Medication Errors

Target Audience

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<th>Learning Disabilities</th>
<th>Children, Young People &amp; Families</th>
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<td>All registered staff involved in the prescribing, dispensing, administering or monitoring of medication</td>
<td>✓</td>
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Explanation of terms used in this policy

**Medication Error (serious / non-serious)** - Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. Such events may be related to professional practice, health care products, procedures and systems including: prescribing; ordering; communication; product labelling; packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and use.

**National Patient Safety Agency (NPSA)** - Contributes to improved safe patient care by informing, supporting and influencing the health sector. On Friday 1 June 2012 the key functions and expertise for patient safety developed by the National Patient Safety Agency transferred to the NHS Commissioning Board Special Health Authority.

**Care Quality Commission (CQC)** - Independent regulator of health and social care in England.

**Assessor** - Each group will identify their assessors for each clinical speciality e.g. for nurses this may include Deputy Modern Matrons, Team leaders, Ward Managers and charge nurses (or equivalent band 6).

**Competence** - A standardised requirement for an individual to properly perform a specific job.

**Service Level Agreement (SLA)** - For the provision of Pharmacy services to the Trust.

**National Reporting and Learning System (NRLS)** - Central database of patient safety incident reports.
1.0 Introduction

1.1 What is a Medication Error?
The National Patient Safety Agency’s (NPSA) definition of medication errors is: “Patient safety incidents involving medicines in which there has been an error in the process of prescribing, dispensing, preparing, administering, monitoring, or providing medicine advice, regardless of whether any harm occurred”.

Examples of medication errors are given below: (this is not an exhaustive list)
- Omissions – any prescribed dose not given
- Wrong dose administered, too much or too little
- Extra dose given
- Un-prescribed medicine – the administration of medication which has not been prescribed
- Wrong dose interval
- Wrong administration route
- Wrong time for administration
- Not following ‘warning’ advice when administering e.g. Take with or after food
- Administration of a drug to which the patient has a known allergy
- Administration of a drug past its expiry date or which has been stored incorrectly

All medicines have inherent hazards. Most medicines are toxic in overdose or have the potential to cause harm if used inappropriately or incorrectly. Usually, medication errors happen because the safeguards and defences intended to prevent medication errors from happening are inadequate or fail.

Medication is the most common medical intervention within the NHS and particularly within mental health. Whilst every care is taken by individuals and the organisation when managing medication, errors involving medicines are sometimes inevitable due to human components.

A medication error can pose a threat to the patient as well as the organisation. Members of staff making errors may become traumatised and may require support.

The safe and secure medicines report (2005) stated that there are key factors in the safe management of medicines. They describe these as:
- An increased emphasis on the need for governance
- A growing awareness of medication errors
- Changing public expectations
- Changing models of patient care
- Technological advances
- Developing roles of staff

CQC Fundamental Standards (2015) Regulation 12: Safe Care and Treatment intends to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. The regulation states that medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure service users are safe. Component (g): Proper and Safe Management of Medicines indicates the registered person’s duties to protect service users and highlights the importance of managing risks through effective policies and procedures about medicines handling.
1.2 Why do Medication Errors Occur?
The administration of a medicine to a patient is the result of several activities by different practitioners and may also be underpinning by organisational policy. Every step in the medicines management process has the potential for failure, to varying degrees. The ideal system is analogous to a stack of slices of Swiss cheese. Consider the holes to be opportunities for a process to fail, and each of the slices as “defensive layers” in the process. An error may allow a problem to pass through a hole in one layer, but in the next layer the holes are in different places, and the problem should be caught, e.g. an unsafe prescription being challenged by a nurse or pharmacist or a clinician challenging unsafe organisational policy. Each layer is a potential defence against potential error impacting on a patient.

For an error to impact on a patient, the holes need to align for each step in the process allowing all defences to be defeated and resulting in an error. If the layers are set up with all the holes lined up, this is an inherently flawed system that will allow a problem at the beginning to progress all the way through to adversely affect the outcome. Each ‘slice of cheese’ is an opportunity to stop an error. The more defences you put up, the better. Also the fewer the holes and the smaller the holes, the more likely you are to catch/stop errors that may occur.

1.3 Why Reduce Medication Errors?
- Reduces the risk of a patient being harmed
- Can prevent unnecessary hospital admissions or re-admissions
- Can prevent prolonged hospital stays
- Reduce unnecessary costs to the NHS
- Increase staff confidence and morale
- Reduces risk of litigation for clinical negligence
- Reduce risks of harm to Trust reputation
- Provide reassurance to regulatory bodies and commissioners

1.4 What are the Statutory Requirements around Reporting Medication Errors?
There is no requirement to notify CQC about medicines errors, but a notification would be required if the cause or effect of a medicine error met the criteria for one of the following to be notified:
- A death
- An injury
- Abuse, or an allegation of abuse
- An incident reported to or investigated by the police
All serious reportable errors are recorded via the SteIS system by the governance assurance unit. A full root cause analysis is completed and this report is shared with the commissioners. Where a report required a report to the CQC, the governance assurance unit will be responsible this is actioned. Where relevant, it should be made clear that a medicine error was a known or possible cause or effect of these incidents or events being notified. Further information and guidance is available on the Notifications section of CQCs website.

2.0 Purpose
This policy describes the procedure that must be followed when a medication error occurs. The procedure describes immediate action to ensure patient safety, grading of errors (where appropriate) and longer term actions to ensure that individuals, team, group and organisation can learn from errors.

This policy is specifically written for all registered staff involved in the prescribing, dispensing, administering or monitoring of medication. The policy is also relevant for managers of such staff and gives instruction for managing staff who have been involved in a medication error.

Nurses are regulated and bound by the Nursing & Midwifery Council (NMC).

Pharmacists and pharmacy technicians are regulated and bound by the General Pharmaceutical Council (GPhC).

Doctors are regulated and bound by the General Medical Council (GMC).

The qualified health professionals who may supply or administer medicines under a patient group direction are: nurses; midwives; health visitors; optometrists; pharmacists; chiropodists; radiographers; orthoptists; physiotherapists; ambulance paramedics; dieticians; occupational therapists; speech and language therapists; prosthetists; orthotists; dental hygienists and dental therapists. They can only do so as named individuals and will be accountable to their respective regulatory bodies.

Any activities relating to medicines must only be undertaken under the direction or supervision of a registered healthcare professional as listed above. Although responsibility can be delegated, overall accountability remains with the registered individual for errors undertaken by “unregistered” staff (e.g. healthcare assistants). A registrant is responsible for the delegation of any aspects of the administration of medicinal products and they are accountable to ensure that the patient, carer or care assistant is competent to carry out the task.

3.0 Objectives
The principle objectives of this policy are to:

- Ensure the immediate and long term safety of the patient
- Support the member of staff who made the error in an individualised manner so that risk of such errors are minimised as far as possible
- Support managers when dealing with staff who have made an error
- Provide a framework for grading errors so that staff are dealt with fairly and consistently
- Ensure that the organisation can learn lessons from the error in order to minimise such occurrence in the future
4.0 Process
Human error is inevitable. A member of staff who has been practising successfully does not suddenly become incompetent or unsafe after a single medication error. However, for an error to occur an important step in the process would have to be omitted and there is a potential for this to recur if the cause is not identified. It is therefore vital that the line manager and member of staff who made the error identify exactly what went wrong, and take steps to rectify this. In the event that clear systemic or organisational factors are identified, the Matron or group pharmacist should be consulted on the best way to manage this.

The line manager must ensure that any remedial action (such as supervised practice) is carried out as soon as possible where appropriate. Prolonged delay in resuming activity could adversely affect the staff member’s confidence and practice in their area.

The severity of a medication error has been defined as 2 levels:
- Medication error
- Serious Medication Error

In order to assign the appropriate level for a given medication error, the incident would have to be assessed individually and the consequence of the error determined by the degree of harm or potential degree of harm.

Tools in place to support the decision making process regarding the levels are the NHS Improvement; A just culture guide (See 4.3), Trust Incident Levels guidance and Risks Categorisation Matrix which are all available on the Trust intranet and should be referred to prior to making a decision.

It is not possible for this policy to be prescriptive in its guidance relating to the determination of the level of seriousness of any given medication error due to the multi-factorial nature of errors. The tools described above and the discretion of the management teams should determine the level. The group pharmacist is able to support with this decision making where support is requested.

4.1 Recognition of Errors
Errors will come to managers’ attention in a variety of ways, including:
- Self-reporting by staff member
- Patient/representative reporting
- Complaints by patient/representative
- Datix reporting process
- Reporting by colleagues
- Routine audits (retrospective reporting)
- Unplanned/Spot audits by managers/regulatory bodies

There may be circumstances where a medication error has not been reported immediately, e.g. missed dose with no reason recorded or administered and not signed – where a nurse/several nurses continue to administer but fail to notice or report the error. These nurse/nurses are further implicated in the error and will be managed within this policy.
4.2 Immediate Actions when Medication Error/Near Miss Identified

Has the patient taken / been given the medication?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
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<tbody>
<tr>
<td>PATIENT’S SAFETY IS PARAMOUNT</td>
<td>SPEAK TO A DOCTOR IMMEDIATELY</td>
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</table>

During **working hours**: contact patient’s ward doctor / GP / specialist doctor

During **Out-of-Hours**: contact on-call doctor or out of hours service

During **working hours**: Inform Manager or equivalent

**Out of hours**: wait until next working day and contact manager or equivalent

Based on clinical assessment/judgement/nature of incident, doctor may attend to review the patient or give advice

Follow any advice given and document in patient’s notes

Following urgent medical advice, further information can be obtained from:
- Ward Pharmacist/pharmacist on-call
- Health Protection Agency
- Medicines Information

Call 999 if concerned about patient’s safety and unable to source medical assistance
Do not delay in contacting others in the algorithm if initial person is unreachable
Keep patient / representative informed as appropriate.
A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate, as patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should not be automatically examined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

Please note:
- A just culture guide is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- A just culture guide can be used at any point of an investigation, but the guide may need to be adjusted as more information becomes available.
- A just culture guide does not replace HR advice and should be used in conjunction with organisational policy.
- The guide can only be used to take one action (or fail to act) through the guide at a time. If multiple actions are involved in an incident, they must be considered separately.

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

Recommendation: follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual.

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

Recommendation: follow organisational substance abuse guidance. Wider investigation is still needed to understand if substance abuse could have contributed.

2b. Are there indications of physical ill health?

Recommendation: follow organisational guidance on health issues relating to work, such as sick note or occupational health referral. Wider investigation is still needed to understand if health issues could have been identified.

2c. Are there indications of mental ill health?

Recommendation: follow organisational guidance on mental health issues. Wider investigation is still needed to understand if mental health issues could have been identified.

No go to next question - Q3. foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

Recommendation: action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.

3b. Were the protocols/accepted practice workable and in routine use?

Yes, go to next question - Q4. substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

Recommendation: action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.

4b. Was the individual missed out when relevant training was provided to their peer group?

Yes, go to next question - Q5. mitigating circumstances

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

Recommendation: action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients.

No go to next question - Q5.

5a. Were there any significant mitigating circumstances?

Recommendation: follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients.

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

Academy of Medical Royal Colleges
azma
BMA
CQC
General Medical Council
NHS England
RCN
RCN
Royal College of Nursing
Society of Healthcare
Society
UNISON
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## Incident Level Guidance

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<th>LEVEL 4</th>
<th>LEVEL 5</th>
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</thead>
<tbody>
<tr>
<td><strong>INAPPROPRIATE SEXUAL BEHAVIOUR</strong>&lt;br&gt;Alleged/Factual (Ability to upgrade severity via discussion with line manager and victim)</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Expected or suspicious death with no cause established</td>
<td>Unexpected inpatient death related to self-harm or death by suicide · staff or patient</td>
</tr>
<tr>
<td><strong>AWOL/Missing Patients</strong>&lt;br&gt;(Detained patient non-return from unescorted leave, detained patient leaves a ward without staff knowledge)&lt;br&gt;(Informal patient non-return from leave, patient leaves a ward without staff knowledge)</td>
<td>AWOL/MISSING PERSON - person missing - assessed as posing no risk of harm to self or others</td>
<td>AWOL/MISSING PERSON assessed as posing minor risk of harm to self or others. (This may be dependent on length of time patient missing)</td>
<td>AWOL/MISSING PERSON assessed as posing moderate risk of harm to self or others. (This may be dependent on length of time patient missing)</td>
<td>AWOL/MISSING PERSON assessed as posing major risk of harm to self or others. (This may be dependent on length of time patient missing)</td>
</tr>
<tr>
<td><strong>ESCAPE</strong>&lt;br&gt;(Patient from low level services who has left the secure area without the permission and knowledge of staff)</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Patient escapes from low secure adult services.</td>
</tr>
<tr>
<td><strong>SEXUAL ASSAULT</strong>&lt;br&gt;Inappropriate sexual remarks, comments, gestures, suggestions with no harm/threat caused</td>
<td>Inappropriate/unwanted physical advances or threats of a sexual nature resulting in medical treatment(e.g. A&amp;E assessment)</td>
<td>Inappropriate/unwanted physical advances or threats of a sexual nature resulting in medical treatment(e.g. A&amp;E assessment)</td>
<td>Attempted/factual sexual assault resulting in long-term harm either physically or psychologically resulting in medical intervention</td>
<td>Serious sexual assault (Rape)</td>
</tr>
<tr>
<td><strong>VIOLENCE AND AGGRESSION (PATIENT &amp; STAFF)</strong>&lt;br&gt;Physical or Verbal aggressive behaviour with no direct harm</td>
<td>Physical assault - minor injury - first aid not RIDDOR reportable</td>
<td>Physical assault - moderate harm causing requiring medical assessment/treatment. Absence from work more than 7 days - RIDDOR reportable, GAR (72hr) required</td>
<td>Physical assault - major harm causing requiring medical treatment and immediate reporting to HSE, e.g. fractures etc. Multiple persons injured in a related incident</td>
<td>Physical assault - resulting in death or permanent injury</td>
</tr>
<tr>
<td><strong>STAFF ACCIDENT</strong>&lt;br&gt;Accident with no personal injury</td>
<td>Staff accident with minor injury - not RIDDOR reportable, first aid required</td>
<td>Staff accident - moderate harm causing requiring medical treatment or A&amp;E assessment (e.g. needlestick injuries X-ray) Absence from work more than 7 days - RIDDOR reportable, GAR (72hr) required</td>
<td>Staff accident with major injury (extensive injuries). Many people injured in a related incident e.g. Fracture - RIDDOR reportable</td>
<td>Accident resulting in death</td>
</tr>
<tr>
<td><strong>PATIENT ACCIDENT</strong>&lt;br&gt;Accident with no personal injury</td>
<td>Patient accident with minor injury e.g. First Aid Required.</td>
<td>Patient accident with moderate injury (e.g. A&amp;E Assessment). GAR (72hr) Required</td>
<td>Patient accident with major injury (extensive injuries). Many people injured in a related incident e.g. Fracture - RIDDOR reportable</td>
<td>Unexpected inpatient death related to self-harm or death by suicide · staff or patient.</td>
</tr>
<tr>
<td><strong>MEDICATION</strong>&lt;br&gt;No potential to cause harm to patient, no breach of policy</td>
<td>Isolated incident potential to cause minor harm e.g. additional dose of incorrect med, minor breach of policy but no legal infringement</td>
<td>Cluster of similar minor incidents demonstrating high risk of recurrence. Isolated incident with potential to cause moderate harm, significant breach of policy and professional standards</td>
<td>Cluster of level 3 incidents or an isolated incident with potential to cause major harm, e.g. change of care setting, prolonged additional obs, legal breach</td>
<td>Extensive permanent injury or death</td>
</tr>
<tr>
<td><strong>DEATH</strong>&lt;br&gt;Death with known cause and not mental health related or death expected and known cause (e.g. care pathway)</td>
<td>Unexpected or suspicious death with no cause established</td>
<td>Unexpected inpatient death related to self-harm or death by suicide · staff or patient. Multiple deaths · staff or patient</td>
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# Medication Errors Policy

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<tr>
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<th>LEVEL 4</th>
<th>LEVEL 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN Significant</td>
<td>Minor</td>
<td>Moderate</td>
<td>Major</td>
<td>Catastrophic</td>
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## Investigation Required
- DF2 Managers to determine type of investigation required: Individual Performance Review, Management Review, Risk Management Plan, Care Plan Review
- Governance Assurance Report (GAR) 72 hour may be required. This will be at the discretion of the Division and/or GAU.
- GOVERNANCE ASSURANCE REPORT (72 HOUR) REQUIRED

## SELF HARM
- Attempted or actual self harm - not requiring first aid.
- Attempted or actual self harm - first aid required
- Actual or attempted self harm resulting in injury requiring medical treatment
- Self harm that could be deemed as life-threatening and/or resulting in multiple permanent injuries.
- Death - suspected suicide

## SERVICE DISRUPTION / FAILURE
- Disruption / failure of services for a brief period of time - no significant impact
- Small scale localised disruption / failure of services that threatens to compromise the continued delivery of critical business functions - disruption for up to 3 hours
- Larger scale disruption / failure of services that threatens to compromise the continued delivery of critical business functions - disruption for 3 - 12 hours
- Significant disruption / failure of critical business functions for more than 24 hours triggering the Trust Business Continuity Plan (To include loss of keys for low secure services)
- Overwhelming impact of critical business functions across BCPFT resulting in the activation of the Business Continuity Plan with Partner Agencies

## PATIENT CARE
- Reduced quality of patient experience/clinical outcome not directly related to delivery of clinical care Not applicable for Pressure Ulcers
- Unsatisfactory patient experience/clinical outcome directly related to care provision - readily resolvable. Not applicable for Pressure Ulcers
- Unsatisfactory patient experience/clinical outcome: short term impact - expected recovery <1wk. Grade 1 Pressure Ulcer
- Unsatisfactory patient experience/clinical outcome: long term impact - expected recovery >1wk. Grade 2 Pressure Ulcer
- Unsatisfactory patient experience/clinical outcome: continued ongoing long term effects. Grade 3/4 Pressure Ulcers requires PU Report Completing

## INFORMATION GOVERNANCE
- Confidentiality/data protection
  - 0 = Minor breach of confidentiality single individual affected.
  - 1 = Potentially Serious Breach, less than 5 people affected
  - Serious potential breach & risk assessed high. EG: unencrypted clinical records lost - up to 20 people affected
  - Serious breach of confidentiality - up to 100 people affected GAR (72hr) required
  - Serious breach with either particular sensitivity or up to 100 people affected
  - Serious breach with potential for ID theft or over 1000 people affected
4.4 Informing Patient/Parent/Carer Regarding Medication Errors
The Trust acknowledges that when things go wrong, open and honest communication with the patient and / or relatives is fundamental to the ongoing partnership between them, those providing their care and the Trust.

Where a medication error at any stage has been detected and has affected a patient, the patient should be informed by the nurse in charge, line manager or the doctor in charge of the patient’s care at that moment in time. The healthcare professional should inform the patient that an error has occurred, and counsel them with regards to the likely risk and outcome of the incident as appropriate. This discussion must be recorded in the patient’s clinical record. They should be reassured that the error is being investigated to avoid it happening again and that their care is a priority.

Where an apology is given, it is acknowledged that an apology is not necessarily an admission of any liability. Duty of Candour is to be applied where a reported incident is rated via the Risk Matrix as moderate (Level 3) or above.

If required and appropriate, following the investigation, a meeting should be offered to the patient and/or relatives with the relevant clinician(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.

It is important not to minimise the seriousness of an error - A balance must be struck that reassures the patient, if no harm is likely, but without suggesting that the error is insignificant.

4.5 Agency, Bank and Locum Staff
Where agency workers are involved in medication errors or incidents, the Trust must also inform the agency for whom the healthcare professional was working. If a substantive member of staff normally employed by the Trust, is involved in an error whilst working extra shifts on the ‘bank’, their substantive line manager must also be informed of the incident.

4.6 Reflection of the Incident
The registered staff member will meet with their line manager to discuss the incident and agree appropriate actions (Appendix 1) Sheila this will need to be inserted from old policy. The registered nurse will also be required to reflect on the incident and complete the Medication Error Monitoring and Reflection form (Appendix 2). This will help to identify what went wrong and why. This is also a useful source of information during the investigation. The contributory factors framework tool to support staff with this is provided (Appendix 3).

4.7 Drug Calculation Tests
If it is apparent through the review of the medication error that a staff member has made an error with a drug calculation, and it is felt appropriate, they will be expected to complete a drug calculations test. The expectation for a pass mark for the drug calculations will be 100%. It is vital that staffs involved in medicines are able to calculate drug dosages and volumes accurately.

A ‘sample’ calculation assessment is provided in Appendix 4, along with a competency assessment specific to Community Registered Mental Health Nurses.
Appendix 5 Additional assessments for use with this policy are available from the Pharmacy department.

Whenever a pass is not achieved first time, staff will have the opportunity to retake the test. A total of three attempts are permitted, before a referral can be made through the capability policy.

4.8 Assessment of Competency
The competency assessment relevant to the profession can be completed with the registered staff member. The assessor will be of the same profession as the individual completing the competency assessment. For example Nursing will be assessed by The Matron, Ward / Team Manager or Band 6 registered nurse. The assessment may consist of questions and observations relating to the medicines management related activities which may be developed by each clinical speciality. The scope of the assessment will be determined by the individual’s area of work and will include all key areas of administration with a specific emphasis on the error that they made. Assessments should be conducted across a variety of shifts.

For nursing the staff member must carry out drug administration under supervision of the assessor a minimum of 3 times using the competency assessment tool provided by the line manager the number of times this is carried out can be extended either at the outset or at the discretion of the assessor.

Following each medication administration assessment, the assessor will provide verbal back regarding their level of competence. The outcome of the final assessment will be recorded on the Assessment review recording sheet (Appendix 6) and the relevant manager notified. A copy of this form will be placed in the registered nurse’s personal file for a 12 month period.

4.9 Supervised Suspension from Medication Management Activities
The registered member of staff may have supervised suspension from prescribing, administration or dispensing of certain medications or all medications if the manager or Matron have assessed that the member of staff can be managed this way over a specific time frame – usually a maximum of 2 weeks. In this case the registered member of staff would be supervised prescribing, dispensing or administering medication by their clinical line manager (where this is a nurse, this should be conducted using the relevant nursing competency assessment.)

4.10 Suspension from Medication Administration
The registered member of staff may be suspended from prescribing, administration or dispensing some or all medication if the reported error requires further investigation and or further training and assessment. This would be in line with the Trust disciplinary process. It is not expected, for example, that a staff member with issues relating to administering a depot injection safely should necessarily be suspended from giving oral medications (unless the concerns are wider than a specific route of administration).

4.11 Disciplinary Process
The member of staff may be managed under the Trust disciplinary process. This is more likely if an error resulted in serious harm to a patient. This would be in line with the Trusts disciplinary processes and this will be supported by a human resources advisor.
4.12 Capability Process
If the registered member of staff who has made the medication error:

- Fails an assessment of competency on the 2nd attempt
- Fails a drug calculation assessment on the 3rd attempt
- Makes a 2nd related serious medication error in a ‘rolling’ 6 month period
- Makes a 4th related medication error (serious or non-serious) in a ‘rolling’ 12 month period

They may be suspended from specified medication management activities as appropriate and managed within the capability policy. Human resource colleagues would support managers and individual staff in this process.

If repeated errors continue to occur by the same member of staff despite all efforts from the Trust to provide additional training and other measures deemed necessary, the line manager should escalate the matter and seek advice from human resources. Together they will consider the options open to them to protect patients from harm. This may include, but is not limited to, the recourse to manage the member of staff using the Trust Capability and Disciplinary policy frameworks.

4.13 Administration Errors
Preparation and Administration Errors may include:

- Administration without a valid prescription
- Administered of 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 / reconstituted
- Incorrect infusion rate
- Inappropriate administration of “prn” medicines
- Medication administered late / early*

*(The Trust 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).

4.13.1 Medication Administration Error (Non-Serious)

- Clarify that an error has been made and establish any facts. Where actions have been taken to avoid patient harm by a registered member of staff, this should be taken into consideration but the error process should still be followed
- The nurse in charge (or their supervisor where the nurse in charge made the error) will make patient safety their first priority in the first instance; their action will be determined by the error, but could include physical observations. Medical advice or examination may also be required
- Datix to be completed within 24 hours
- Line manager to be notified of the error, timing of the notification will be determined by the nature of the error. This can be done via a variety of routes, face to face, by email or telephone whichever is timelier
- The line manager will determine the seriousness of the error, and the course of action required. Managers will need to check whether there have been any previous errors
- Line manager will issue a medication error monitoring and reflection form (Appendix 1)
In the absence of the line manager, the Matron/Head of Nursing should be notified of the error and determine action required.

The line manager will meet with the registered member of staff to discuss the error. This discussion should explore any factors that could have contributed to the error (e.g. stress, health, organisational and environmental factors).

Actions will be recorded on the medication error monitoring and reflection form, a copy of which will be given to the nurse; a further copy will be placed on their personal file for 12 months.

Actions may include:
- A reflection on the incident
- The nurse receiving a copy of the NMC guidance
- Review medicines policy in relation to the specific incident

Where a 3rd non-serious medication error (incidents can be unrelated) occurs within a rolling 6 month period, the serious medication error protocol should be followed.

4.13.2 Serious Administration Medication Error
In addition to the actions for a non-serious error, the line manager will discuss the action to take with the Matron or Head of Nursing.

Actions will be recorded on the medication error monitoring and reflection form, a copy of which will be given to the nurse; a further copy will be placed on their personal file.

Additional actions may include:
- Review controlled drug legislation/policy in relation to the specific incident
- Further additional supervision
- Assessment of competency
- Calculations Assessment
- Supervised suspension from administration of medication
- Restrictions/Suspension from administration of medication
- Referrals through HR (Capability Policy Framework)
4.13.3 Management Flowchart of Actions Following a Medication Administration Error

Medication Error

DATIX form to be completed within 24 hours
Inform Line manager within 72 Hours

Complete Medication Error Monitoring and Reflection Form

Discuss with line manager (within 7 days)

Note remains on personal file for 12 months

DATIX form to be completed within 24 hours.
Inform Line manager within 72 Hours
Manager to discuss with Deputy Modern Matrons, Lead nurse & Service Manager

Competency Assessment (Optional)
Calculations Test (Optional)

Review with line manager

Competency Achieved

Seek HR support in line with Capability Policy Framework (Optional)

Suspension/ Restricted /supervised suspension from administration of medicines (Optional)

Local Resolution

Note remains on personal file for 12 months
4.14 Prescribing and Monitoring Errors

Any prescribing error must be discussed with the prescriber as soon as it is discovered, and if appropriate, the consultant in charge of that patient’s management. A Datix report must be completed within 24 hours.

Prescribing Errors may include:
- Incorrect or incomplete patient or medicine details on the prescription including incomplete “prn” details
- Inappropriate medicine / dose / route / rate
- Poor or illegible prescribing
- Inappropriate indication
- Prescribing without taking into account the patient’s clinical condition, including past medical history, past drug history
- Incorrect length of course for the patient
- Medication prescribed to the wrong patient
- Transcription errors
- Inappropriate monitoring/follow up
- Medicine prescribed that the patient is allergic to
- Prescription not signed

Monitoring Errors:
- Inappropriate monitoring/follow up
- Failure to monitor therapeutic levels
- Failure to monitor patient’s / carer’s self-medication

Skill based errors – Slips or memory lapses are generally picked up by senior doctors or pharmacists and are therefore rectifiable with practice and learning.

Rule based errors will require active learning of medications. Once learning is firmly established, these can usually be avoided by checking interactions and allergies.

Knowledge based errors usually occur in the initial few weeks of starting a new post and in situations novel to the doctor and can be a contributory factor.

Prescribing errors (such as poor legibility or failure to use capital letters) can be pointed out to the member of staff and corrections made as part of a peer/pharmacist review using discretion.

In the case of the below, the framework on the next page should be used:
- Repetitive errors of this kind
- More serious errors
- Errors which have resulted in patient harm

In all cases, a medication error monitoring and reflection form should be completed (Appendix 1). The line manager will meet with the prescriber to discuss the error. This discussion should explore any factors that could have contributed to the error (e.g. stress, health, organisational and environmental factors).

Actions will be recorded on the medication error monitoring and reflection form, a copy of which will be given to the prescriber; a further copy will be placed on their personal file for 12 months.
4.14.1 Management of Prescribing Errors

**Prescribing Error Detected**

DATIX form to be completed (within 24 hours by person discovering error)

Medication Error Monitoring and Reflection Form completed

Prescribing Error Monitoring Form discussed with appropriate *clinical supervisor

**If an FP10 error has resulted in incorrect supply or administration of medication to the patient, inform patient’s GP**

Does the prescribing error (or an accumulation of prescribing errors made by the individual in the last 6 months) raise concern?

**YES**

Formal competency review by *clinical supervisor

**NO**

Retain error form on personal file for 12 months

* *clinical supervisor
  - for a junior doctor this would be the consultant
  - for a consultant this would be the clinical director or associate clinical director
  - for a non-medical prescriber, this will be their relevant clinical supervisor
4.15 Dispensing Errors
Some examples of dispensing errors are:

- Patient dispensed the wrong medication / dose / formulation / strength / quantity
- Medication dispensed to the wrong patient
- Patient dispensed an out of date medicine
- Medication is labelled incorrectly or not at all

4.15.1 What to do in the Event of a Dispensing Error

4.15.1.1 Establish if the patient has taken any of the incorrect medicine
Where the individual discovering the error is a registered doctor, nurse or pharmacist, they should determine if the patient has taken any of the incorrect medicine and establish whether the patient has been harmed. This may require medical examination or diagnostic testing. Where the person discovering the error is not a registered doctor, nurse or pharmacist, this should be escalated to facilitate this.

If there has been evidence of harm, a pharmacist should provide the patient and the prescriber responsible for the patient with the medicines advice they may need with the appropriate urgency. The on call pharmacist may need to be contacted outside work hours. Obtain information from Toxbase or contact the local drug information or poisons centre, if appropriate, for advice on the possible effects on the patient (giving details of concurrent medication).

Where no harm appears to have been caused, the prescriber responsible for the patient should still be informed.

4.15.1.2 Inspect the incorrect medicine where possible
Inspecting the medicine can give valuable clues about what went wrong.

4.15.1.3 Make a supply of the correct medicine ordered on the prescription, if appropriate
Depending upon whether the pharmacist was working alone or with someone assisting, this covers every part of the dispensing process. The type of error may direct your attention to one area of dispensing practice.

When reviewing dispensing errors which have resulted in a serious patient safety incident, the NPSA incident decision tree helps to identify why individuals acted in a certain way, and this may be a very useful tool for pharmacists, managers and organisations to consider using prior to action being taken. Additional information on the incident decision tree can be found at [www.npsa.nhs.uk](http://www.npsa.nhs.uk).

Type of error can be split into: labelling errors, selection errors and bagging errors. A dispensing error may involve more than one type of error e.g. misreading a prescription written as Ramipril 2.5mg and dispensing Ramipril 5mg may involve an error in labelling and an error in selection.

A medication error monitoring and reflection form should be completed (Appendix 1). The line manager will meet with the staff member to discuss the error. This discussion should explore any factors that could have contributed to the error (e.g. stress, health, organisational and environmental factors).
Actions will be recorded on the medication error monitoring and reflection form, a copy of which will be given to the staff member; a copy will also be placed on their personal file for 12 months.

4.15.2 Management of Dispensing Errors

Did the incorrect medicine(s) leave the supplying pharmacy?

No

For Medicines dispensed at the Trust pharmacy, was error identified before leaving pharmacy (near miss)

Inform the dispenser of error

Error logged onto an internal pharmacy database

Senior Pharmacist reviews database periodically and monitors trends for ALL dispensing errors. E.g. number of errors per individual, number of errors as a percentage of total items handled

Yes

Dispensing error identified in clinical areas (e.g. detected by nurse / patient)

DATIX form to be completed

Inform group pharmacist / on-call pharmacist as appropriate

If a Trust dispensing error, staff member to complete Medication Error Monitoring and Reflection Form (Appendix 1) and send to Chief Pharmacist – Placed on file for 12 months

If error originated from SLA provider, Trust to request written assurance from SLA provider and follow up. Recorded on Errors Database Discussed at SLA meeting. Monitored as part of KPIs with SLA supplier.

Individuals causing concern interviewed by line manager to identify any support or specific learning needs and agree actions to address this
5.0 Procedures Connected to this Policy
There are no procedures connected to this policy.

6.0 Links to Relevant Legislation

Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
The regulation states that the registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

Human Medicines Regulations 2012
These Regulations came into force on 14th August 2012. The regulations are the result of the initiative by the Medicines and Healthcare products Regulatory Agency (MHRA) to consolidate and review UK medicines legislation. They replace much of the Medicines Act 1968 and around 200 statutory instruments in the process repealing much obsolete law and contributing to the government’s drive for burden reduction.

6.1 Links to Relevant National Standards

CQC Fundamental Standards- Regulation 12
The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people’s health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe.

Medicines must be supplied in sufficient quantities and managed safely. Medicines must also be administered accurately, in accordance with any prescriber instructions and at suitable times to make sure that people who use the service are not placed at risk.

Staff must follow policies and procedures about managing medicines, including those related to infection control. This should be in line with current legislation and guidance and address: supply and ordering; storage, dispensing and preparation; administration; disposal and recording.

NMC Standards for medicines management (2010)
The Standards for medicines management (2007) and underpinning NMC Circulars 16/2008 and 05/2009 were withdrawn on 28 January 2019.
The NMC did this because it’s not within their remit as a regulator to provide this type of clinical practice guidance.
However, they recognise that it’s important that all healthcare professionals can access accurate information on the safe and effective handling, management and administration of medicines. Please see relevant RPS/RCN Guidance as follows.

Professional guidance on the administration of medicines in healthcare settings
Advisory guidance on administration of medicines by nursing associates
GMC Good practice in prescribing and managing medicines and devices (2013)
Good practice in prescribing and managing medicines and devices explains how the principles in Good Medical Practice, apply to decisions about prescribing, managing medicines and medical devices.

It covers:
• Prescribing at the recommendation of a colleague or where a patient’s care is shared (for example between specialists and GPs)
• Making sure decisions are based on adequate knowledge of the patient’s health and needs, not for the convenience of those treating or caring for the patient, for example, staff in care homes
• Prescribing unlicensed medicines, including giving patients information about the license for their medicine
• Reporting both actual and potential adverse drug reactions and medical device adverse incidents

GPhC Responding to complaints and concerns (2010)
This document provides guidance for pharmacy professionals on dealing with complaints and concerns raised by patients, the public and other healthcare professionals. As dispensing errors are frequently the basis for complaints, the guidance also covers:
• How to minimise the risk of a dispensing error occurring
• What to do in the event of a dispensing error
• How to review dispensing errors

6.2 Links to Other Key Policy/s

Medicines Policy and associated SOPs
The purpose of this policy is to ensure that all staff dealing with medicines follow safe practice in the prescribing, requisition, storage, administration and control of medicinal products. It applies to all individuals employed or contracted by Black Country Partnership NHS Foundation NHS Trust including all locum and agency staff and to all activities relating to medicines use within in-patient, out-patient, community and any residential facilities.

Controlled Drugs policy
The purpose of this policy is to ensure that all controlled drugs are used in a safe, secure and effective way and that all processes involving controlled drugs adhere to current regulations across the Black Country Partnership NHS Foundation Trust.

Capability Policy
The purpose of this policy is to support and encourage staff to achieve and maintain the high standards of performance expected by the Trust and to provide a consistent framework for handling performance issues in a fair and consistent manner.

Disciplinary Policy
This policy is designed to underpin the commitment of the Trust to create a working environment where the highest possible standards may operate. It will ensure employees maintain high standards of conduct and professionalism, and the Trust applies a consistent fair approach to dealing with inappropriate conduct.
6.3 References

- Advisory Guidances on Administration of Medicines by Nursing Associates, HEE, 2017
- Professional guidance on the safe and secure handling of medicines, RPS, December 2017
- Professional Guidance on the Administration of Medicines in Healthcare Settings, RCN & RPS January 2019
- CQC: Guidance for Providers on Meeting the Fundamental Standards and on CQC’s Enforcement Powers (July 2014)
- NHS Improvement; A Just Culture Guide 14th December 2018 (Updated)
- Professional Guidance on the Administration of Medicines in Healthcare settings, January 2019 (Royal Pharmaceutical Society)
- GMC Good Practice in Prescribing and Managing Medicines and Devices (2013)
## 7.0 Roles and Responsibilities for this Policy

<table>
<thead>
<tr>
<th>Title</th>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| Executive Director of Nursing, AHPs and Governance | Executive Lead         | - Has lead responsibility for the implementation of this policy and ensuring this policy is discharged appropriately  
- Ensure a systematic and consistent approach to medication errors in all service areas |
| Trust Board                                | Strategic              | - Strategic overview and final responsibility for overseeing the implementation of managing medication errors in the Trust  
- Legal responsibility for Trust policies and for ensuring that they are carried out effectively |
| Executive Committee                        | Responsible            | - Ensure that medication errors are managed efficiently and effectively in accordance with the Board’s Assurance Framework and strategic priorities |
| Quality & Safety Steering Group            | Scrutiny and Performance | - Oversee the implementation of a systematic and consistent approach to managing medication errors  
- Provide exception and progress reports to the Executive Committee |
| Medicines Management Committee             | Monitor                | - Monitors all medicine related incidents across the organisation  
- Receives all medicine related audit reports and considers their recommendations and action plans to improve current practice  
- Ensure that lessons are learnt from such incidents and that this information is then disseminated to all those who may benefit from it |
| Group Quality & Safety Steering Groups     | Monitor                | - Responsible for monitoring medication errors in their group  
- Receive the results and recommendations of all completed clinical audits |
| Medicines Management Improvement Group      | In depth Analysis and Scrutiny | - Detect trends and clusters of activity  
- Make recommendations to Medicines Management Committee for actions to improve and change current practice |
| Human Resource Advisor                     | Advise                 | - Support clinical managers in situations where management of a medication error involves the use of the disciplinary and capability policy |
| Trade Union Representative                 | Represent              | - Provide trade union representation at all points of the process and can be consulted as required by members relating to the application of this |
| Pharmacy Team                              | Support                | - Support training for individuals or groups of staff in the implementation of the guidance within this policy  
- Support assessors with individuals or groups if themes are coming from errors where wider training needs have been identified  
- Responsible for acting on and investigation of dispensing errors and concerns occurring under the service level agreement with the provider of medicines to the Trust |
| Group Governance Assurance Units and Corporate Risk Team | Governance | - Support the clinical team in relation to medication errors  
- Support the clinical team with medication administration error concerns arising from incident reports, critical incident reviews and route cause analysis where required |
| Chief Pharmacist                           | Implementation Lead    | - Advise on the relevant guidance and regulations related to this policy  
- Ensure that policies and procedures are up to date |
<table>
<thead>
<tr>
<th>Title</th>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| **Group Clinical & Associate Clinical Directors, Group Director and Group Project Managers** | Implementation | - Support the promotion of adherence to this policy  
- Ensure that pharmacists, technicians and support staff are aware of the policy  
- Carry out audits relating to this policy  
- Ensure all managers are aware of this policy and promote good practice  
- Provide support and guidance regarding resources to enable this policy to be implemented  
- Ensure all clinical staff implement safe systems of work in accordance with the procedures referred to in the policy  
- Ensure that there are appropriate resources provided within their service area to implement and adhere to the policy |
| **Service Managers and Team Leaders** | Implementation | - Ensure systems are in place to enable this policy to be implemented within their service area and that they are familiar with the policy  
- Support their teams in ensuring that medication errors are managed consistently  
- Report any concerns around medication errors to the group lead nurse  
- Ensure this policy is implemented in their area of responsibility  
- Manage medication errors in line with this policy  
- Ensure their staff are appropriately trained in line with the requirements of this policy |
| **Matrons** | Operational | - Support line managers in managing serious medication errors and agree who will be the lead assessor. In the event of the absence of deputy modern matrons, this supporting role can be provided by the lead nurse for the group  
- Lead on assessment in practice for some serious medication errors  
- Lead on some medication errors in the absence of managers. This could potentially be delegated to the charge nurse (or equivalent clinical lead – band 6) |
| **Ward Managers and Team Leaders** | Operational | - Ensure that staff within their areas of responsibility adhere to this policy  
- Lead on the initial management of an error, meeting with the staff member, liaising with the deputy modern matron/senior nurse  
- Lead on medication errors and some serious medication errors  
- Management of medication errors may, where appropriate, be delegated to the charge nurse (or equivalent clinical lead – band 6)  
- Ensure that staff attend training applicable to their role  
- Report concerns to their service manager |
| **Staff** | Adherence | - Ensure that they are familiar with this policy, particularly the immediate actions to take when a medication error is identified  
- Ensure they undertake medicines management training specific to their role as provided by the Trust as part of their mandatory and ongoing training |

### 8.0 Training

Version 2.1 May 2019
Medication Errors Policy

What aspect(s) of this policy will require staff training?

| Medicines Management | Registered Nurses and other registered staff involved in administering medication, Medical staff & Non-Medical Prescribers | Yes | E-Learning Matrons | Learning and Development Team | 2 yearly | Workforce Development Group |

Which staff groups require this training?

<table>
<thead>
<tr>
<th>9.0 Equality Impact Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Country Partnership NHS Foundation Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy has been completed and is readily available on the Intranet. If you require this in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Equality &amp; Diversity Team on Ext. 8067 or email <a href="mailto:bcpft.equalityimpactassessment@nhs.net">bcpft.equalityimpactassessment@nhs.net</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10.0 Data Protection and Freedom of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Protection Act provides controls for the way information is handled and to gives legal rights to individuals in relation to the use of their data. It sets out strict rules for people who use or store data about individuals and gives rights to those people whose data has been collected. The law applies to all personal data held including electronic and manual records. The Information Commissioner’s Office has powers to enforce the Data Protection Act and can do this through the use of compulsory audits, warrants, notices and monetary penalties which can be up to €20million or 4% of the Trusts annual turnover for serious breaches of the Data Protection Act. In addition to this the Information Commissioner can limit or stop data processing activities where there has been a serious breach of the Act and there remains a risk to the data. The Freedom of Information Act provides public access to information held by public authorities. The main principle behind freedom of information legislation is that people have a right to know about the activities of public authorities; unless there is a good reason for them not to. The Freedom of Information Act applies to corporate data and personal data generally cannot be released under this Act. All staffs have a responsibility to ensure that they do not disclose information about the Trust’s activities; this includes information about service users in its care, staff members and corporate documentation to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies. The Information Governance Team provides a central point for release of information under Data Protection and Freedom of Information following formal requests for information; any queries about the disclosure of information can be forwarded to the Information Governance Team.</td>
</tr>
</tbody>
</table>

Version 2.1 May 2019
### 11.0 Monitoring this Policy is working in Practice

<table>
<thead>
<tr>
<th>What key elements will be monitored? (measurable policy objectives)</th>
<th>Where described in policy?</th>
<th>How will they be monitored? (method + sample size)</th>
<th>Who will undertake this monitoring?</th>
<th>How Frequently?</th>
<th>Group/Committee that will receive and review results</th>
<th>Group/Committee to ensure actions are completed</th>
<th>Evidence this has happened</th>
</tr>
</thead>
<tbody>
<tr>
<td>That measures in place have been effective in managing errors</td>
<td>7.0 Roles and Responsibilities for this Policy</td>
<td>Aggregate Analysis Reports</td>
<td>Group Governance Assurance Units</td>
<td>Quarterly</td>
<td>Medicines Management Improvement Group under direction of Medicines Management Committee</td>
<td>Group Quality and Safety Steering Groups</td>
<td>Completed action plan signed off/minutes of meeting</td>
</tr>
<tr>
<td>The type and number of errors reported</td>
<td>7.0 Roles and Responsibilities for this Policy</td>
<td>Aggregate Analysis Reports</td>
<td>Group Governance Assurance Units</td>
<td>Quarterly</td>
<td>Medicines Management Improvement Group under direction of Medicines Management Committee</td>
<td>Group Quality and Safety Steering Groups</td>
<td>Completed action plan signed off/minutes of meeting</td>
</tr>
<tr>
<td>Consistency in the management of errors</td>
<td>7.0 Roles and Responsibilities for this Policy</td>
<td>Aggregate Analysis Reports</td>
<td>Group Governance Assurance Units</td>
<td>Quarterly</td>
<td>Medicines Management Improvement Group under direction of Medicines Management Committee</td>
<td>Group Quality and Safety Steering Groups</td>
<td>Completed action plan signed off/minutes of meeting</td>
</tr>
</tbody>
</table>
**Medication Error Monitoring and Reflection Form**

<table>
<thead>
<tr>
<th>Staff name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Job title</td>
<td></td>
</tr>
<tr>
<td>Manager leading discussion</td>
<td></td>
</tr>
<tr>
<td>Date of error</td>
<td></td>
</tr>
<tr>
<td>Date DATIX completed</td>
<td></td>
</tr>
</tbody>
</table>

**Description of error:**

<table>
<thead>
<tr>
<th>Repeated error?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious error?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Reflection on incident:**
(Refer to Appendix 2: Contributory Factors Framework)

Describe the context of the error (e.g. shift, time of day, staff resources, activity levels etc.). Provide a description of the circumstances surrounding the error. What were you trying to achieve? How did you feel at the time immediately before the incident? How do you feel following the incident?

**What have you learnt from this error? How do you feel a similar error could be avoided?**

**Comments by manager/supervisor:**

**Follow up action(s) agreed:**

**Staff member’s signature:**  
**Manager’s signature:**

**Date of discussion:**

Copy to: Staff member. If a serious medication error has occurred copy to Matron/Chief Pharmacist/Consultant or Clinical Director or Medical Director as appropriate

*This form should be retained in the staff member’s personal file for monitoring purposes for a period of 12 months and does not serve as a sanction.*
### Appendix 2

#### Contributory Factors Framework (to Support Reflective Accounts)

<table>
<thead>
<tr>
<th>Prompting Question</th>
<th>Relevant to Incident?</th>
<th>CONTRIBUTORY FACTOR DOMAIN</th>
<th>General Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did any time or bed pressures play a role in the incident?</td>
<td>□ Yes</td>
<td>Scheduling &amp; Bed Management - example: Delay</td>
<td>Safety Culture - For example: Patient</td>
</tr>
<tr>
<td></td>
<td>□ Maybe</td>
<td>in the provision of care Transfer to</td>
<td>safety awareness Fear of</td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td>inappropriate ward Difficulties finding a bed</td>
<td>documenting errors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of out-of-hours support</td>
<td>Attitude to risk management</td>
</tr>
<tr>
<td>Did local policies &amp; protocols help or hinder?</td>
<td>□ Yes</td>
<td>Local Policies, Protocols &amp; Procedures - e.g. No</td>
<td>Communication</td>
</tr>
<tr>
<td></td>
<td>□ Maybe</td>
<td>protocol exists</td>
<td>Written and Verbal Communication For</td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td>Protocol too complicated</td>
<td>example:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of standardisation</td>
<td>Poor communication between staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contradictory policies exist</td>
<td>Handover problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lack of communication/notes</td>
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<td></td>
<td></td>
<td></td>
<td>Unable to read notes</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Inappropriate abbreviations used</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Unable to contact correct staff.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Notes availability</td>
</tr>
<tr>
<td>Were there any issues with staff skill or knowledge?</td>
<td>□ Yes</td>
<td>Staff Training &amp; Education - For example</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Maybe</td>
<td>Inadequate training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td>No protected time for teaching</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Training not standardised</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No regular/yearly updates</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Were there any problems from other departments?</td>
<td>□ Yes</td>
<td>Support from other departments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Maybe</td>
<td>This includes support from IT, HR, porters,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td>estates or clinical services such as radiology,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>phlebotomy, pharmacy, biochemistry, blood</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>bank, microbiology, physiotherapy, medical or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>surgical sub-specialities, theatres, GP,</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>ambulance...</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there any characteristic about the equipment, disposables or drugs used that</td>
<td>□ Yes</td>
<td>Design of Equipment, Supplies &amp; Drugs - e.g.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Maybe</td>
<td>was unhelpful?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td>Confusing equipment design</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Equipment not fit for purpose</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Similar drug names</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ambiguous labelling &amp; packaging</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Have any national policies influenced this incident?</td>
<td>□ Yes</td>
<td>National Policies - For example:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Maybe</td>
<td>Commissioned resources</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td>National screening policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interference by government organisations</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>National medical / nursing standards 4 hour Emergency</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Department target</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>How would you describe the culture of your clinical area in relation to patient</td>
<td>□ Yes</td>
<td>Safety Culture - For example:</td>
<td>Communication</td>
</tr>
<tr>
<td></td>
<td>□ Maybe</td>
<td>safety awareness</td>
<td>Written and Verbal Communication For</td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td>Fear of documenting errors</td>
<td>example:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Poor communication between staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Handover problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lack of communication/notes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unable to read notes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Inappropriate abbreviations used</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unable to contact correct staff.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Notes availability</td>
</tr>
<tr>
<td>Were the notes available, accurate &amp; readable?</td>
<td>□ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Maybe</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did poor or absent verbal communication worsen the situation?</td>
<td>□ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Maybe</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td></td>
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</table>
### Medicines Competency Sample Calculations Assessment

#### ADMINISTRATION OF MEDICINES

#### ASSESSMENT OF COMPETENCY

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Date of assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designation</td>
<td>Time of medication round</td>
</tr>
<tr>
<td>Ward</td>
<td>Assessor</td>
</tr>
</tbody>
</table>

No calculator should be used for this test.

20 minutes is permitted for this assessment.

100% is the required pass mark.

1. Express 100 milligrams in grams

2. Express 5000 micrograms in milligrams

3. Express 2.2 liters in milliliters

4. If a dose for a given drug is 10 mg/kg and a patient weighs 70 kg and is 180 cm tall, what is the dose to be administered?

5. If a dose is 1 mg/kg and the patient weighs 120 kg, what is the dose to be given?

6. You need to give 7.5 mg of drug to a patient but the liquid medicine you have says it is a 15 mg/5 ml suspension. How much liquid do you need to give?
7. A patient has been prescribed 300mg Zuclopenthixol Decanoate IM as a depot. The preparation is only available as a 500mg/1ml dose. What volume would you administer?

8. If a 38 year old female patient weighs 50kg and is 150cm tall and is prescribed a drug with a dose of 100mg/kg, what is the dose to be administered?

9. A patient is prescribed a course of a drug at 100mg TDS for 7 days. You have 25mg tablets in stock. How many tablets will be required to complete the course?

10. A drug has been prescribed at 100mg/kg. The total dose of the infusion is 1600ml and is to be given over 8 hours. What is the flow rate (in millilitres per hour) to be administered?
Medication competency assessment for Community Mental Health

ADMINISTRATION OF MEDICINES

ASSESSMENT OF COMPETENCY

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Date of assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designation</td>
<td>Time of medication round</td>
</tr>
<tr>
<td>Ward</td>
<td>Assessor</td>
</tr>
</tbody>
</table>

Version 2.1 May 2019
<table>
<thead>
<tr>
<th>Competency activity</th>
<th>Y/N</th>
<th>Registered Nurse / Assessors comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Able to identify the requirements and standards for The Storage and Security of Depot / Long Acting Injections as outlined within the “Management of Depot / Long Acting Injections (LAI) Within Community Mental Health Services” SOP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Able to identify the requirements and standards of The Prescribing of Depot / Long Acting IM Injections as outlined within the “Management of Depot / Long Acting Injections (LAI) Within Community Mental Health Services” SOP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Able to identify the Trust agreed requirements for the monitoring of Depot / Long Acting Injections as outlined within the “Management of Depot / Long Acting Injections (LAI) Within Community Mental Health Services” SOP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Able to identify the agreed governance around Monitoring side-effects / Adverse Drug Reactions as outlined within the “Management of Depot / Long Acting Injections (LAI) Within the Community Mental Health Services” SOP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Able to confirm the procedure / actions required for the escalation of medication errors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Able to identify the governance standards around the Transportation of Depot / Long Acting Injections within Home Visits as outlined within the “Management of Depot / Long Acting Injections (LAI) Within Community Mental Health Services” SOP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Demonstrates confidence in approaching the patient explaining procedure to the patient, ascertaining any contra-indications to the injectable and discussing any side effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Able to obtain valid consent from the patient prior to administering the injection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Demonstrates ability to select appropriate equipment with rationale for use.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Demonstrates good hand hygiene technique</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Able to identify correct patient to receive injection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Demonstrates understanding of the anatomy and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>physiology of sites used for injection technique</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Demonstrates an understanding of Policy relating to safe administration of injectable medicines and Infection Control Policy</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Ability to draw up correct injectable safely and appropriately, check expiry date and correct use.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Performs correct procedure for administering a IM injection according to the Trust Guidelines</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Demonstrates ability to ensure the correct administration technique of a drug via the intramuscular route to the right patient in the prescribed sites safely</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Demonstrates ability to dispose of sharps according to local policies related to safe disposal of sharps and infection control</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Demonstrates ability to record the procedure in a patient’s records accurately, contemporaneously and according to local record keeping policy / NMC record keeping standards</td>
<td></td>
</tr>
</tbody>
</table>
### Review of Assessment

I have conducted the above assessment and consider

(Name)………………………………………………. Competent/Not Competent in their knowledge in the administration of medicines

<table>
<thead>
<tr>
<th>Assessors overall comments</th>
<th>(please use this space to record all issues highlighting good practice or issues of concern and reason for referral)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurses comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Further training required? YES/NO

Agreed and signed by Nurse ………………………………………………………

Assessor…………………………………………………………………..

Date……………………………………………………………………

Copy to: Personal file

Nurse

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**Policy Details**

<table>
<thead>
<tr>
<th>Title of Policy</th>
<th>Management of Medication Errors Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique Identifier for this policy</td>
<td>BCPFT-CLIN-POL-04</td>
</tr>
<tr>
<td>State if policy is New or Revised</td>
<td>Revised</td>
</tr>
<tr>
<td>Previous Policy Title where applicable</td>
<td>Management of Medicine Administration Errors for Nursing Staff</td>
</tr>
<tr>
<td>Policy Category Clinical, HR, H&amp;S, Infection Control etc.</td>
<td>Clinical</td>
</tr>
<tr>
<td>Executive Director whose portfolio this policy comes under</td>
<td>Executive Director of Nursing, AHPs and Governance</td>
</tr>
<tr>
<td>Policy Lead/Author Job titles only</td>
<td>Chief Pharmacist</td>
</tr>
<tr>
<td>Committee/Group responsible for the approval of this policy</td>
<td>Medicines Management Committee</td>
</tr>
<tr>
<td>Month/year consultation process completed *</td>
<td>n/a</td>
</tr>
<tr>
<td>Month/year policy approved</td>
<td>May 2019</td>
</tr>
<tr>
<td>Month/year policy ratified and issued</td>
<td>July 2019</td>
</tr>
<tr>
<td>Next review date</td>
<td>May 2022</td>
</tr>
<tr>
<td>Implementation Plan completed *</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality Impact Assessment completed *</td>
<td>Yes</td>
</tr>
<tr>
<td>Previous version(s) archived *</td>
<td>Yes</td>
</tr>
<tr>
<td>Disclosure status</td>
<td>‘B’ can be disclosed to patients and the public</td>
</tr>
<tr>
<td>Key Words for this policy</td>
<td>Recognition of errors, A Just Culture, decision tree, drug calculation test, administration errors, prescribing and monitoring errors, dispensing errors, medication error monitoring and reflection form</td>
</tr>
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</table>

* For more information on the consultation process, implementation plan, equality impact assessment, or archiving arrangements, please contact Corporate Governance

**Review and Amendment History**

<table>
<thead>
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<th>Version</th>
<th>Date</th>
<th>Details of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0</td>
<td>Oct 2015</td>
<td>Full policy review and new policy format</td>
</tr>
<tr>
<td>1.0</td>
<td>Jul 2013</td>
<td>New Policy for BCPFT</td>
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</table>

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