

## TMM086

### Medication error management procedure

<b>State whether the document is:</b> <input checked="" type="checkbox"/> <b>Trust wide</b> <input type="checkbox"/> Business Group <input type="checkbox"/> Local	<b>State Document Type:</b> <input type="checkbox"/> Policy <input checked="" type="checkbox"/> <b>Standard Operating Procedure</b> <input type="checkbox"/> Guideline <input type="checkbox"/> Protocol		
<b>APPROVAL / VALIDATION</b>	<i>Medicines Management Committee</i>		
<b>DATE OF APPROVAL / VALIDATION</b>	<i>July 2016</i>		
<b>INTRODUCTION DATE</b>	<i>July 2016</i>		
<b>DISTRIBUTION</b>	<i>Pharmacy Intranet Site</i>		
<b>REVIEW</b>	<b>Original Issue Date July 2016</b>  <b>Review Date ( If appropriate)</b> <i>October 2017 (Expiry date extended to 31/03/2020 by Dr P Buckley)</i>		
<b>CONSULTATION</b>	<i>Medicines Management Committee Intranet and Safe Medicines Practice Group</i>		
<b>EQUALITY IMPACT ASSESSMENT</b> (Tick)	<input checked="" type="checkbox"/> Initial		
<b>RELATED APPROVED TRUST DOCUMENTS</b>	<i>Trust Medicines Management Policies and Procedures on Pharmacy Intranet Site</i>		
<b>AUTHOR/FURTHER INFORMATION</b>	<i>J Wareham</i>		
<b>THIS DOCUMENT REPLACES</b>			
<b>Document Change History:</b>			
<b>Issue No</b>	<b>Page</b>	<b>Changes made</b> (include rationale and impact on practice)	<b>Date</b>

## 1. INTRODUCTION/PURPOSE AND SUMMARY OF THE DOCUMENT

This procedure describes the action to be taken when medical, nursing, allied health professionals (AHP) or pharmacy staff both in the hospital and in community are involved in a medication error. It does not include near miss reporting

## 2. STATEMENT OF INTENT / SCOPE OF THE DOCUMENT

It applies to all staff who administer, prescribe or handle medicines

## 3. DEFINITIONS

- **Medication error** is any incident relating to medication that did or had the potential to harm a patient. It includes omitted doses whether in the hospital or in the community.
- **Same type of error** means the same drug or same process.  
Examples include:
  - Administration of a drug to the wrong patient on two occasions
  - Omitting IV antibiotics on two occasions
  - Administering out of date drugs on two occasions
  - Not prescribing low molecular weight heparin on two separate occasions
- **LMWH** is low molecular weight heparin
- **Relevant regulatory body** eg NMC, GMC or GPhc
- **Relevant Line Managers** are: Ward Manager, Consultant, Clinical Services Manager, Team Leader, Line Manager

## ROLES & RESPONSIBILITIES

**Chief Pharmacist** is responsible for ensuring that the Trust has a procedure for dealing with medication errors and for ensuring it is followed by pharmacists

**Director of Nursing and Midwifery** takes overall responsibility for ensuring that nursing staff comply with this procedure.

**Medical Director** takes overall responsibility for ensuring that medical staff comply with this procedure.

**Associate Directors** are responsible for ensuring that all staff in their area are made aware of this procedure and know their responsibilities.

**Ward Managers, Team Leaders, Pharmacy and AHP managers** are responsible for the day to day implementation.

**Registered nurses, Prescribers, Pharmacy staff and AHPs** must be familiar with this procedure and adhere to it.

## THE PROCEDURE

**In the event of a medication error being made the following actions must be taken:**

- The immediate health needs of the patient should be attended to. If necessary a senior doctor or GP should be contacted to discuss the patient's condition and whether further action needs to be taken.
- The immediate line manager must be informed both in the hospital and the community. Out of hours bleep 1090 for both hospital and community errors
- Details of the incident and actions taken must be recorded in the patient's records.
- Patients must be informed of any error in an open and honest manner. The "Duty of Candour" Trust procedure must be followed where appropriate.
- A Datix incident form must be completed
- Action should be taken as directed on the table below

### **Notes on using the table below**

- Errors are recorded on a rolling basis
- The manager should always check procedure relating to the incident to see if it needs amending or the system needs changing
- On the table below, there are different levels of severity which affects how the error is dealt with. For level 2 and above an action plan must be agreed within two weeks by the member of staff and their manager. Details of the training required will be documented on the "Medication Incident Action Plan" form and will be relevant to addressing the cause of the error
- The Line Manager can escalate the action taken to a higher level if competency is in doubt and follow the capability procedure
- Out of hours inform night sisters/1090, if senior medical input is required the on call consultant or Manager on call.
- NHSP staff. If an error is made an online form must be completed on the NHSP website (Contact us link/sending feedback which includes incidents/submit). This goes to the clinical incident management system team for their staff to investigate. If it is a member of our staff, NHSP let Trust managers do the action plan but the Trust need to inform NHSP of the outcome for their records.

### **Action to be taken following a medication error**

No harm to patient			Harm to patient or never event
Level of severity	Errors	May need to follow Duty of Candour process	Follow Duty of Candour process
1	Not made an error in the previous 6 months	<ul style="list-style-type: none"> <li>Verbal counselling <i>by relevant line managers</i></li> <li>Manager to follow Incident decision tree which may mean further action is required</li> </ul>	<p>Use Trust Serious Incident Management Procedure</p> <p>If not deemed a serious incident then revert to the pathway for “No harm to patient” but start at level 1</p>
2	Had one previous error in last 6 months but not the same type	<ul style="list-style-type: none"> <li><i>Relevant line managers</i> to follow Incident Decision Tree then complete Medication Incident Action Plan</li> <li>Inform Matron and Educational Supervisor</li> <li><i>Relevant line managers</i> to check the procedure related to the incident to see if it needs reviewing or changing.</li> </ul>	
3	Had one previous error in last 6 months but of the same type	<ul style="list-style-type: none"> <li><i>Relevant line managers</i> to follow Incident Decision Tree then complete Medication Incident Action Plan</li> <li>Inform Matron and Educational Supervisor</li> <li><i>Relevant line managers</i> to check the procedure related to the incident.</li> <li>Procedure not to be carried out by the staff member unsupervised until the training specified in the action plan has been completed</li> </ul>	
4	Has made two previous drug errors or more in the last 6 months regardless of error type	<ul style="list-style-type: none"> <li><i>Relevant line managers</i> to follow Incident Decision Tree then complete Medication Incident Action Plan</li> <li><i>Relevant line managers</i> to check the procedure related to the incident.</li> <li>Procedure not to be carried out by the staff member unsupervised until the training specified in the action plan has been completed</li> <li>Inform the appropriate senior manager eg Head of Nursing, Matron, Clinical Director, HR, Chief Pharmacist or Educational Supervisor</li> <li>Trust capability or disciplinary procedure to be instigated if determined applicable</li> </ul>	

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## Medication Incident Action Plan

Name of Staff Member	Ward/Department	Number previous
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Issue Date :

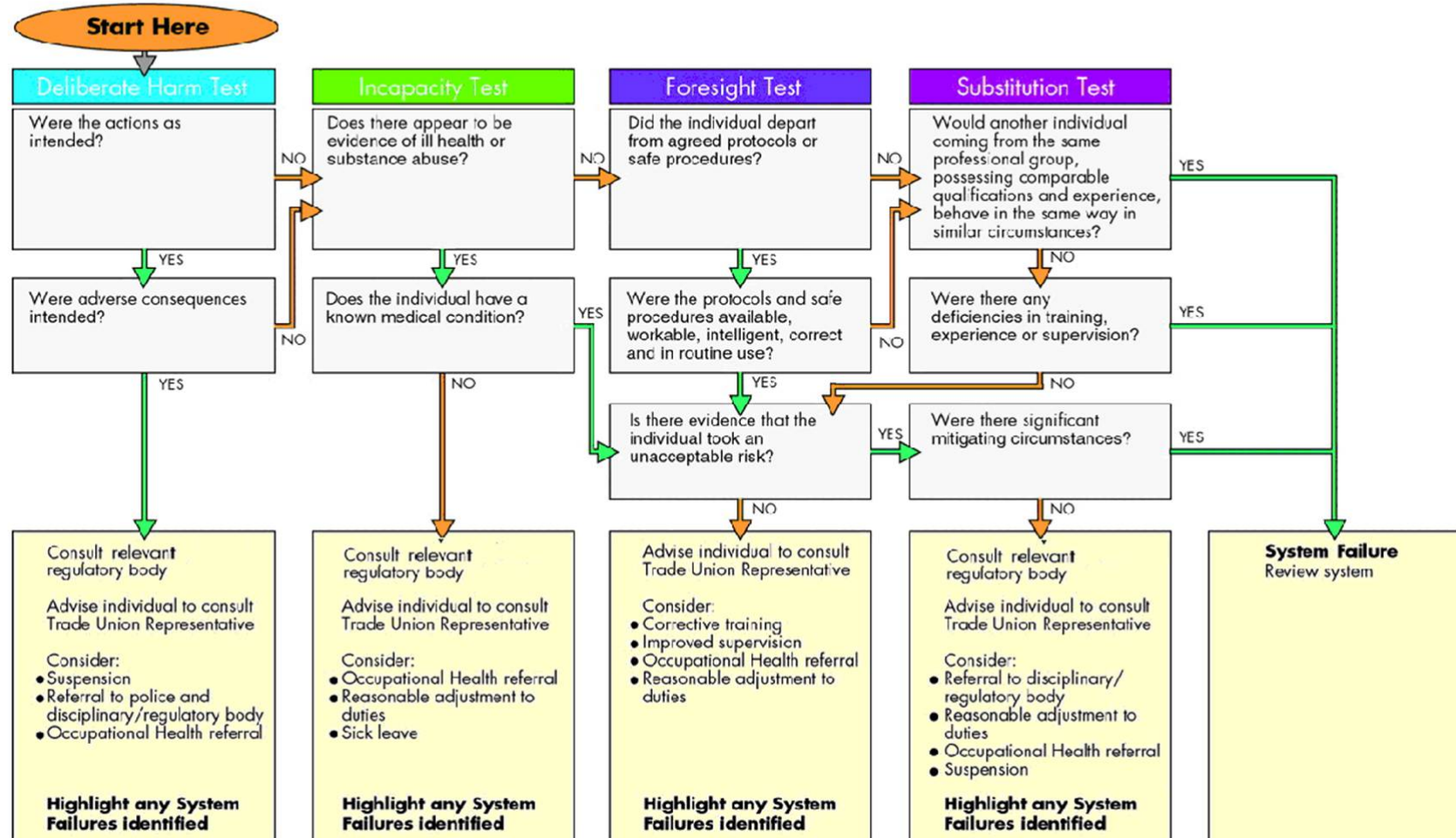
Issue / Version

		errors
Datix Number	Incident date	Level
<b>Specific Area to be addressed</b>	<b>Specific Action to be taken</b>	<b>Date completed/ signed by manager</b>
<b>Staff member's actions</b>		
<b>Manager's actions</b> eg procedure amended		
Plan agreed. Signature of staff member	Plan agreed Signature of Manager	Date

**File in personal file**

## INCIDENT DECISION TREE\*

Work through the tree separately for each individual involved



\* Based on James Reason's culpability model

## Monitoring

Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
Incidents reported via the Datix system	Safe medicines Practice Group (SMPG) and or Medicines Management Committee(MMC)	Continuous	SMPG/ MMC	SMPG/ MMC	SMPG/ MMC

**If you would like this policy in a different format, for example, in large print, or on audiotape, or for people with learning disabilities, please contact:**

Patient and Customer Services, Poplar Suite, Stepping Hill Hospital. Tel: 0161 419 5678.

Email: [PCS@stockport.nhs.uk](mailto:PCS@stockport.nhs.uk).

This information can be provided in other languages and formats if you are unable to read English. Please contact the Patient and Customer Services department and inform them of your preferred language. The department telephone number is 0161 419 5678. You could also email [PCS@stockport.nhs.uk](mailto:PCS@stockport.nhs.uk).

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如果您不能閱讀英語，這些資料是可以其他語言和格式來提供。請致電患者及客戶服務部門，並告知他們您的首選語言，該部門的電話號碼是 0161 419 5678，您還可以發送電子郵件至 [PCS@stockport.nhs.uk](mailto:PCS@stockport.nhs.uk) –

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اگر آپ انگریزی نہیں پڑھ سکتے تو یہ معلومات دوسری زبانوں اور صورتوں میں بھی فراہم کی جاسکتی ہیں۔ براہ کرم پیشہ اور کسٹمر سروس والوں سے رابطہ کر کے انہیں بتائیں کہ آپ کو کئی زبان میں معلومات چاہتے ہیں۔ ان کا فون نمبر ہے 0161 419 5678۔ آپ انہیں [PCS@stockport.nhs.uk](mailto:PCS@stockport.nhs.uk) پر ای میل بھی کر سکتے ہیں۔



**Office Use Only**

Submission Date:	
Approved By:	
Full EIA needed:	Yes/No

**Equality Impact Assessment – Policies, SOP's and Services not undergoing re-design**

1	Name of the Policy/SOP/Service	Medication Error Procedure	
2	Department/Business Group	Medicines Management Committee	
3	Details of the Person responsible for the EIA	<b>Name:</b>	Joan Wareham
		<b>Job Title:</b>	Clinical Services Manager
		<b>Contact</b>	0161 419 4461
4	What are the main aims and objectives of the Policy/SOP/Service?	To ensure a consistent approach to dealing with medication errors across the Trust. It applies to all staff who are involved in handling medicines	

For the following question, please use the EIA Guidance document for reference:

5	A) IMPACT	B) MITIGATION	
	Is the policy/SOP/Service likely to have a <u>differential</u> impact on any of the protected characteristics? If so, is this impact likely to be positive or negative?	Can any potential negative impact be justified? If not, how will you mitigate any native impacts?	
Age			
Carers / People with caring responsibilities			
Disability			
Race / Ethnicity			
Gender			
Gender Reassignment			
Marriage & Civil Partner			
Pregnancy & Maternity			
Religion & Belief			
Sexual Orientation			
General Comments across all equality strands	Each disciplinary is monitored by the protected characteristics by the Equality and Diversity Manager and so will be picked up in this way.		

EIA Sign-Off	<p>Your completed EIA should be sent to Sue Clark , Equality and Diversity Manager for approval and publication:</p> <p><a href="mailto:Susan.clark@stockport.nhs.uk">Susan.clark@stockport.nhs.uk</a> 0161 419 4784</p>
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