Other Root Cause Identified :

Completed by : (Print name and Job title )		BU/Service	Date :	Datix Ref No :
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### Monitoring Errors Root Cause Analysis Checklist

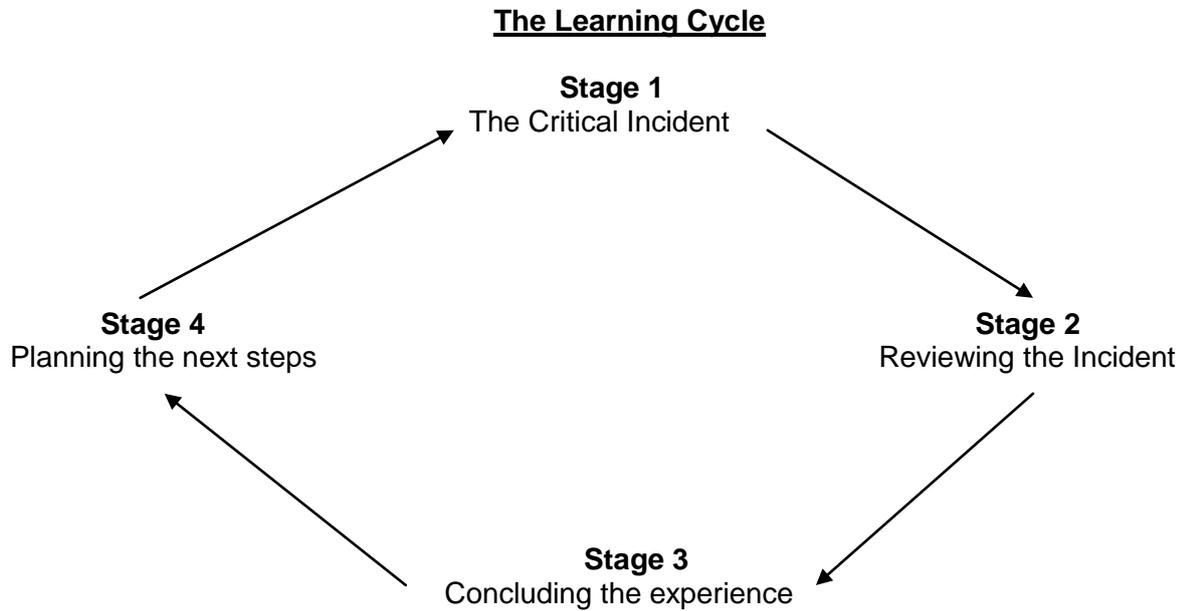
Use this checklist to undertake a systematic review of the error. It will help pinpoint where things went wrong and identify areas for action/improvement



Completed by : (Print name and Job title )		BU/Service	Date :	Datix Ref No :
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**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 Medicine Management Team and your line manager. You will keep the original form; your manager will keep a copy.



**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, and your colleagues?
- What did other people do? (e.g. colleagues, patient, visitors)

Write your statement here

(Continue on another sheet if necessary)

<b>Name of person completing the form:</b>		<b>Signature:</b>		<b>Date:</b>
<b>Name of person receiving the form:</b> <i>(attach to relevant Datix)</i>		<b>Signature:</b>		<b>Date:</b>

**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: <i>MM Team</i>		Signature:		Date:
Name of person reviewing the form: <i>Line Manager</i>		Signature:		Date:

**Section 1 – to be completed for all policies**

## Appendix Three\_\_ Equality Analysis

**NB - It is the responsibility of the author / reviewer of this document to complete / update the Equality Analysis each time it has a full review and to contact the Equality Diversity and Inclusion Lead if a full equality impact analysis is required**

### Equality Impact Analysis Screening Form

Title of activity	Management of Medication Errors Policy		
Date form completed	May 2020	Name of lead for this activity	Helen Oliver

Analysis undertaken by:		
Name(s)	Job role	Department
Helen Oliver	Medicines Management Skills Facilitator	Medicines Management Team

What is the aim or objective of this activity?	<p>This policy has been developed to ensure that there is consistency in practice and aims to:</p> <ul style="list-style-type: none"> <li>Strengthen the organization's Just Culture in response to adverse healthcare events</li> <li>Facilitate organisation learning through the findings of thorough and careful investigation at local level</li> <li>Provide a framework for practitioners to improve practice</li> <li>Ensure appropriate actions are taken by managers and applied consistently across the Trust</li> </ul> <p>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 categorizes them into prescribing errors, dispensing errors, preparation and administration errors and monitoring errors</p>
Who will this activity impact on? <i>E.g. staff, patients, carers, visitors etc.</i>	<p>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)</p> <ul style="list-style-type: none"> <li>Nursing staff including registered NA</li> </ul>

	<ul style="list-style-type: none"> <li>• Medical staff</li> <li>• Emergency Care Practitioners</li> <li>• Pharmacy associated staff</li> <li>• Allied Health Professionals</li> </ul>
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**Potential impacts on different equality groups:**

<b>Equality Group</b>	Potential for <b>positive</b> impact	<b>Neutral</b> Impact	Potential for <b>negative</b> impact	Please provide details of how you believe there is a potential positive, negative or neutral impact (and what evidence you have gathered)
<b>Age</b>	<input type="checkbox"/>	x	<input type="checkbox"/>	
<b>Disability</b>	<input type="checkbox"/>	x	<input type="checkbox"/>	
<b>Gender reassignment</b>	<input type="checkbox"/>	x	<input type="checkbox"/>	
<b>Marriage &amp; civil partnerships</b>	<input type="checkbox"/>	x	<input type="checkbox"/>	
<b>Pregnancy &amp; maternity</b>	<input type="checkbox"/>	x	<input type="checkbox"/>	
<b>Race</b>	<input type="checkbox"/>	x	<input type="checkbox"/>	
<b>Religion or belief</b>	<input type="checkbox"/>	x	<input type="checkbox"/>	
<b>Sex</b>	<input type="checkbox"/>	x	<input type="checkbox"/>	
<b>Sexual Orientation</b>	<input type="checkbox"/>	X	<input type="checkbox"/>	
<b>Additional Impacts</b> <i>(what other groups might this activity impact on? Carers, homeless, travelling communities etc.)</i>	<input type="checkbox"/>	x	<input type="checkbox"/>	

If you have ticked one of the above equality groups please complete the following:

**Level of impact**

	Yes	No
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Could this impact be considered direct or indirect discrimination?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how will you address this?		

	High	Medium	Low
What level do you consider the potential negative impact would be?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If the negative impact is high, a full equality impact analysis will be required.*

**Action Plan**

How could you minimise or remove any negative impacts identified, even if this is rated low?
How will you monitor this impact or planned actions?
Future review date: