Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

STANDARD OPERATING PROCEDURE	**Medication Error Procedure**
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VERSION NUMBER	**3**
APPROVING COMMITTEE	**Medicines Management Strategy Group (MMSG)**
DATE THIS VERSION APPROVED	**March 2022**
RATIFYING COMMITTEE	**PARG (Policy Approval and Ratification Group)**
DATE THIS VERSION RATIFIED	**August 2023**
AUTHOR(S) (JOB TITLE)	**Medicine Safety Pharmacist** **Medicines Safety Nurse** **Medicines Safety Technician**
DIVISION/DIRECTORATE	**Corporate**
ASSOCIATED TO WHICH POLICY?	**TW10-037 Medicine Management Policy** **TW10-054 Being Open and Duty of Candour Policy**
CONSULTED WITH	**MMSG Membership**

DATES PREVIOUS VERSION(S) RATIFIED	**March 2018 (v2.2)**
DATE OF NEXT REVIEW	**March 2025**
MANAGER RESPONSIBLE FOR REVIEW (Job Title)	**Professional Practice Lead**

The WWL Way

Version Control

Version	Date	Amendment
3	March 2022	• Trust title amended to Teaching Hospital status • Titles of committees and groups updated • Definitions of near miss incidents added (section 4.1)

Contents

1 Introduction

1.1 WWL has a robust training programme for all members of staff involved in the prescribing, dispensing, administering and monitoring of medications to ensure the safe delivery of medications to our patients. This training is supported by trust wide policies, regular point prevalence audit and continual monitoring of Datix Web incident reports.

1.2 However, to err is human, and medication incidents are inevitable from even the most dedicated healthcare professionals. It is how we manage and learn from medication related incidents that is important. The procedures in this document describe how to manage medication errors.

2 Purpose

2.1 Ensure the immediate and long-term safety of the patient.

2.2 Support members of staff involved in medication errors.

2.3 Support managers when dealing with staff who have made an error.

2.4 Provide a framework for grading errors so that all members of staff involved in a medication incident are treated fairly and consistently.

2.5 Ensure that the Trust can learn lessons from the medication error in order to minimise such occurrence in the future.

2.6 Ensure that the Trust is open and honest with patients when an incident occurs.

3 Duties within the Organisation

3.1 The Trust Board has a legal responsibility for Trust policies and procedures and for ensuring that they are carried out effectively.

3.2 The Medicines Safety Group is responsible for updating the procedure as necessary.

3.3 Managers and Team leaders are responsible for ensuring the procedure is implemented in their area of responsibility and that staff are appropriately trained in line with the requirements of this policy.

3.4 It is the responsibility of staff who manage medicines to ensure that they have read this procedure and are aware of the immediate actions to take when an error is identified.

4 What Constitutes a Medication Error?

The definition of a medication error is very wide ranging and staff often find it difficult to know what to report. Medication Incidents are any Patient Safety Incidents (PSI) where an unintended or unexpected incident which could have, or did, lead to harm for one or more patients. This therefore includes near miss incidents.

Near miss incidents are events or omissions, or a sequence of events or omissions, arising during clinical care that fail to develop further, whether as a result of compensating action or not, thus preventing injury to a patient.

Examples of errors below:

4.1 Prescribing Errors

- 4.1.1 Illegible prescription
- 4.1.2 Incorrect or inappropriate medicine/dose/route, including incomplete 'when required' (PRN) details
- 4.1.3 Inappropriate indication
- 4.1.4 No signature
- 4.1.5 Allergy not recorded/allergy status overlooked
- 4.1.6 Medication prescribed to the wrong patient
- 4.1.7 Transcription error

4.2 Dispensing Errors

- 4.2.1 Labelling error
- 4.2.2 Wrong medication/strength dispensed
- 4.2.3 Wrong quantity dispensed
- 4.2.4 Medication dispensed to the wrong patient
- 4.2.5 Expired medication dispensed
- 4.2.6 Delay/problem obtaining medication

4.3 Preparation and Administration Errors

- 4.3.1 Medication administered to the wrong patient
- 4.3.2 Wrong medication/dose/formulation/route administered
- 4.3.3 Wrong frequency/rate/time
- 4.3.4 Medicine omitted without clinical rationale
- 4.3.5 Expired medicine administered
- 4.3.6 Allergy recorded but treatment given
- 4.3.7 No record of administration
- 4.3.8 Medication administered late/early
- 4.3.9 Medication incorrectly prepared
- 4.3.10 Inappropriate use of 'PRN' medication

4.4 Monitoring and Advice

- 4.4.1 Adverse drug reaction
- 4.4.2 Wrong/omitted verbal or written advice
- 4.4.3 Failure to monitor side effects/therapy
- 4.4.4 Failure to monitor therapeutic levels
- 4.4.5 Failure to monitor self-administration

5 Immediate Actions to take when a Medication Error is Identified as Having Reached a Patient

5.1 Assess the patient's condition and take any necessary actions to maintain patient stability.

5.2 The incident must be reported to immediately to the nursing in charge / line manager / person in charge and the consultant team in charge of care for the patient as appropriate for the incident. In the community setting the patient's GP may also be required to be informed.

5.2. Further information/advice can be obtained from ward pharmacist/pharmacist on-call, Medicines Safety Pharmacist, Medicines Safety Nurse, Medicines Information.

5.6 Complete Datix Web Based Incident Report and document the details of the incident in the patient's notes.

5.7 Inform the patient, as appropriate (see section 9).

6 Medium to Long Term Actions Following a Medication Error

Patient safety is paramount and must be addressed immediately when an error is discovered. In the medium to long term, the individual, service, division, and the organisation must learn lessons from the error to ensure that such occurrence is minimised as far as possible. Where divisional governance mechanisms identify themes and trends in medication errors, local action will be taken as well as escalating to the Medicines Safety Group and Medicines Management Strategy Group. Following trend analysis, recommendations or actions will be made by these groups to the appropriate areas of the organisation.

7 Reporting a Medication Incident

7.1 All incidents must be reported via Datix by the person who discovers the incident. An accurate and concise account of what happened, and any immediate actions taken should be reported.

7.2 The name of the staff member(s) involved in the error should be inputted onto datix when the incident is reported; this is to help monitor the number of incidents the staff member(s) have or are involved in and therefore helps to identity any staff member(s) which require further support.

7.3 Any incident which has caused moderate harm or above should be escalated to the daily teleconference by the divisional governance and or the medicines safety team.

8 Management and Support of Staff Following a Medication Error

8.1 To err is human, and it is inevitable that incidents involving medications will occur. It is important that staff involved in medication incidents are treated fairly and consistently and are supported throughout the investigation period.

Please see the algorithms in appendices 1-3 to help guide the management of administration, dispensing/accuracy checking and prescribing errors.

8.2 For a medication error to occur an important step in the usual process of prescribing, dispensing or administering of the medication must have been omitted. There is potential that the error may recur if the cause is not identified. Therefore, it is very important that the member of staff involved in the incident and their line manager identify what went wrong and take steps to rectify this. The Line Manager may wish to involve the Medicines Safety Nurse, Pharmacist or Technician in this process.

8.3 It is important that staff involved in medication incidents are treated fairly and consistently and are supported throughout the investigation period. Following this policy will ensure this happens. However, line managers do have overall responsibility, but if they deviate from this policy, they need to discuss the reason with the Medication Safety Officer and document their reason within the staff member's record.

8.4 The member of staff involved in causing the medication error should provide reflective practice (Appendix 4) within 7 days of the incident occurring. This is a written account of the events leading up to, during and after the incident. This can help the member of staff and their line manager to identify what went wrong, how and why.

8.5 Minor prescribing errors (such as poor legibility, minor spelling mistakes) can be pointed out to the prescriber and changes made. Errors of this type are usually intercepted by the Ward Pharmacy Team. However, repetitive errors of this kind should be reported to the prescriber's Line Manager.

8.6 Carrying out supervised practice following a medication related error can be beneficial for the member of staff involved in the incident, by increasing confidence. The Line Manager can be assured that correct procedures are followed, and competency audited during supervised practice (see appendices). The method or length of supervised practice will depend on severity of the error, insight of the member of staff as demonstrated in the completed reflective practice, previous incidents, and staff member's confidence.

8.7 The method and length of supervised practice should ideally be a joint decision between staff member and their line manager with advice from the Medicines Safety team. At the end of the supervised practice both the member of staff and line manager must be able to demonstrate that the staff member is competent, and the risk of repeat incidents is low.

8.8 If repeated errors occur by the same staff member, despite all efforts to train and improve safety, and patients are at risk, the line manager must seek advice from the governance lead, their professional lead and Human Resources in order to ensure patients are protected.

9 Informing Patient/Parent/Carer

In line with Being Open and Duty of Candour, it is imperative that the Trust is open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. When a medication incident occurs, the Trust must ensure that the patient or relevant persons are informed about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The consultant in charge of the patient's care should be tasked with informing the patient and other relevant persons. If this is not possible, another member of the team can carry out the task (pharmacist, ward/department manager).

For further information please refer to TW10-054 Being Open and Duty of Candour Policy.

10 Controlled Drug Discrepancies

When a discrepancy between the balance in the Controlled Drug Register and the physical stock is notified this must be dealt with as per TW10-037 SOP14 – Procedure for Dealing with Controlled Drugs Incidents

11 Human Rights Act

Implications of the Human Rights Act have been taken into the account in the formulation of this policy and they have, where appropriate, been fully reflected in its wording

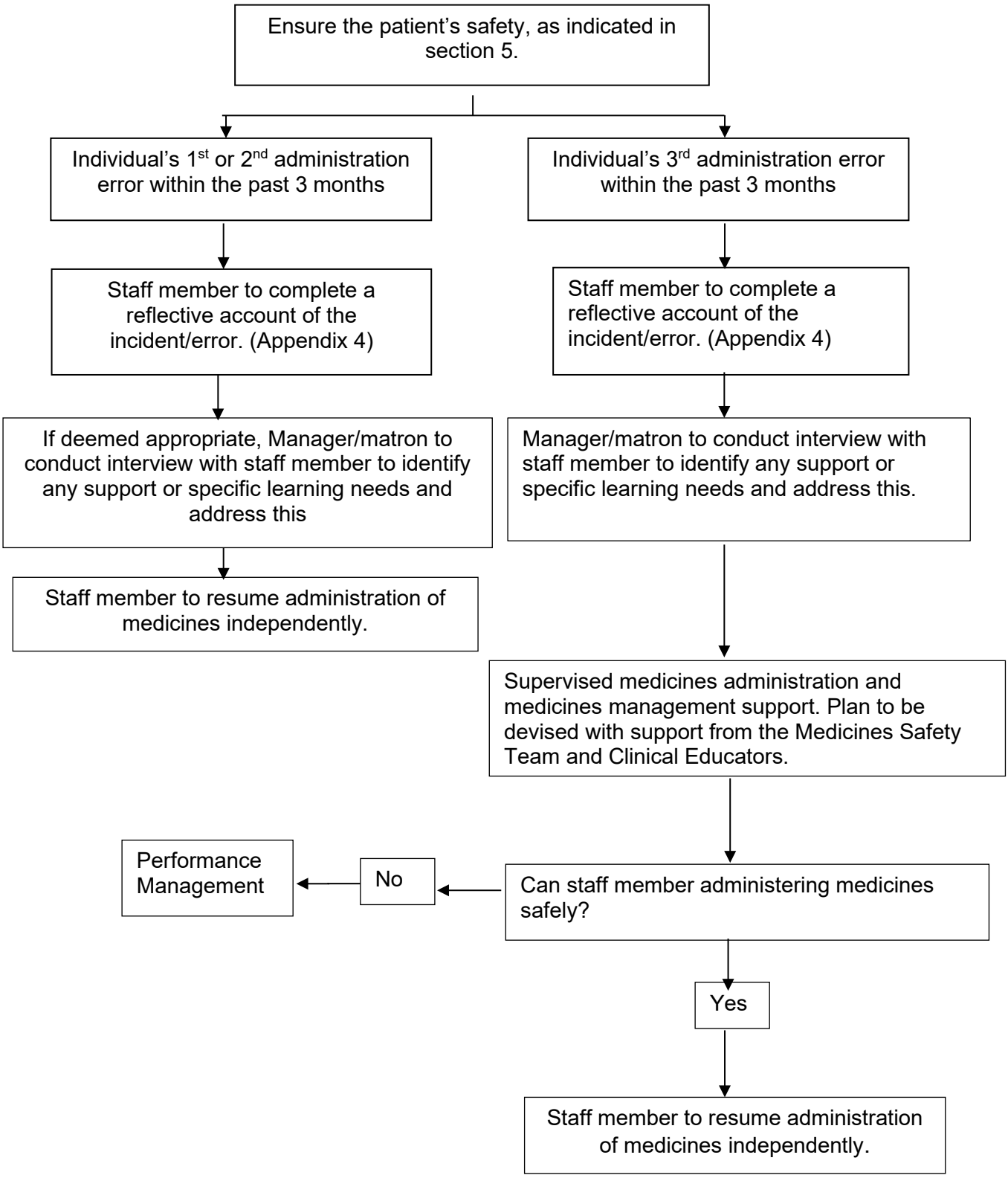
12 Accessibility Statement

This document can be made available in a range of alternative formats e.g. large print, Braille and audio cd.

For more details, please contact the HR Department on 01942 77(3766) or email equalityanddiversity@wwl.nhs.uk

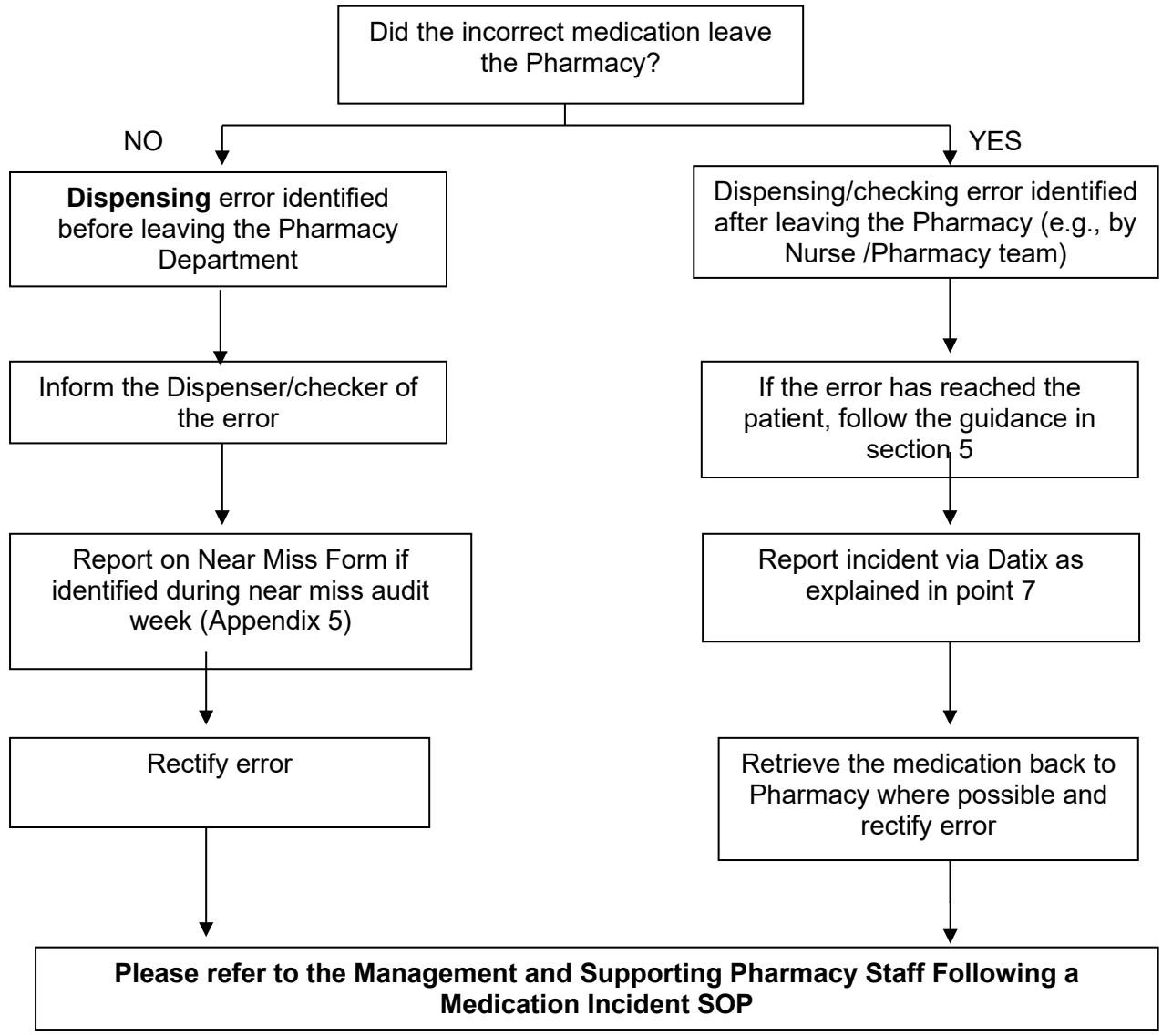
Appendix 1

Management of Administration Error



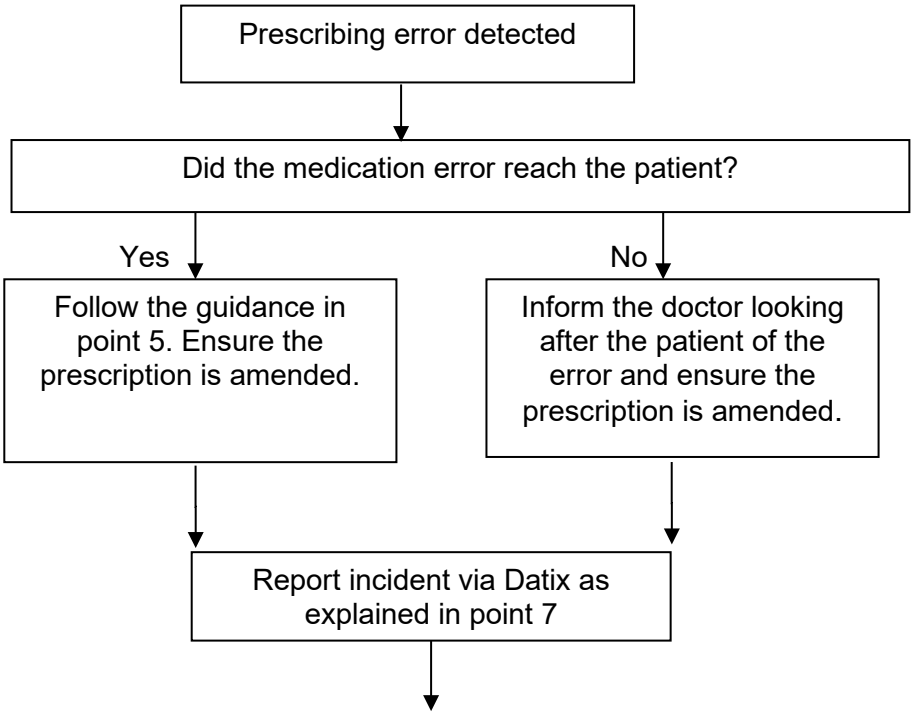
Appendix 2

Management of Dispensing/Checking Error



Appendix 3

Management of a Prescribing error



Reflective practice to be completed (appendix 4)

If a Prescriber has been involved in 3 or more prescribing incidents within 3 months, this will be escalated to their Educational Supervisor. A discussion should take place to identify any support or specific learning needs and address this through and not limited to:

- Reflective Practice Appendix 2
- Shadowed work
- Performance Management

Appendix 4

Medication Error Monitoring and Reflection Form	
Staff name	
Job title	
Manager leading discussion (if applicable)	
Date of error	
Datix WEB number	
Description of error including medication(s) involved:	
What would have/has been the implications of this error on the patient?	
Contributory factors to the error:	
How do you feel a similar error could be avoided?	
Comments by manager/supervisor (if applicable)**:**	
Follow up action(s) agreed (if applicable)**:**	

Appendix 5
Medicine Safety Unit – Near Miss Reporting Form – RAEI Pharmacy

Intended product (Name / Strength / Form)			**Date** **Time**				
Prescription Type (Please circle)	**Outpatient**	**Discharge**	**OSD**	**Stock**	**OSD**	**CD**	**Other (Specify)**

Type of Error

Attach incorrect label(s) here

Label Error	Description
Selection Error	Description
Clinical Error	Description
Other	Description

Enter initials in box

Error By				
Discovered By				
Stage Discovered (Please circle)	Before Labelling	Before Dispensing	Self Check	Accuracy Check