Shropshire Community Health
NHS Trust

Document Details	
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Author	Medicines Management
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Sub Category	Medicine
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Required by NHLSA	Yes
Other	None

Amendments History		
No	Date	Amendment
1	June 2017	Re-write of the policy including flow chart and template documentation
2	April 2021	Scheduled review Inclusion of dispensing and prescribing incidents and how to manage. New definitions with broader content for high-risk medicines Addition of RCA template Reference to Patient Safety Strategy

Contents

1.0 Introduction

1.1 What is a Medication Error?

The NHS Long Term Plan says that when organisations work together they provide better care for the public. The National patient safety strategy seeks to develop a culture of learning, that focus on what needs to change rather than punitive actions. As an organisation, SCHT aims to identify, contain and recover from errors with a ethos of learning and continuous improvement.

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:

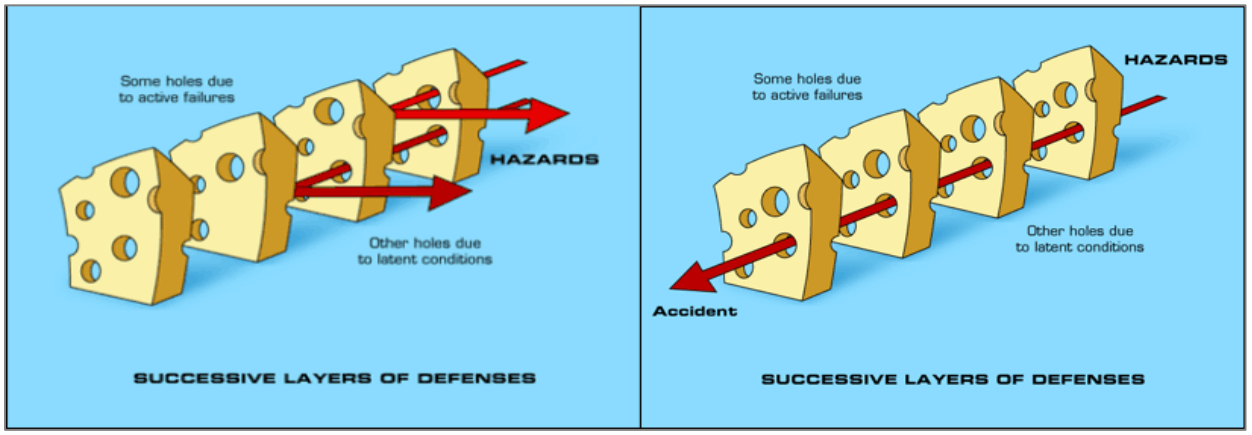
- An increased emphasis on the need for governance
- A growing awareness of medication errors
- Changing public expectations
- Changing models of patient care
- Technological advances
- Developing roles of staff

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 underpinned 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 Datix system. There is no definitive list of incidents that should be declared as SIs and each incident must be considered on a case-by-case basis. In broad terms, SIs are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Serious Incidents are externally reportable to our Commissioners and to NHS England and NHS Improvement.

At the current time notification is made via the Strategic Executive Information System (StEIS) and details must be logged onto StEIS within 48 hours of declaration via the Risk Team. As the new National reporting system becomes available in 2022, the Trust will adopt this process for investigating serious patient safety events.

2.0 Purpose

This policy describes the procedures that should 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. At the current time, the process is aligned to the NHSI serious incident framework, however, this will be adjusted in light of the patient safety strategy, as further guidance and processes become available in 2021/2022.

This policy is specifically written for all clinical 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 registered and regulated by the Nursing & Midwifery Council (NMC).

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

Doctors are registered and regulated 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 the Health and Care Professions Council (HCPC).

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 in-line with the “just culture” framework
- Support and provide guidance for 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 in-line with the “just culture” framework and National Patient Safety Strategies
- Ensure the organisation embeds a culture of learning from the error in order to minimise such occurrence in the future and adopt a pro-active quality improvement approach to patient safety

4.0 Process

Human error is inevitable. Identifying incidents, recognising the needs of those affected, undertaking meaningful analysis and responding to reduce the risk of recurrence remain essential to improving safety. This policy aims to support staff and managers to operate systems, underpinned by behaviours, decisions and actions, that assist learning and improvement, and allow the Trust to examine incidents openly without fear of inappropriate sanction, support those affected and improve services.

All medication errors should be reported via the Trusts incident reporting system Datix and all staff involved in the incident should also be recorded to support the review process and ongoing learning and improvement.

For the purpose of this policy medication errors will be categorised as follows based on the severity of a medication error. 2 levels have been identified:

- **Medication error** – omission of medicine at prescribing, supply or administration, wrong dose, wrong drug, non-compliance with antimicrobial stewardship.

- **Serious Medication Error** – Usually those that involve a high-risk medicine, wrong patient, penicillin prescribed for a patient with penicillin allergy, lengthened the stay of an in-patient, resulted in a patient admission or resulted in patient death.

For the purposes of this policy, the following classes of medicine or incident types will now be defined as high risk and require completion of an RCA at the request of the Chief Pharmacist, appropriate Pharmacy staff as delegated or the Medicines Safety Officer:

- Anticoagulants
- Insulin
- Controlled Drugs
- Cytotoxic agents
- Anti-epilepsy medicines
- Parkinson's Disease medicines
- Medicines prescribed by intravenous route
- Resuscitation medicines
- Use of PGD's outside of their scope
- Medication incidents identified as part of the patient safety incident response plan (PSIRF)

In order to assign the appropriate level for a given medication error, the incident should be assessed individually and the consequence of the error determined by the degree of harm or potential degree of harm to the patient (e.g. near misses).

Tools in place to support the decision making around this process include NHS Improvement (NHSI); A just culture guide. In addition, the Trust's Incident Levels guidance and Risks Categorisation Matrix which are all available on the Trust intranet and should also 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 Chief 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/PALS by patient/representative
- Datix reporting process
- Reporting by colleagues
- Routine audits (retrospective reporting)
- Unplanned/Spot audits by managers/regulatory bodies
- One of the identified priorities on the local Patient Safety Incident Response Framework (PSIRF)

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 Informing Patient / Parent / Carer Regarding Medication Errors

The importance of the role of patients, their families and carers, and other lay people in improving the quality of NHS care is increasingly recognised.
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 and to support the review and learning process.

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. Following this, 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. They should also be given the opportunity to be involved in the review process wherever possible

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 (Refer to the risk matrix 4.2.1 and 4.2.2 and Duty of Candour pathway 4.2.3 to illustrate this).

The flowchart also describes time frames for when actions should be complete and references the need for providing written responses within 10 working days of the incident.

If required and appropriate, following the investigation / review process, 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.

4.2.1 Summarised Risk Matrix for Assessment of Medicines Incidents

Most likely consequences (if in doubt grade up not down)				
None 1.	**Minor 2.**	**Moderate 3.**	**Major 4.**	**Catastrophic 5.**
No potential to cause harm to patient, no breach of policy **Datix closed**	Isolated incident potential to cause minor harm e.g. additional dose of correct meds, minor breach of policy but no legal infringement **Reflection required then Datix closed**	Cluster of similar minor incidents demonstrating high risk of recurrence. Isolated incident with potential to cause harm, significant breach of policy / professional standards **RCA required**	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 **RCA required**	Extensive permanent injury or death **Serious Incident**

The summary risk matrix enables a quick snapshot for decision making. This matrix should not be confused with the matrix used within the Datix pro-forma which can be seen below.

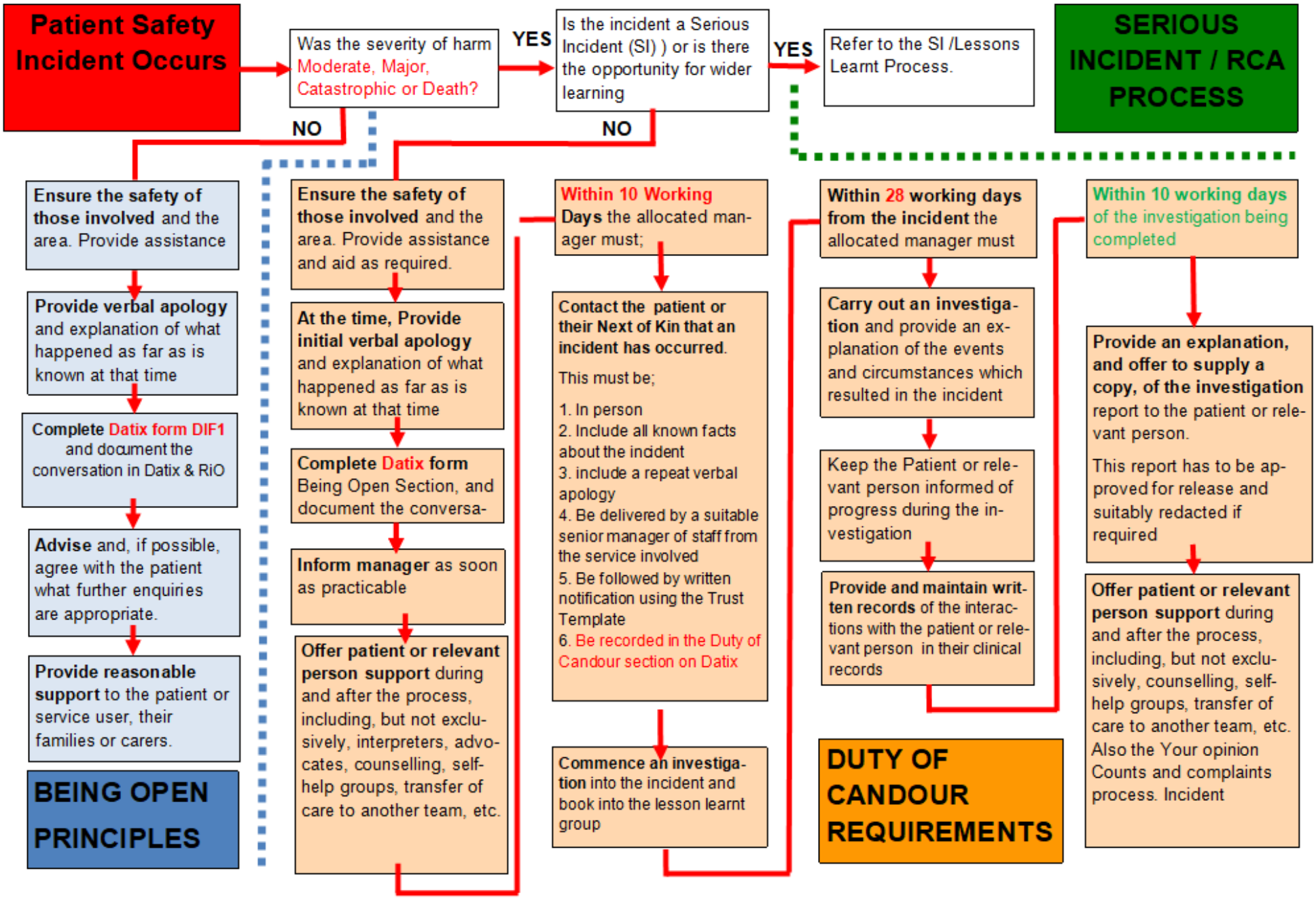
4.2.2 Scoring the Consequence and Harm Rating to patient

Injury/Harm	Finance	Service	Reputation	Consequence Score	Will undoubtedly occur, possibly frequently	Will occur but not persistently	May occur occasionally	Do not expect to happen but is possible	Cannot believe this will ever happen
Likelihood Score					Almost certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
Very minor or no harm	Less than £10,000	No or very little impact on services	Some negative publicity	None 1	LOW 5	LOW 4	VERY LOW 3	VERY LOW 2	VERY LOW 1
Minor injury/ illness (e.g. cuts and bruises) will resolve within a month	£10,000 to £50,000	Disruption of services causing inconvenience. May cause efficiency/ effectiveness problems	Regular negative publicity	Minor 2	MODERATE 10	MODERATE 8	LOW 6	LOW 4	VERY LOW 2
Injuries of illness which requires extra treatment or protracted period of recovery. Should resolve within a year.	£50,000 to £500,000	Loss of service for a significant period of time (less than a month)	Loss of public confidence, protest action	Moderate 3	HIGH 15	MODERATE 12	MODERATE 9	LOW 6	VERY LOW 3
Single serious (life threatening) injuries/ illness	£500,000 to £3.5m	Loss of services to such an extent that effects on public health will be measurable	Punitive action, e.g. HSE, Healthcare Commission, significant organisational change results	Major 4	HIGH 20	HIGH 16	MODERATE 12	MODERATE 8	LOW 4
Multiple serious (life threatening) injuries/ illness	£3.5m plus	Permanent loss of a significant service. Threatens the viability of the organisation	Damage to such an extent that the organisation must cease to exist as is	Catastrophic 5	HIGH 25	HIGH 20	HIGH 15	MODERATE 10	LOW 5

The incident must be scored appropriately using the above matrix within the Datix proforma to capture the seriousness of the incident or near miss. Where the incident is a near miss, ensure it is still scored as if it happened.

In these instances, this information will be used as a positive learning point as no harm came to the patient but, may still require some investigating to ensure the process which captured the incident is failsafe and unlikely to allow an incident to take place unnoticed.

4.2.3 Duty of Candour Pathway



4.3 Temporary workers (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 and the centralised bank team. 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.

When any incident is reported, the staff member involved in the incident must be captured within the Datix form and where it is identified that they are involved in multiple incidents, support will be provided in line with the just culture guide.

4.4 Reflection of the Incident

The member of staff will meet with their line manager to discuss the incident and complete a piece of written reflection before agreeing appropriate supportive actions using the just culture guide **(Appendix 1, 2 & 3)**

The clinicians will also be required to reflect on the incident and complete the Medication Error Monitoring and Reflection form (**Appendix 3**). This will help to identify what went wrong and why to support improvement. This is also a useful source of information during the investigation or review process.

4.5 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 following supportive action. The expectation for a pass mark for the drug calculations will be 100%. It is vital that staff involved with medicines are able to calculate drug dosages and volumes accurately.

A 'sample' calculation assessment is provided in **Appendix 6**

Whenever a pass is not achieved first time, staff will be supported to undertake further training prior to retaking the test. A total of three attempts are permitted, before consulting HR processes in line with the Maintaining High Standards of Performance Policy described in section **4.10**.

4.6 Assessment of Competency

The competency assessment relevant to the professional group can be completed with the member of staff. The assessor, ideally, should be of the same profession as the individual completing the competency assessment. For example, Nursing will be assessed by the Ward / Team Manager / Clinical Practice Teacher or a Band 6 registered nurse or a subject matter expert. 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 area for improvement following the error made.

Assessments should be conducted across a variety of shifts or days as necessary.

For clinical care staff, 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 feedback including their level of competence and any further areas of development. The outcome of the final assessment will be recorded on the Assessment review recording sheet (**Appendix 4**) and the relevant manager notified. A copy of this form will be placed in the member of staff's personal file for a 12 month period.

4.7 Supervised Suspension from Medication Management Activities

The member of staff may have supervised withdrawal from prescribing, administration or dispensing of certain medications or all medications if the manager has 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 member of staff would be supervised prescribing, dispensing or administering medication by their clinical line manager or nominated deputy (where this is a nurse, this should be conducted using the relevant nursing competency assessment.)

4.8 Suspension from Medication Activities

The member of staff may be withdrawn from prescribing, administration or dispensing some or all medication if the reported error requires further review / investigation and or further training and assessment. This would be in line with the just culture framework and HR processes. It is not expected, for example, that a staff member with issues relating to administering a depot injection safely should necessarily be removed from giving oral medications (unless the concerns are wider than a specific route of administration).

4.9 Performance Improvement Process

The member of staff may be managed under the Trust processes if all the supportive mechanisms have failed to enable an improvement. This is more likely if an error resulted in serious harm to a patient. This would be in line with the Trusts processes and this will be supported by a human resources advisor.

4.10 Supporting and Maintaining High Standards of Performance

If the member of staff who has made the medication error:

- Is unsuccessful at assessment of competency on the 2nd attempt
- Is unsuccessful at a drug calculation assessment on the 3rd attempt
- Is involved in a 2nd related serious medication error in a 'rolling' 6 month* period
- Is involved in a 4th related medication error (serious or non-serious) in a 'rolling' 12 month* period

(*) = Consideration will be given to the severity of the incident e.g. level of harm and the medication involved.

They may be withdrawn from specified medication management activities as appropriate and supported using the Just Culture Framework and relevant Trust policies. 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 supportive 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 preserve patient safety. This may include, but is not limited to, the recourse to manage the member of staff using the Trust's policies and processes.

4.11 Administration Errors

Preparation and Administration Errors may include:

- Administration without a valid prescription
- Administered of the wrong medication / dose / route / formulation
- 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).

4.11.1 Medication Administration Error (Non-Serious)

- The line manager will meet with the 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, human and environmental factors). The Just Culture Guide should be consulted.

- Clarify that an error has been made and establish any facts. Where actions have been taken to avoid patient harm by a member of staff, this should be taken into consideration, but the error process should still be followed

- The person 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

- A Datix to be completed within 24 hours of the incident

- Line manager to be notified of the error, timing of the notification will be determined by the nature of the error and the submission of the Datix form. 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, any additional actions to preserve patient safety, and the course of action required related to the incident. Managers will need to check whether there have been any previous errors involving the member of staff or similar themes and processes and take this into account when considering any course of action. Managers should also consider the opportunity for wider Trust learning when reviewing the error.

- Line manager will discuss the error and supply a medication error monitoring and reflection form to be completed by the staff involved to support the review process, learning and improvement (**Appendix 1 & 3**)

- In the absence of the line manager, their deputy should action or escalate to Locality Manager / Head of Nursing and determine action required

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

Actions may include:

- A reflection on the incident
- Supportive actions e.g. mentorship, training, shadowing opportunities
- The health professional be provided with professional guidance e.g. Professional Guidance on Administration of Medicines in Healthcare Settings
- Competency reassessed / observation in practice of medicines duties
- Review medicines policy in relation to the specific incident

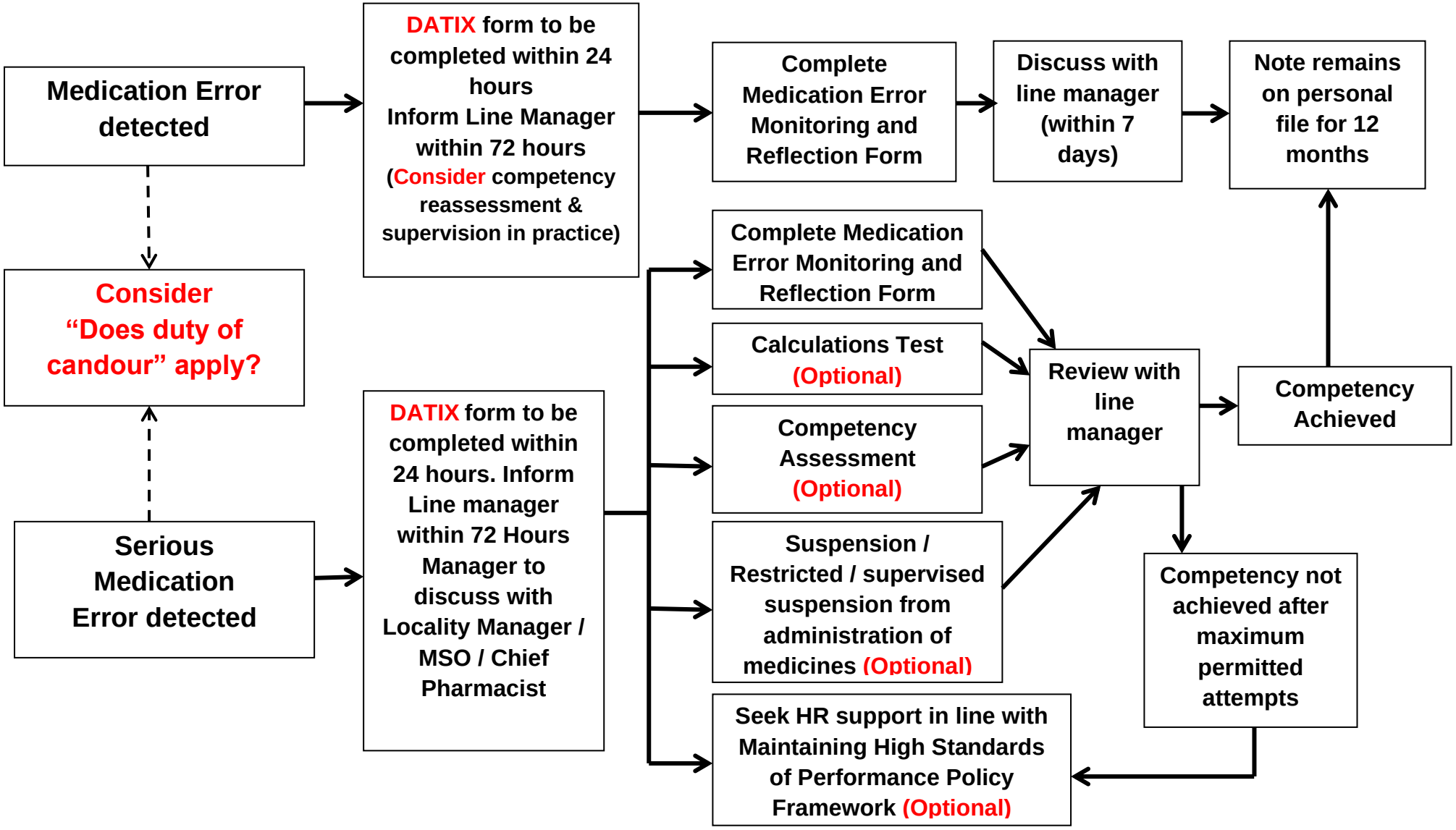
Where a 3rd non-serious medication error (incidents can be unrelated) occurs within a rolling 6 month period, the serious medication error protocol should be followed.

4.11.2 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 Clinical lead for Quality 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 and mentorship
- Assessment of competency
- Calculations Assessment
- Supervised withdrawal from administration of medication
- Restrictions/limitations from administration of medication
- Referrals through HR policies and frameworks

4.11.3 Management Flowchart of Actions Following a Medication Administration Error



4.12 Prescribing and Monitoring Errors

Any prescribing error must be discussed with the prescriber as soon as it is discovered, and / or Medical Advisor. 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 / preparation / 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
- Allergy status not recorded or incorrect
- Prescription not signed

Monitoring Errors may include:

- Inappropriate monitoring / follow up
- Failure to monitor therapeutic levels

Skill based errors – Memory lapses are generally picked up by pharmacists and senior staff and are therefore rectifiable with practice and learning.

Rule based errors e.g. antimicrobial stewardship will require supportive actions to ensure learning is firmly established, these can usually be avoided by checking interactions, allergies and ensuring full documentation of indications and course lengths.

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.

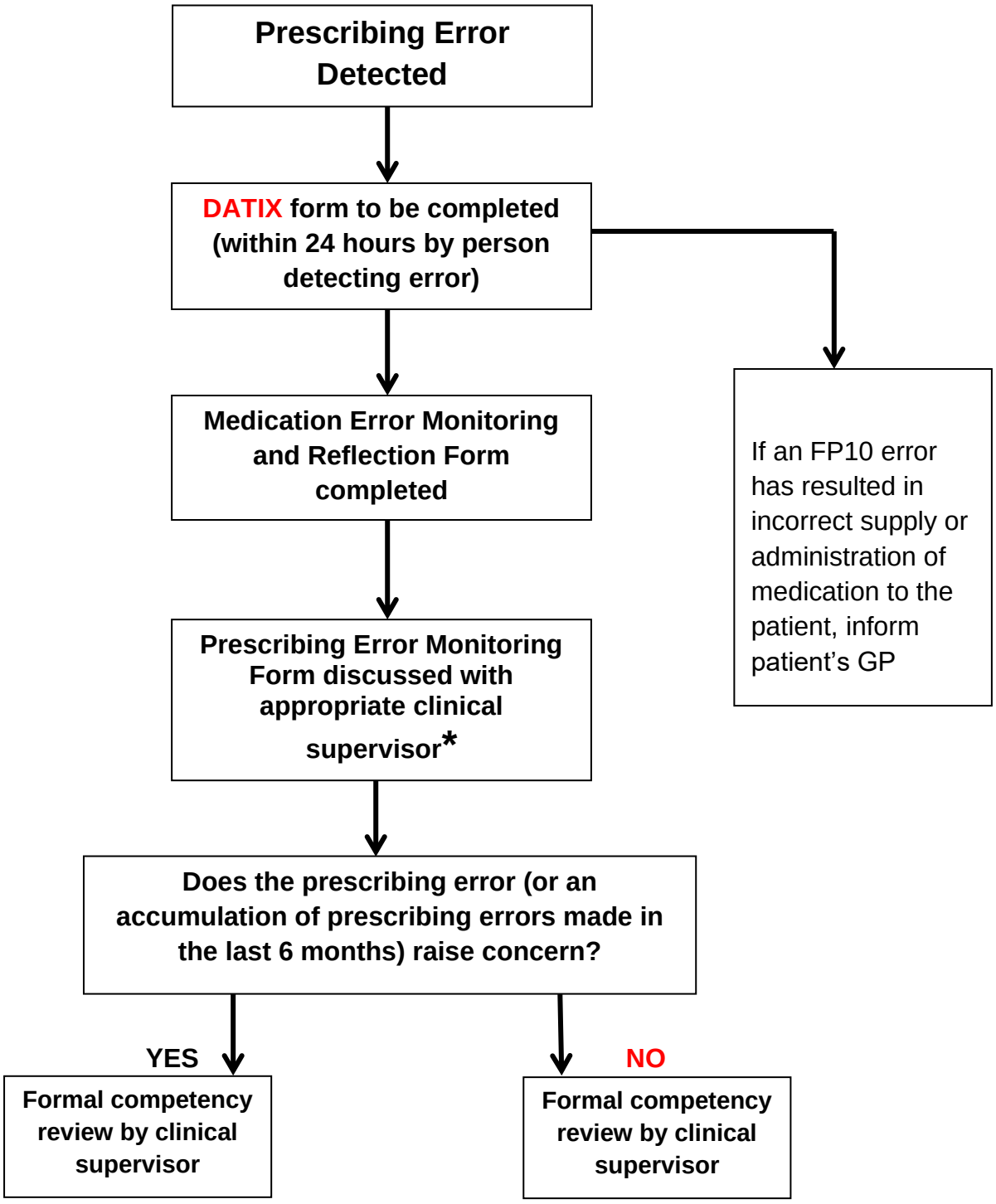
In the case of the below, the framework on the next page should be used:

- Repetitive errors of this kind
- More serious errors
- Errors which have resulted in patient harm or increased monitoring

In all cases, a medication error monitoring and reflection form should be completed (**Appendix 1**). The appropriate clinical supervisor***** 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.

4.12.1 Management of Prescribing Errors



***clinical supervisor**

For a community hospital doctor this would be the Medical Advisor •
For a Medical Advisor this would be the Associate Medical Director or Medical Director
For a non-medical prescriber, this will be their relevant clinical supervisor

4.13 Supply or Dispensing Errors

This type of error can be undertaken by any member of clinical staff, particularly where the selection of a medicine is required. Some examples of selection / dispensing errors are:

- Patient supplied / dispensed the wrong medication / dose / formulation /strength / quantity (on a ward, MIU, clinic, dental service or their own home)
- Medication supplied / dispensed to the wrong patient e.g. medicines placed into wrong medicine locker
- Patient supplied / dispensed an out of date medicine
- Medication is labelled incorrectly or not at all
- Medication supplied contains incorrect quantity

4.13.1 What to do in the Event of a Supply / Dispensing Error

Once an error has been discovered, it is important to establish if the patient has taken any of the incorrect medicine, as this may change how the incident is dealt with.
Any external dispensing error should be raised via the CCG

4.13.1.1 Establish if the patient has taken any of the incorrect medicine

Where the individual discovering the error is a prescriber, 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 Out of Hours Doctor service may need to be contacted outside work hours.

Where no harm appears to have been caused, the prescriber responsible for the patient (e.g. their usual GP) should still be informed and this should be documented in the patient's notes.

Refer to various pathways **4.13.2** and **4.13.3** on dealing with the incidents.

4.13.1.2 Inspect the incorrect medicine where possible

Inspecting the medicine can give valuable clues about what went wrong.

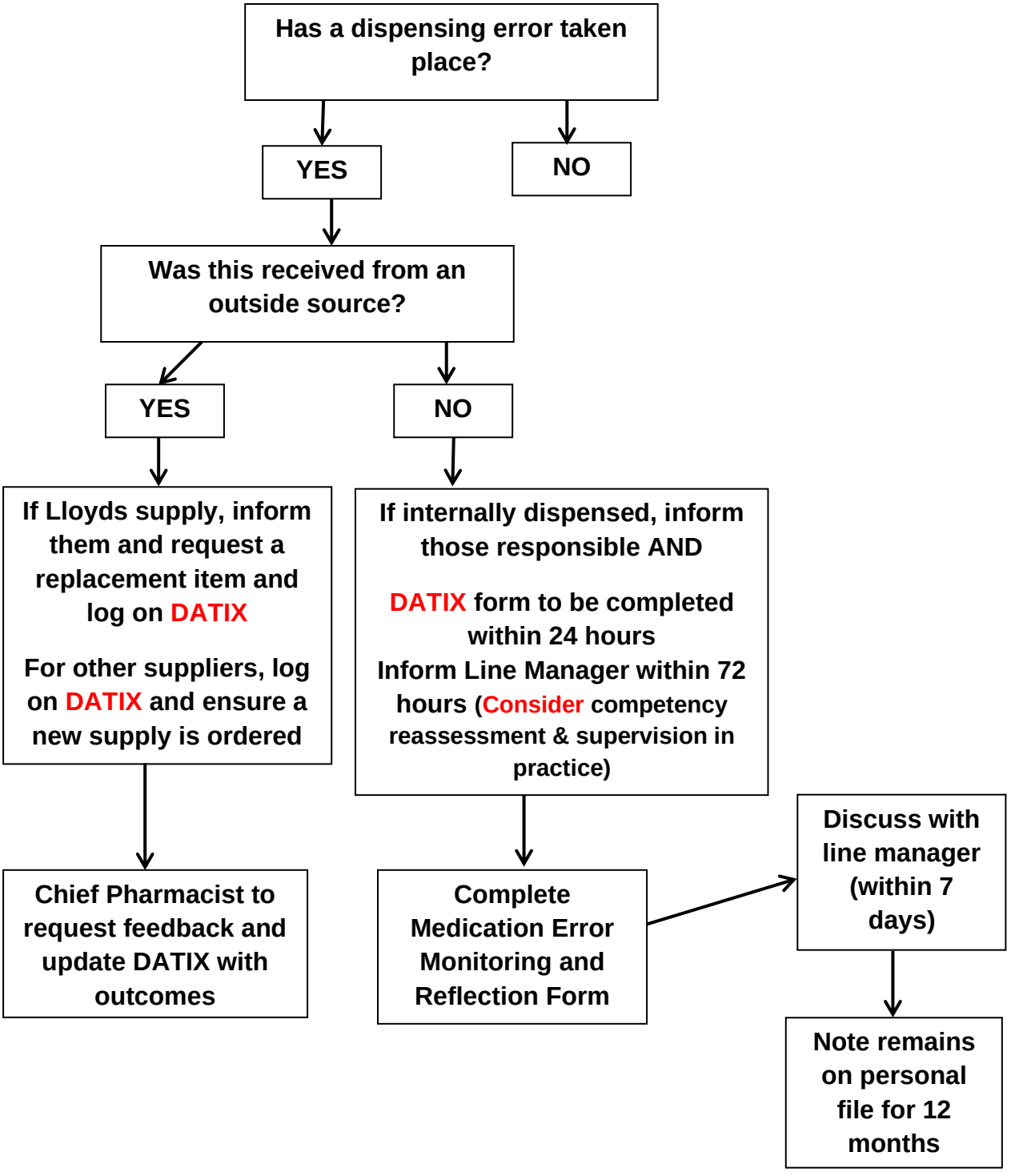
When reviewing dispensing errors which have resulted in a serious patient safety incident, the Incident Framework helps to identify why individuals acted in a certain way, and this may be a very useful tool for pharmacists, managers and organisations to consider using prior to action being taken. Additional information on the incident decision tree can be found at Serious-Incident-Framework or in the Patient Safety Strategy

From a pharmacy point of view, a dispensing error may be seen as wrong label, drug, strength or quantity. However, for the purposes of this policy, dispensing relates to selection of a drug by a member of staff that may not be labelled. Therefore, any member of clinical staff could be involved with a "dispensing" incident.

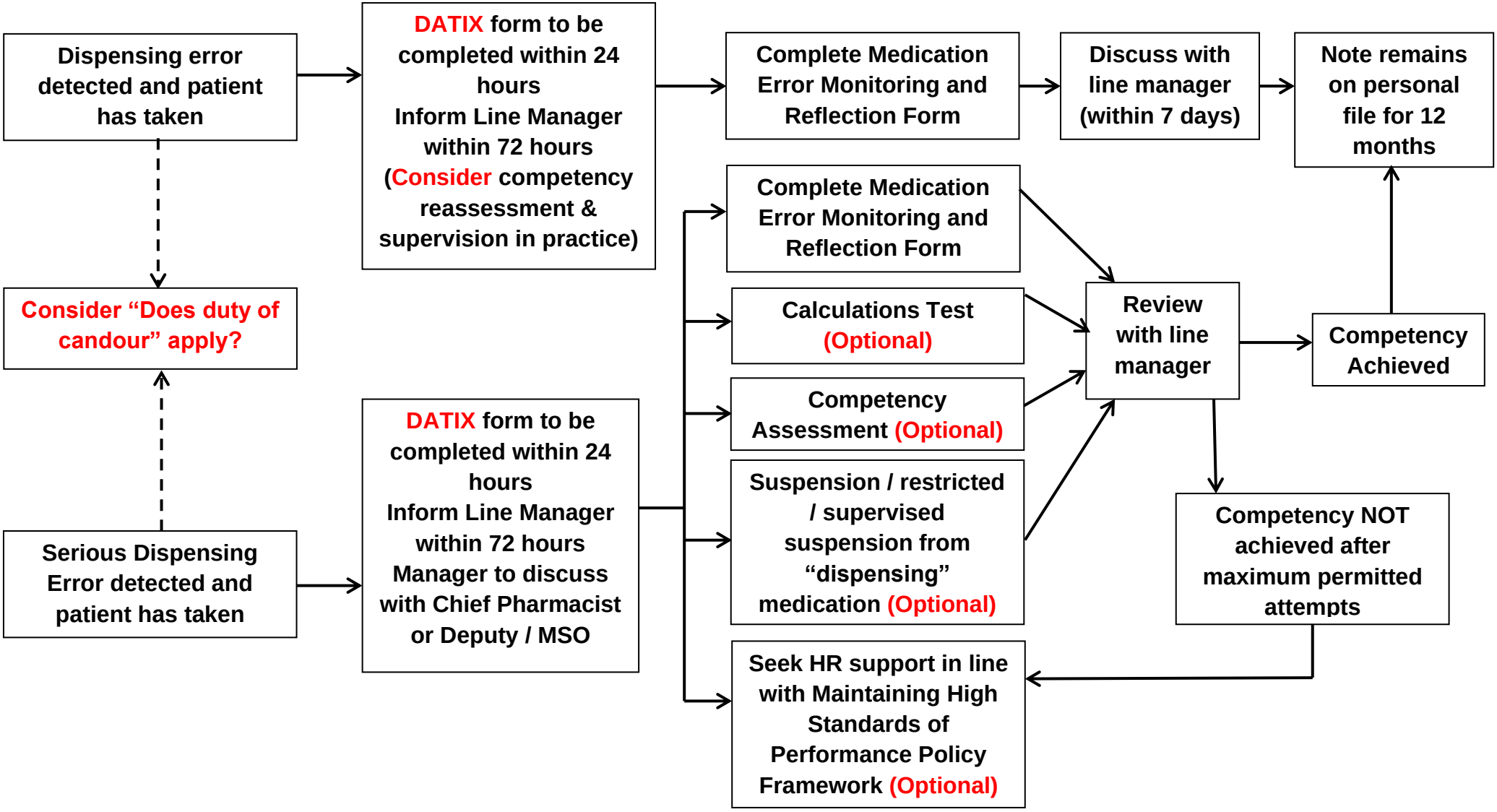
Once an error has been detected, a medication error monitoring and reflection form **must** be completed (**Appendix 1**). The line manager will meet with the staff member to discuss the error. This discussion should explore any factors that could have contributed to the error (e.g. Human Factors **Appendix 7**).

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.

4.13.2 Management of Dispensing Errors Where the Patient hasn't taken



4.13.3 Management of Internal Dispensing Errors Where the Patient has taken the medicine



5.0 Policies and Procedures Connected to this Policy

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 Shropshire Community Health NHS Trust.

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.

Maintaining High Standards of Performance
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.

Maintaining High Standards of Performance (Medical and Dental)
This policy details the arrangements for managers to deal with issues of conduct and capability with regard to medical and dental staff.

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 Medicines. It applies to all individuals employed or contracted by Shropshire Community Health 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.

Risk Management policy
This policy describes how risk is managed within the Trust and the responsibilities of managers and committees that review these risks. It also describes how to assess risks and record new risks onto a risk register.

Supervision Policy
This policy ensures that staff have access to quality supervision and support at work.

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 in 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. There have been

various addendums since then with the latest being in 2020 to enable the management of pandemics.

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
The NMC no longer regulates medicines, therefore, there are no specific NMC guidelines. However, there is relevant guidance available (RPS/RCN) related to this remit.

Professional Guidance on the administration of medicines in Healthcare settings

Medicines Administration Guidance for Nursing Associates

GMC Good practice in prescribing and managing medicines and devices (2021)
Good-practice-in-prescribing-and-managing-medicines-and-devices (2021)
This contains the principles in Good Medical Practice, and provides guidance on how to apply decisions about prescribing, managing medicines and medical devices. This includes the following points:

- Ensuring that prescribing is clear and includes treatment course length.
- Where a new allergy is picked up during an in-patient stay, this is communicated to the patient’s usual GP
- 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 References

- Advisory Guidance 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
- The Safe and Secure Handling of Medicines (a Team Approach). Royal Pharmaceutical Society of Great Britain March (2005). A revision of the Duthie Report (1988)
- CQC: Guidance for Providers on Meeting the Fundamental Standards and on
- CQC's Enforcement Powers (July 2014)
- NHS Improvement; A Just Culture Guide 2018 A Just Culture Poster & Appendix 8
- Professional Guidance on the Administration of Medicines in Healthcare settings, January 2019 (Royal Pharmaceutical Society)
- Driscoll, J. (2007). Practising Clinical Supervision: A Reflective Approach for
- Healthcare Professionals. Blackwell: Philadelphia
- GMC Good Practice in Prescribing and Managing Medicines and Devices
- (2013)
- British National Formulary (BNF) Edition 80 – (September 2020 - March 2021)
- https://www.radcliffehealth.com/sites/radcliffehealth.com/files/samplechapter/mandalia_chapt_01.pdf
- http://www.gmcuk.org/FINAL_Report_prevalence_and_causes_of_prescribing_errors.pdf_28935150.pdf
- http://spars.rcpe.ac.uk/sites/spars/files/uploads/hospital-medication-errors-the-junior-doctors-perspective.pdf
- "Swiss Cheese" Model – James Reason, 1991. Found in: Reason, J. (1990) Human Error. Cambridge: University Press, Cambridge
- Health Care Commission (2007). The Best Medicine. The management of medicines in acute and Specialist Trusts. London: Health Care Commission
- Statutory Instruments. Medicines Act 1968 and 1971. London: HMSO
- National Prescribing Centre. (2004). Patient Group Directions. A practical guide and framework of competencies for all professionals using PGDs. London: National Prescribing Centre
- Department of Health (2004). Building a safer NHS. Improving Medical Safety. London: HMSO
- Serious Incident Framework, NHS England (2020) https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf
- Parts of the Black Country Policy for Management of Medicines Incidents has been adopted into this policy with thanks.
- Patient Safety Strategy 2019 Patient Safety Strategy Version 4

7.0 Roles and Responsibilities for this Policy

7.1 The roles and responsibilities for this policy can be seen in the following tables, this demonstrates that all staff working within the Trust that also handle medicines will contribute to the execution of this policy.

Title	Role	Responsibilities
Directors for Nursing, Operations 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 effective
Quality and Safety Committee	Responsible	• Ensure that medication errors are managed efficiently and effectively in accordance with the Board's Assurance Framework and strategic priorities
Quality and Safety Delivery Group	Scrutiny and Performance	• Oversee the implementation of a systematic and consistent approach to managing medication errors • Provide exception and progress reports to the Q&S Committee
Medicines Governance Group	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
Medicines Management Team	Monitor	• Detect trends and clusters of activity • Make recommendations to Medicines Governance Group and Lessons Learned Group for actions to improve and change current practice • 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
Service Delivery Groups	Monitor	• Responsible for monitoring medication errors in their group • Receive the results and recommendations of all completed clinical audits
Chief Pharmacist	Implementation Lead	• Advise on the relevant guidance and regulations related to this policy • Ensure that policies and procedures are up to date

Title	Role	Responsibilities
Lessons Learned Group	Monitor and 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 • Ensure any lesson learned is disseminated and shared widely within Trust and System
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
Ward Managers and Locality Managers	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 locality manager / MSO / Chief Pharmacist as appropriate • Lead on medication errors and some serious medication errors investigations • Management of medication errors may, where appropriate, maybe 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
Risk Managers	Governance	• Support the clinical team in relation to the use of the Datix system • Support the Lessons Learned Group by contributing to analysis of incidents and advising on duty of candour where required
Human Resource Advisor	Advise	• Support clinical managers in situations where management of a medication error involves the use of the Managing High Standards of Performance 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 policy
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

8.1 Medicines Management training will be provided on induction as supported by the Medicines Management Team

8.2 Medicines competency and training will be provided / assessed by Teams Leaders / Ward Managers / Service leads during an induction period

8.3 The reporting of medicines incidents using Datix will be introduced at induction by the Risk Management Team.

8.3.1 Datix training in greater depth can be requested from the Risk Management Team

8.3.2 Root Cause Analysis (RCA) training can also be requested from the Risk Management Team

9.0 Quality Equality Impact Assessment (QEIA)

Shropshire Community Health NHS 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.

10.0 Data Protection and Freedom of Information

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.

11.0 Monitoring this Policy is Working in Practice

11.1 Routine monitoring and provision of reports will demonstrate that this policy is working. The table below will identify relevant reports.

Monitored Activity	Where is it described in policy?	Method	Who will undertake?	Frequency	Group / Committee that will review results?	Group / Committee that ensure actions completed	Evidence this has happened?
Medicines incidents are routinely assessed and shared for scrutiny	Section 7	Report is created following analysis	Medicines Management team	Monthly	QSDG	QSDG	Minutes of meetings
The type and number of errors	Section 7	Creation of monthly narrative	Chief Pharmacist	Monthly	QSDG	QSDG	Minutes of meetings
Consistent management of incidents	Section 7	Analysis of RCA's	Lessons Learned Group	Monthly	QSDG / Q&S Committee	QSDG	Minutes of meetings

12.0 Consultation

The following people have been consulted in the development of this document:

Name	Role	Name	Role
Angela Cook	Head of Nursing & Medicines Safety Officer	Claire Horsfield	Allied Health Professional Lead
Stanley Mukwenya	Risk Manager	Laura Lane	Lead ACP
David Young	Lead Pharmacist – Community Hospitals and MIU's	Narinder Kular	Consultant Nurse (C,YP&F)
Emily Peer	Associate Medical Director	Cath Molineux	Consultant Nurse (Adults)
Jane Povey	Medical Director	Jo Gregory	Head of Nursing (C,YP&F)
Sarah Yewbrey	Clinical Practice Facilitator	Karen Taylor	SDG Lead for TeMs and Adults Group(s)
Phil Atkins	Lead for MIU and DAART	Donna Jones	Locality Manager
Gill Richards	Information Governance Lead	Fiona MacPherson	Senior HR advisor

Appendix 1: Record of Informal Interview - Medication Incidents

Shropshire Community Health NHS Trust

Datix reference number	
Date of incident	
Date of interview	
Practitioner	
Line Manager conducting interview	
Level of Medicines Incident	

Discussion of the event (brief summary)

Action - (should include personal reflection (Appendix 3) any restrictions to practice (Level 2) , support and supervision AND any service or /and process issues identified that may have contributed to the incident)

Practitioner signature and date	
Line Manager signature and date	

Appendix 2: Medication Incident Level Two / Serious Incident Letter

Date <insert date>

Dear <insert name>

Medication Incident Level Two / Serious Incident (<delete>): Actions following initial informal interview

Datix reference number:	
Date of incident:	
Date of Informal Interview	

Following our discussion of the above named incident it has been necessary to suspend you from XXXXX element of medicines management

The enclosed supportive action plan has been agreed to support you in preventing any further medicines incident

Following successful completion of the agreed actions, a further meeting will be held to confirm restrictions placed on your practice will be lifted and you will be able to resume all aspects of your role including bank work (Appendix D).

A copy of this letter will remain on your personal file. If you have any questions, please contact me.

Yours sincerely,

< your signature>

<print name>

<your job title>

Copy to be retained in personal file and copy to staff member

Action Plan Following Staff / Manager Discussion:

N.B: Not all sections will be relevant – only complete those required.

Learning need	Actions required to address learning need	Completion date	Signature of completion
Refresh / update medicines administration in accordance with Trust policy	Re-assessment of medicines administration competency. This will be conducted by <insert name>		
Update on XX required e.g. Diabetes	Undertake additional training <state which>		
Refresh Numeracy Skills	Undertake medicines calculation test Locality Manager holds bank of tests		
Identify any additional learning needs	Complete reflective practice (Appendix 3) a copy to be held in personal file and retained by yourself as part of professional revalidation process		
Any Other			

Staff member signature		**Date**	
Line Manager signature		**Date**	

Copy to be retained in personal file and copy to staff member

Appendix 3: Reflective Practice Record and Identification of Personal Learning Needs

Reflective Practice Record (based on Gibbs reflective cycle 1998)

Name:
Work base:
Datix reference number:

Description: what happened?
Feelings: what were you thinking and feeling at the time of the incident.
Evaluation: what was good and bad about the experience?

What else was going on at the time of the incident? (eg. Carers or family interruptions)
Analysis: what sense can you make of the situation? (Why did it happen?)
Conclusion: what else could you have done to prevent the incident?
What measures did you take to ensure patient safety following the incident?
Action plan: if the situation arose again, what would you do?
Signature of practitioner:
Date:

Appendix 4: Confirmation of Competency

Shropshire Community Health NHS Trust

Date <insert date> Dear

<insert name>

Medication Incident Level Two/ Serous Incident (< delete >): Confirmation of return to medicines management

Datix reference number:	
Date of incident:	

Following successful completion of the required actions following the above named incident, you may resume full Medicines Management responsibilities required as your Practitioner role.

Yours sincerely,

< Your signature>

<Print name>

<Your job title>

Appendix 5: RCA Template

Medicines Incident Investigation Form
Root Cause Analysis (RCA)

SECTION 1 - *Please note: This section is automatically populated by Datix:*

Datix Ref:

Datix ID: «RECORDID»

Date of incident: «INC_DINCIDENT»

Description:
«INC_NOTES»

Action taken at the time:
«INC_ACTIONTAKEN»

Medication:

Drug Administered	
Error	
High Risk Medication	

Duty of Candour:
- **Does it apply:** «EXTRA138»
- **Verbal notification:** «EXTRA137»
- **Written notification date:** «EXTRA136»

SECTION 2

Duty of Candour (continued)
The Duty of Candour (DoC) is a legal duty to be open and honest with patients, services users or their families. It covers any incident that appears to have caused or has the potential to cause harm. The DoC letter template is available in the 'Templates' section on Datix (left hand side of screen whilst in patient record – select 'Duty of Candour Letter Template' from the list then click 'Merge in MS Word').

- **Was the patient informed of the medication error?**

- **If the patient was informed of the medication error, by whom:**
  - **Staff initials:**
  - **Staff role:**
  - **Date informed:**

- **If the patient was not informed of the medication error, please state reasons why:**

- **If the patient was not informed of the medication error, were the patient's next of kin / carers informed?**

  - **If yes, please state the relationship of the person informed:**

- **If the patient's next of kin / carer was informed of the medication error, by whom:**
    - **Staff initials:**
    - **Staff role:**
    - **Date informed:**

- **Significant events in the chronology:**

Date and Time	Event

- **Other Relevant Information:**

- **What went wrong, what should have happened that didn't or what did happen that shouldn't have (care and service delivery problems):**

- **Good Practice identified:**

- **Why did they go wrong (contributory factors – refer to NPSA information at the end of this form):**

- **Root Cause (Fundamental contributory factor):**

- **What Human Factors have been identified as contributory to the cause of the incident? (E.g. Lack of communication, distraction, lack of resources, stress, complacency, lack of teamwork, pressure, lack of awareness, lack of knowledge, fatigue, lack of assertiveness, norms)**

- **What we are doing about it (consider what steps may be needed to prevent this from happening again):**

- **Actions already taken (to include action taken to address immediate patient safety and action taken to prevent recurrence):**

Learning identified	**What will be done to improve** *Preventative and risk reducing improvements*	**Accountable Owner**	**By When**	**Action sign off** *To be signed off by Head of Nursing when action completed*	**Date**

- **What actions are still required to take place to prevent recurrence?**

Learning identified	**What will be done to improve** *Preventative and risk reducing improvements*	**Accountable Owner**	**By When**	**Progress**	**Action sign off** *To be signed off by Head of Nursing when action completed*	**Date**

Additional points to note (optional):

SECTION 3

Investigator name:

Date report completed:

NPSA Contributory Factors

Use contributory factors to analyse the issues raised in the incident and identified during the process of investigation and analysis. (It is unlikely that all the areas below will be directly correlated to the outcome, but consider all potential factors). The contributory factors identified below can also be formulated as a fishbone diagram

- **Patient factors**, for example;
  - Clinical condition – co-morbidities, complex condition disability etc. which may have contributed to the outcome
  - Physical factors – malnourished, dehydrated, age, obesity etc.
  - Social factors – culture, language, lifestyle, high risk activity.
  - Mental/psychological factors – stress/trauma, mental health, capacity, learning disability
  - Interpersonal relationships – staff to patient, patient to staff, staff to family, family to staff, patient to patient, patient to family, family to patient

- **Staff factors**, for example;
  - Physical issues – poor health, disability, fatigue
  - Psychological issues – stress, mental issues, motivation
  - Social and domestic issues – domestic/lifestyle problems, culture, language
  - Personality issues – confidence, risk taker (look at just culture)
  - Cognitive factors – distraction, overload, boredom
  - Human factors – factors which influence decision making within the team and the environment – Lack of communication, stress, pressure, fatigue, distraction, complacency, lack of awareness, lack of assertiveness, lack of resources, lack of teamwork, lack of knowledge and norms.

- **Task factors**, for example;
  - Guidelines, SOPs, policies & procedures (not up to date, unavailable, unclear, not followed, not reviewed.
  - Decision making aids – not available, difficult in accessing senior advice, incomplete information such as results or patient history
  - Procedural or task design – too complex, too many tasks to perform at one time, misinterpretation of information, inadequate audit/assurance

- **Communication factors**, for example;
  - Verbal communication – inappropriate tone of voice, ambiguous commands, incorrect use of language, incorrect communication channels
  - Written communication – inadequate patient ID, records difficult to read or not available, all information not accessible, communication not received, lack of information for patients
  - Non-verbal communication – confusing or inappropriate body language
  - Communication management – patient/carer not involved in decisions, lack of being open, lack of communication to patients/carers, ineffective communication between staff, ineffective communication with other agencies

- **Team factors**, for example;
  - Role congruence – such as lack of shared understanding, role definitions not understood (can also be part of communication factor)
  - Leadership – ineffective clinical/management leadership, lack of or inappropriate decision making
  - Support and cultural factors – lack of support networks, negative team reaction to adverse events/conflict, routine violation of rules, lack of communication with colleagues, failure to address issues of competence.

- **Education and training factors**, for example;
  - Competence – such as lack of knowledge/skills, inexperience, unfamiliar or rarely performed task, lack of assessment.
  - Supervision – inadequate supervision/mentorship
  - Availability or accessibility of training – i.e. training unavailable, not given access, cancelled

- **Equipment factors**, for example;
  - Visual displays unclear

- Integrity of equipment – not in good working order, poor maintenance, failure of services such as power, water etc.
- Positioning – incorrectly placed or stored
- Usability, poor quality user manual, items have similar names/packaging etc.

- **Work environment factors**, for example;
  - Administrative factors – unreliable systems, unreliable administrative infrastructure/ support.
  - Design of environment – poor office/area design, inadequate security
  - Environment – distractions, ligature points, cleanliness, temperature, lighting, noise levels, breach of single sex accommodation

- **Organisational factors**, for example;
  - Structure – unclear accountability/responsibility, poor governance structure
  - Priorities – not safety driven, financial balance unfocussed
  - External risks – adverse impact of national policy, contractor related, equipment laod related, lack of service provision, bed occupancy
  - Themes, trends or ongoing issues noted from previous incidents – what action had been put into place? Why did the action not prevent reoccurrence

Medicines Competency Example Calculations Assessment

ADMINISTRATION OF MEDICINES ASSESSMENT OF COMPETENCY

Staff Name		Date of assessment	
Designation		Assessor Name	
Department / Site		Result	

No calculator should be used for this test
20 minutes is permitted for this assessment
100% is the required pass mark

1. Express 100milligrams in grams

2. Express 5000micrograms in milligrams

3. Express 2.2L in millilitres

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

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

6. You need to give 7.5mg of drug to a patient but the liquid medicine you have says it is a 15mg/5ml 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?

Human Factors that may affect your performance

Questions to ask:

- How are human factors linked to team behaviours?
- Do any of the human factors indicate a problem with team behaviour?
- If so, how can team behaviour and individual behaviour be modified?

Appendix 8: A Just Culture

A link can be found in references for a clearer copy