Leicestershire Partnership NHS Trust

Medication Error Policy

This policy describes how medication errors are managed. Medication error can include administration, prescribing, monitoring and dispensing.

Key Words:	Medication error, incident, administration, prescribing, dispensing, monitoring	
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Adopted by:	Trust Policy Committee	
Date this version was adopted:	12 October 2021	
Name of Author:	Tejas Khatau	
Name of responsible Committee:	Medication Risk Reduction Group	
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Expiry date:	1 October 2024	
Target audience:	Medical, nursing, pharmacy and any other staff dealing with medicines. Managers of above staff.	
Type of Policy	Clinical √	Non Clinical
Which Relevant CQC Fundamental Standards?	Medicines Management	

Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
Version 2, Draft1	February 2012	City and County CHS Policy harmonised. Incorporated BESS (used by LPT) and Leicestershire Medicine code chapter 17.
Version 2, Draft 2	April 2012	Amendments made following consultation across Divisions. Changes include alterations to the flowcharts to make management of prescribing errors and dispensing errors more robust. Acknowledgement that more work is needed to make the management of prescribing errors more robust.
Version2, Draft 3	April 2012	Following amendments made by the Policy Group; 1. Policy adopted by Quality Assurance Committee 2. Change wording for "Duties within the organisation" 3. Slight change in wording in 5.2 4. Wording in 7 amended to include an audit to monitor compliance and effectiveness
Version 3, Final	February 2013	Updated NHSLA Self Assessment Form
Version 3, draft 1	October 2013	Introduction of an objective scoring system for grading and managing prescribing errors, primarily in the in-patient setting. Addition of appendix 7 – Losses or Discrepancies in

		Community
Version 3, draft 2	August 2015	Section 5.4 updated to take into account thresholds for prescribing errors, notification to line managers/deanery and authority for LPT pharmacist to terminate prescription. Layout of BESS paperwork changed, addition of categories and some scores changed following consultation with various staff. Layout of Policy amended in line with new Policy structure.
Version 4	March 2017	In Roles and Responsibilities, strengthened role of Medicines Risk Reduction Group for management of prescribing errors. Slight change to section 5.4 and appendix 4a to reflect that the prescriber can query or disagree with an error logged against them.
Version 5	August 2018	Updated BESS tool following task and finish group. Education and training section strengthened and scoring for prescribing error brought in line with administration error
Version 6	August 2021	Minor changes to BESS form to bring it in line with Ulysses changes

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area. This applies to all the activities for which LPT is responsible, including policy development and review.

All LPT Policies can be provided in large print or Braille formats, if requested, and an interpreting service is available to individuals of different nationalities who require them.

Did you print this document yourself?

Please be advised that the Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version.

For further information contact:

Head of Pharmacy - 0116 225 3709

Lead Pharmacist for CHS Directorate - 0116 295 6651

Lead Pharmacist for FYPC Directorate - 0116 295 8308

Definitions and abbreviation that apply to this Policy

CASE	Clinical Audit Standards and Effectiveness
BESS	Bennion Error Scoring System
TWMRRG	Trust Wide Medicines Risk Reduction Group
Medication Error	'A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. Such events may be related to professional practice, health care products, procedures, and systems including; prescribing; ordering, communication; product labelling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use'. (The National Coordinating Council for Medication Error Reporting and Prevention)
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

1.0 Summary of Policy

Whilst every care is taken by individuals and the organisation when managing medication, errors involving medicines are inevitable.

This policy describes how medication errors are managed. The policy describes immediate action to ensure patient safety, grading of errors (where appropriate) and longer term actions to ensure that individuals, team, directorate and organisation can learn from errors.

2.0 Introduction

Medication is the most common medical intervention. LPT deals with medicines on a day-to-day basis. LPT has robust polices, training program and audit to ensure that medicines are managed safely. Due to the high volume of activity involving medicines, complexity of the procedures and the human component, medication errors are inevitable.

A medication error can pose a threat to the patient as well as the organisation. The member of staff who made the error can also be affected.

Broadly speaking, medication errors encompass prescribing error, preparation error, dispensing error, administration error and monitoring error.

The procedures in this policy describe how to manage medication errors including immediate actions to consider as well as medium and long term actions.

3.0 Purpose

The principle objectives of this policy are to:

1. Ensure the immediate and long term safety of the patient;
2. 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;
3. Identify any factors that may have contributed to the error (e.g. team, staffing, level of noise etc…)
4. Support managers when dealing with staff who have made an error;
5. Provide a framework for grading errors so that staff are dealt with fairly and consistently;
6. Ensure that the organisation can learn lessons from the error in order to minimise such occurrence in the future.

4.0 Duties within the Organisation

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

4.2 The TWMRRG monitors <u>all</u> medicine related incidents across the LPT; detect trends and clusters of activity. The Group ensures that lessons are learnt from such incidents and that this information is then disseminated to all those who may benefit

from it. TWMRRG analyse prescribing errors amongst inpatient clinicians and determines what actions are taken based on pre-agreed thresholds. The TWMRRG will escalate any issues it considers appropriate to the Trust Patient Safety Group.

4.3 Directors and Heads of Service are responsible for ensuring that there are appropriate resources provided within their service area to implement and adhere to the policy.

4.4 The Directorate Patient Safety sub groups or equivalent group will monitor adverse incidents across all service areas including aggregate analysis and identify any trends and themes. This includes advising the directorate management team on significant areas of risk through their local governance reporting mechanisms.

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4.5 Managers and Team leaders will be responsible for:

- Ensuring this policy is implemented in their area of responsibility.
- Manage medication errors in line with this policy
- Ensuring that their staff are appropriately trained in line with the requirements of this policy;

4.6 Responsibility of Staff:

It is the responsibility of staff who manage medicines to ensure that they are familiar with this policy, particularly the immediate actions to take when a medication error is identified.

4.7 Managing medication errors will be part of the medicines management training. Relevant staff will be expected to undertake medicines management training at least every three years as part of the mandatory training. Refer to the training needs analysis for full details

5.0 Medication Error

5.1 What Constitutes a Medication Error (not an exhaustive list)

Prescribing Errors

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

Dispensing Errors

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

Preparation and Administration Errors

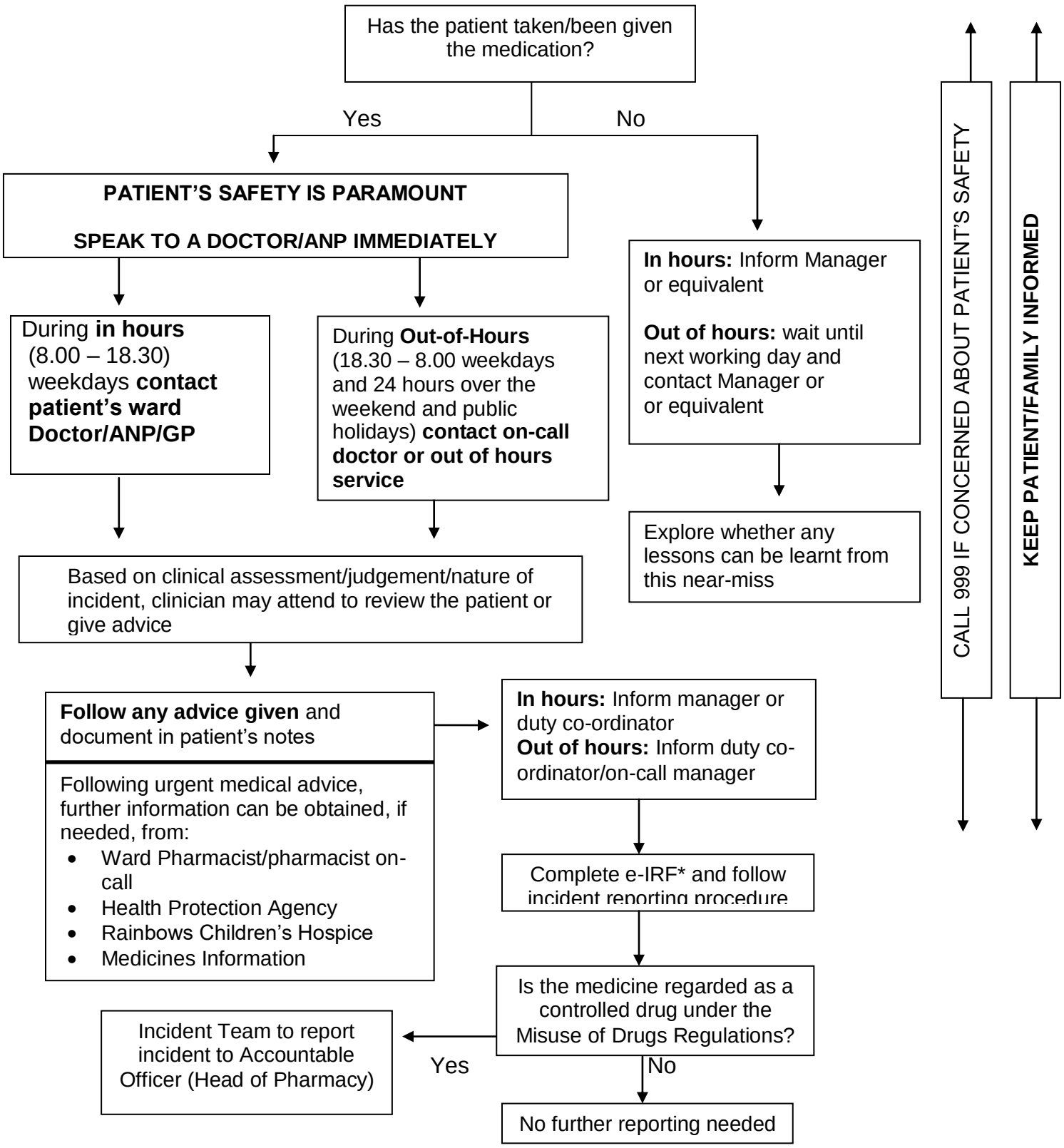
- Administration without a valid authorisation
- Patient administered the wrong medication / dose / route
- Patient administered an out of date medicine
- Medication administered to the wrong patient
- Medication omitted without a clinical rationale
- Medication incorrectly prepared
- Incorrect infusion rate
- Inappropriate use of “prn” medicines
- Medication administered late / early*****

*****(LPT 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)

Monitoring Errors

- Inappropriate monitoring/follow up
- Failure to monitor therapeutic levels
- Failure to monitor patients / carers self medication

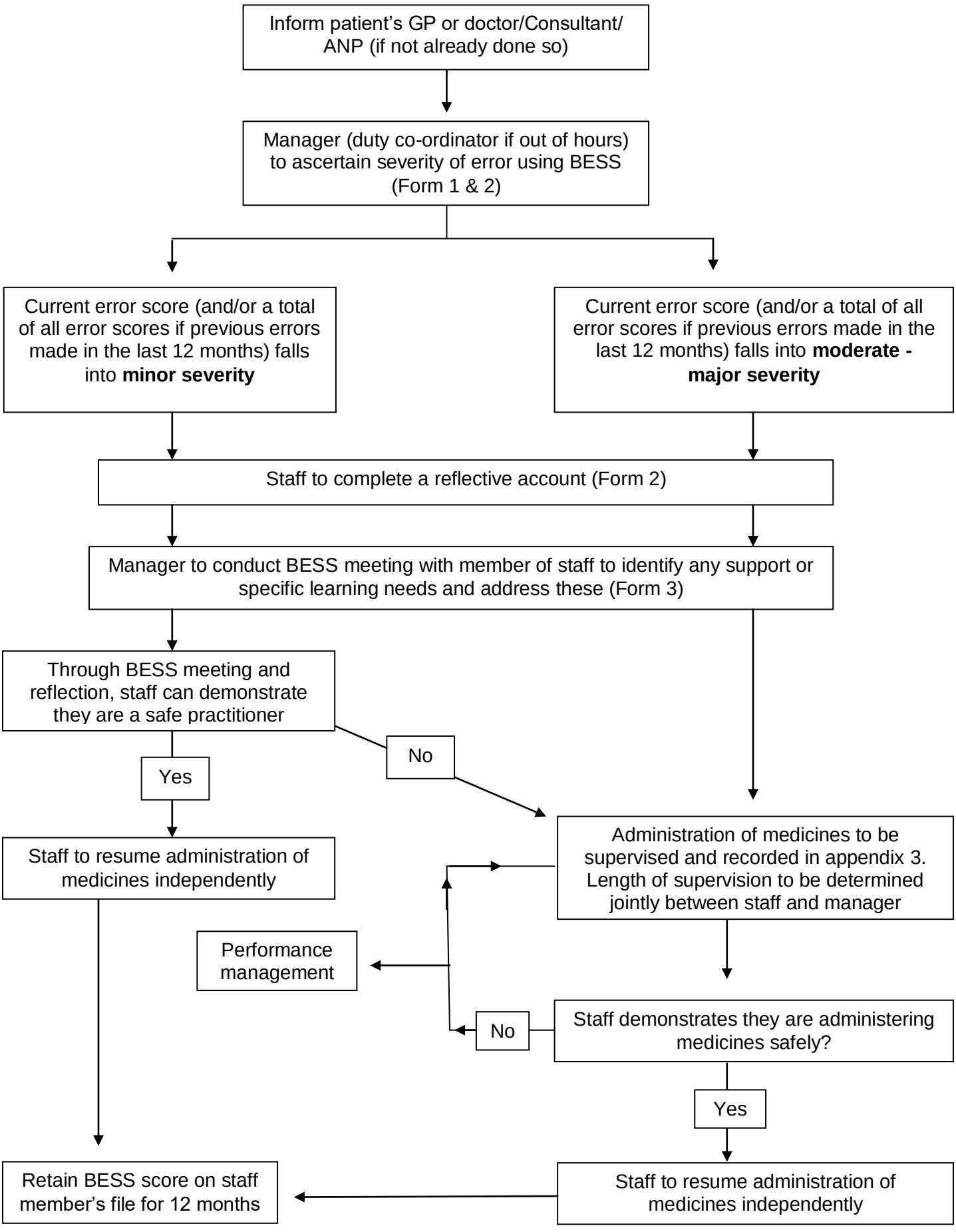
5.2 Immediate Actions When Medication Administration Error/Near Miss Identified



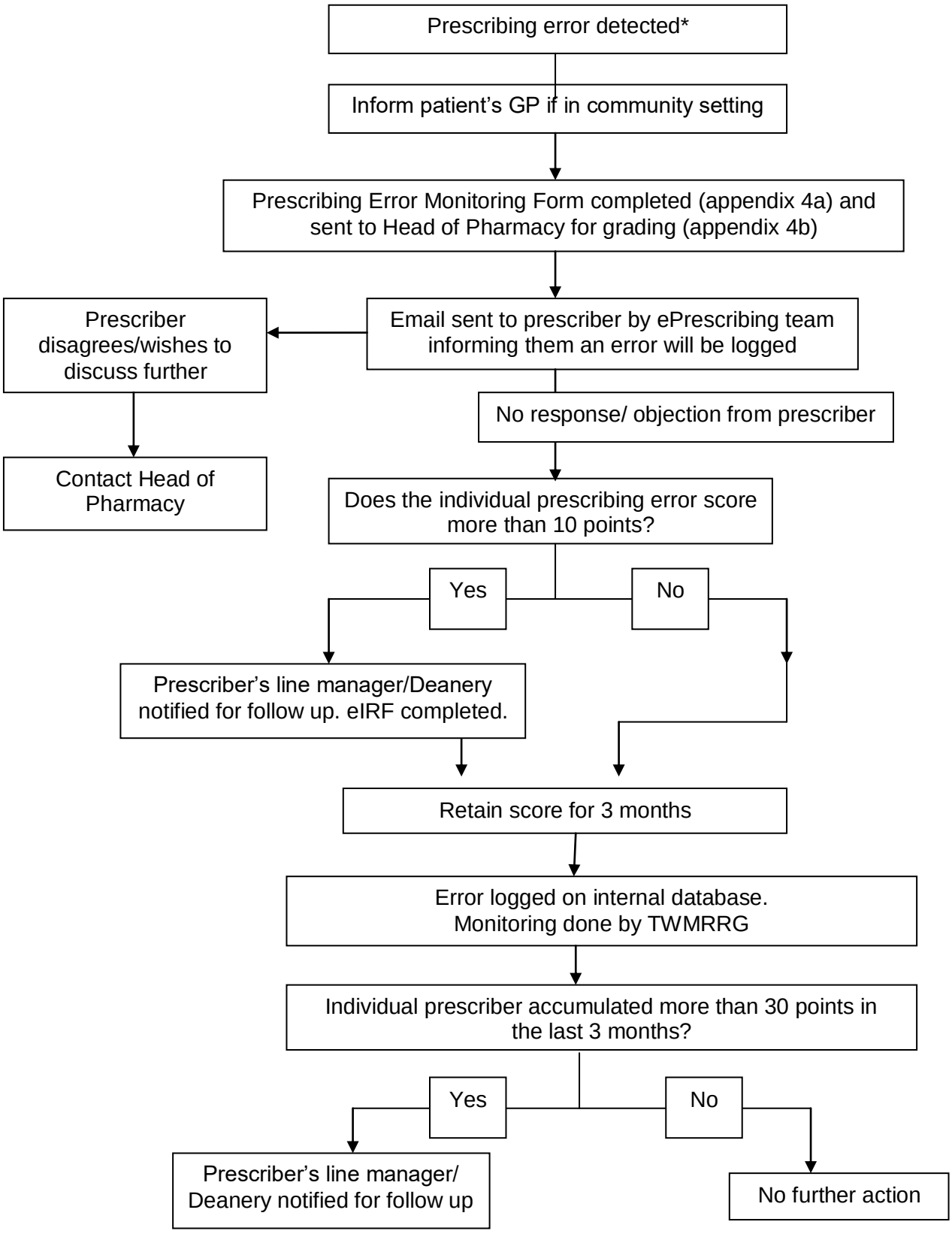
NOTE: do not delay in contacting others in the algorithm if the initial person is proving hard to reach.

*** eIRF does not need completing for all prescribing errors – see 5.4**

5.3 Management of <u>Administration</u> Error (using BESS tool – see appendix 2)

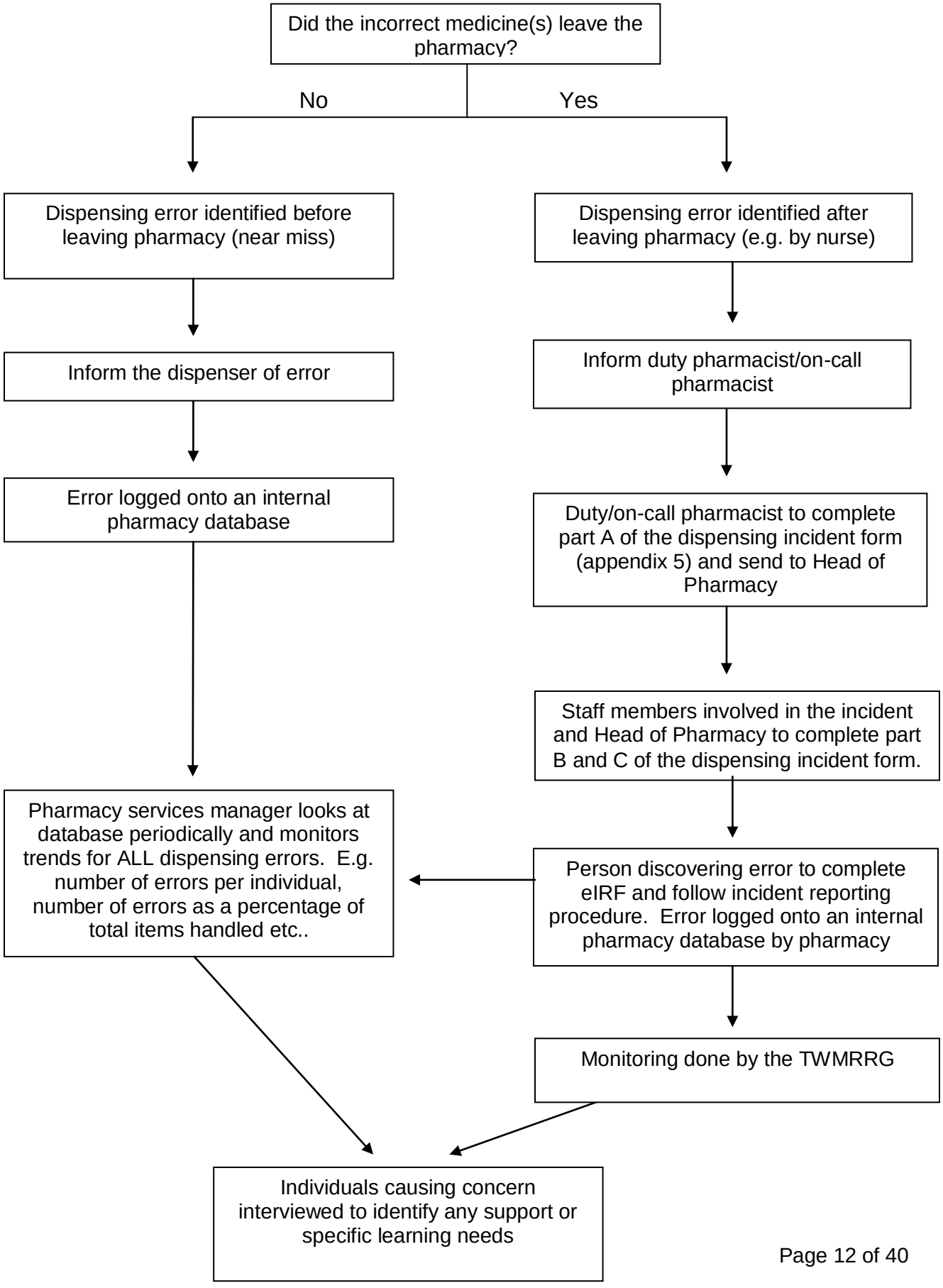


5.4 Management of Prescribing Error



***In exceptional circumstances LPT pharmacist can terminate the prescription if that is in the patient's best interest.**

5.5 Management of Dispensing Error



5.6 Management of Member of Staff Making Medication Error

Human error is inevitable. A member of staff who has been practising successfully does not suddenly become incompetent or unsafe after a single medication error. However, for an error to occur an important step in the process would have to be omitted and there is a potential for this to recur if the cause is not identified. It is therefore vital that the line manager and member of staff who made the error identify exactly what went wrong, how and take steps to rectify this.

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

Minor prescribing errors (such as poor legibility or failure to use capital letters) can be pointed out to the member of staff and corrections made. Repetitive errors of this kind should be reported to the prescriber's line manager.

Carrying out supervised practice can provide assurance that staff who made the error is following correct procedures. The method and length of supervised practice will depend primarily on the severity of the error and/or potential for harm. Other factors to consider include availability of support staff to supervise, insight of the member of staff as detailed in their reflective account (appendix 2, Form 3)), circumstances surrounding the medication error, confidence of the member of staff and any previous incidents. The method and length of supervised practice should ideally be decided in partnership between the line manager and staff who made the medication error. At the end of the supervised practice both parties must be confident that the member of staff has changed his/her practice so that the likelihood of future medication error is minimal. Tool in appendix 3 must be used when supervising/ assessing member of staff following administration error.

If repeated errors occur by the same member of staff despite all efforts from the Trust to provide additional training and other measures deemed necessary, the line manager should seek advice from the Clinical Governance Lead, their professional lead and Human Resources. Together they will consider the options open to them to protect patients from harm. This may include, but not limited to, the recourse to manage the member of staff using the LPT Performance Management Policy and Procedure and/or LPT's Disciplinary Policy and Procedure.

5.7 Reflection for Member of Staff Making Medication Error

The member of staff should be encouraged to write a written account of the events leading up to, during and after the incident. This can help the member of staff and line manager identify what went wrong, how and why. This is also a useful source of information during the investigation. A tool to do this is in appendix 2 (Form 3).

5.8 Informing Patient/Parent

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.

The patient should be informed by nurse in charge, line manager or the doctor in charge of the patient's care at that moment in time. If appropriate an apology should be given, acknowledging that an apology is not an admission of liability.

If appropriate, following the investigation, a meeting should be offered to the patient and/or relatives with the relevant clinician(s) / personnel. The purpose of such a meeting would be to discuss the findings of the investigation, share the lessons learned and outline the recommendations put into place to reduce the risk of a similar incident re-occurring in the future. Refer to the Duty of Candour Policy for more information.

5.9 Medium to Long Term Actions following 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, directorate and the organisation must learn lessons from the error to ensure that such occurrence is minimised as far as possible. Where directorate governance mechanisms identify themes and trends in medication error incident reporting, local action will be taken in addition to the escalation as described in point 4.4. This may include escalation outside of the directorate to the TWMRRG. The TWMRRG monitor trends across LPT. Following trend analysis, recommendations or actions will be made by these groups to the appropriate areas of the organisation.

6.0 Management and Implementation

This policy will be implemented and disseminated throughout the organisation, in accordance to the post ratification process. Following approval the policy will be catalogued in the Trust register of Policies and posted on the intranet.

It is the responsibility of the Service Lead to ensure that staff are familiar and compliant with this policy and have documented evidence of this.

7.0 Training Needs

All staff required to manage administration errors will receive a one-off face-to-face training from a member of the pharmacy team or individual approved by the pharmacy team to deliver the training.

8.0 Monitoring Compliance and Effectiveness

The Directorate Patient Safety and Experience sub groups or equivalent group will monitor adverse incidents across all service areas of their directorate including aggregate analysis and identify any trends and themes. This includes advising the

directorate management team on significant areas of risk through their local governance reporting mechanisms. The TWMRRG will also obtain reports on medication errors. This group, supported by directorate Patient Safety and Experience sub group or equivalent will ensure that themes are identified and the organisation learns from medication incidents.

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
5.3	Spot check for administration errors	BESS process followed	Search on Safeguard	Policy Author, TWMRRG	Annual
5.4	Spot check for prescribing errors	Flowchart followed	Search internal database	Policy Author, TWMRRG	Annual
5.5	Spot check for dispensing errors	Flowchart followed	Search internal database	Policy Author, TWMRRG	Annual

References and Associated Documentation

Cobbs, D and Davis, M 1986. Evaluating Medication Errors, *Journal of Nursing Administration,* 16 (4) pp.41-44.
Incident Reporting Policy
Performance Management Policy and Procedure
Disciplinary Policy and Procedure
Duty of Candour Policy (Incorporating being Open Principles)

Appendix 1

Stakeholders and Consultation

Circulated to the following individuals for comments

Name	Designation
Anthony Oxley	Head of Pharmacy
Joanne Charles	Lead Pharmacist CHS Directorate
Rachel Calton	Pharmacist
Robyn McAskill	Pharmacy Clinical Services Manager
Joanne Wilson	Lead Nurse – FYPC Directorate
Claire Armitage	Lead Nurse – Adult Mental Health Directorate
Vicki Spencer	Clinical Governance Lead – FYPC Directorate
Heather Darlow	Clinical Governance Lead – CHS Directorate
Jacquie Burden	Clinical Governance Lead – Adult Mental Health Directorate
Jenny Dolphin	Clinical Governance Manager - AMH
N O' Kelly	Clinical Director – CHS Directorate
Helen Burchnall	Clinical Director – FYPC Directorate
Caroline Barclay	Nurse Consultant – CHS Directorate
M Al-Uzri	Clinical Director – Adult Mental Health Directorate

BESS Task and Finish Group

Name	Designation
Anthony Oxley	Head of Pharmacy
Joanne Charles	Lead Pharmacist CHS Directorate
Tejas Khatau	Lead Pharmacist FYPC Directorate
Rebecca Mitchell	Ward Matron
Jenny Dolphin	Clinical Governance Manager AMH Directorate
Roshnee Gill	Ward Manager
Jodhun Persand	Acting Ward Matron
Lynn Wroe	Team Leader
Christine Ives	Leicester University

Appendix 2

Bennion Error Scoring System (BESS) Paperwork

Introduction

The Bennion Error Scoring System must be applied to medication administration errors made by staff. It is a simple, easy to follow process. It is derived from The El Dorado Medication Error Tool (D Cobb and M Davis, 1986). It should not be used to assess other kinds of medication incidents.

Where possible this process should be undertaken by the line manager in the presence of the member of staff who has made the error but could be conducted over the telephone if necessary. Line managers must be trained in the application of the tool before using it.

All incidents where a BESS score is required should also have been entered as IRFs. Please note that Form 1 and Form 3 are to be completed on Ulysses only (it is in this policy for illustration only). Once both of these forms are completed on Ulysses, you can print them and combine with Form 2 before putting into the individual's personal file.

Remember to inform the patient that a medication incident has occurred.

It is essential that confidentiality is maintained at all times. Only the member of staff who has made the error should be informed of the score at the time (although scores will be archived centrally and will be reviewed by the medicines management/governance teams after the fact) unless the error results in actual physical harm to the patient and immediate medical interventions are required i.e. transfer to A & E. In such cases the incident may well have to be investigated as a Serious Incident and appropriate actions therein that may be necessary. Under these circumstances the following should contacted:

Monday – Friday 09.00 – 17.00. Matron

Out of these office hours – Duty co-ordinator/on call manager

Overview of Steps to Complete BESS and Ulysses

Activity	Person Responsible for completion
Complete an eIRF	Whoever discovers the error
Complete 'BESS Error Reporting Form' (Form 1) on Ulysses only. Print a completed copy to put into the individual's personal file.~~;~~	Line manager/senior member of staff
Complete 'Reflection on Incident' (Form 2) on paper.	Staff member who made the error
Complete 'BESS Meeting and Outcome' (Form 3) on Ulysses only. Print a completed copy to put into the individual's personal file	Line manager/senior member of staff (with staff member who made the error)
Add BESS score and outcome on eIRF	Line manager/senior member of staff
Scan any other associated paperwork on eIRF	Line manager/senior member of staff

Stage 1 – Error Category

The tool is underpinned by the Leicestershire Medicine Code and an error is judged to have occurred when the person administrating has deviated from this code.

The tool should be used to score errors in the following categories:

Wrong time
Wrong date
Wrong patient
Wrong route
Wrong medication
Wrong formulation
Wrong dose
Extra dose
Medication omitted (without medical guidance or clinical justification from nurse) provided it is clear that an individual is implicated
Medication given when allergy stated
Medication given without legal authorisation (T2/T3/C6 or unsigned prescription)
Expired drug
Presence of a known contra-indication

Stage 2 – Route given

The scoring system for this stage is based upon 2 factors

1) The absorption rate
2) The reversibility of effects

IV
I/M or S/C
Oral/entracheal/nebuliser
Topical
PV or PR
Sub Lingual.

Stage 3 – The drug administered in error

The attributed scores for each category of drug reflect the potential harm that could result were the drug to be administered inappropriately.

Scoring of second qualified member of staff, if involved in an error

For an injection or a Controlled Drug the nurse administering the injection/drug and the nurse checking the injection/drug are both deemed to be equally responsible for the error. Two sets of documentation must be completed - one for each nurse.

Scoring errors involving more than 1 member of staff

If an error is reported to the co-ordinator and it is noted that previous nurses have made the same error e.g. omission of medication over a number of days; one BESS score should be calculated which will be attributable to all staff involved.

Scoring when nurse has made more than one error in the last 12 months

The BESS scores from all previous errors made in the last 12 months should be added to the most recent BESS score. The accrued BESS score should be used when deciding on the severity of error. Example: Nurse A has a BESS score of 7 on file owing to an error made in the last 12 months. If same nurse makes another error also scoring 7, although the most recent error is in the low severity, the accumulation of the two BESS scores results in high severity and therefore must be managed as such.

Scoring of error involving more than one medicine

The medication with the highest BESS scoring should be selected.

Errors not scored under BESS

1. **Incidents involving dietary supplements in food or fluid preparations e.g. Fortisip.**

Errors are not to be reported unless the patient suffers an adverse reaction.

2. **IV fluids are only scored under BESS in the following circumstances:**

- Wrong medication, wrong patient or wrong dose
- Medication omitted
- Medication given when allergy stated
- Medication given against an unsigned prescription

In cases where the fluid has not run through in the identified time e.g. too fast or too slow, do not score under BESS.

3. **Medication administration issues involving T2/T3 forms**

An IRF should be completed but not a BESS score.

BESS Error Reporting Form (Form 1)
(to be completed on Ulysses only)

IRF Number:

Staff involved: See IRF

Staff Level at the Time of Incident

	Planned Staffing	Actual Staffing	Number of Bank/Agency staff
Number of Registered staff:			
Number of non-registered staff:			

For handwritten Prescription/authorisation, was it clear and legible (circle)? (if 'No' enclose a copy)	Yes	No	N/A
For incidents in in-patient areas was the nurse carrying out the drug administration round wearing a tabard indicating she was not to be disturbed?	Yes	No	N/A
Drug name, dose and formulation identifiable from manufacturer's box/pharmacy label (circle)?	Yes	No	
For incidents in in-patient areas, was the patient wearing a wrist band (circle)?	Yes	No	N/A

Form Completed by (name and signature):	Date: / /

BESS Rating Scale

ERROR CATEGORY	POINTS AWARDED
WRONG TIME	1 POINT
WRONG DATE	1 POINT
WRONG PATIENT	3 POINTS
WRONG ROUTE	2 POINTS
WRONG MEDICATION	3 POINTS
WRONG DOSE	2 POINTS
EXTRA DOSE	2 POINTS
MEDICATION OMITTED	2 POINTS
MEDICATION GIVEN WHEN ALLERGY STATED	3 POINTS
MEDICATION GIVEN WITHOUT LEGAL AUTHORISATION (E.G. UNSIGNED PRESCRIPTION)	1 POINT
WRONG FORMULATION (E.G. LIQUID, TABLET ETC…)	1 POINT
EXPIRED DRUG	2 POINTS
PRESENCE OF A KNOWN CONTRAINDICATION	3 POINTS

Medication Classification (if in doubt of what classification a drug belongs to, please look up in the BNF)

Topical drugs & ENT Antacids. Anti-motility medicines Antidiarrhoeal agents Laxatives Vitamins & Minerals Peripheral vasodilators Anti-platelets Lipid-regulators Leukotriene receptor antagonist Anti-histamines Mucolytic Cough preparations Orlistat Paracetamol Acamprosate NRT	Antidementia drugs. Non-MAOI Antidepressants Anti-inflammatory agents Endocrine system drugs (not listed elsewhere) Hypnotics and anxiolytics Ulcer healing drugs Diuretics Nitrates/anti-anginals Dihydopyridine Calcium channel blockers Inhaled broncodilators and steroids Oral salbutamol Pseudoephedrine CNS stimulants Disulfuram Oral penicillin, cephalosporin and trimethoprim Contraceptives Allopurinol/colchicine Eye preparations	Antibiotics/anti-infectives.(not listed elsewhere) Antipsychotic agents Barbiturates Narcotic antagonists Oral antidiabetic agents Oral steroids Glucose infusion/glucagon Management of inflammatory bowel disease Beta-blocker Centrally acting vasodilators & anti-hypertensive Alpha-blockers ACEI and ARB Diltiazem Non-antihistamine anti-emetics Drugs for genito-urinary disorders Vaccines	Oral anti-coagulants (except warfarin) LMWH Thrombolytic agents. Antiarrythmics including digoxin, verapamil Narcotic analgesics Electrolytes Any IV agents MAOIs Anti-epileptics Parkinsons medication Aminoglycosides Anti-virals Penicillinamine/gold Ciclosporin, Leflunomide and tacrolimus Cytokine modulators	Warfarin & Heparin Blood & blood components Chemotherapeutic & Antineoplastic agents Insulin Clozapine Lithium
1 point	**2 points**	**3 points**	**4 points**	**6 points**

Add 2 points if in under 18 year old

ROUTE GIVEN	POINTS AWARDED
I/V, I/M OR S/C	3 POINTS
ORAL (INCLUDES PEG, JEG ETC…)	2 POINTS
TOPICAL (INCLUDING EYE/EAR/NOSE DROPS)	1 POINTS
INHALED	1 P0INT
RECTAL OR VAGINAL	1 P0INT
SUB LINGUAL	1 POINT

BESS category (provide details)	Points score
Error category:	
Route Given:	
Medication classification (if more than one medicine involved, use highest scoring medication classification):	
Total	

Form Completed by (name and signature):	Date: / /

Name and signature of staff member:	Date: / /

Interpretation of Score and Outcome

TOTAL POINTS SCORE (if more than one error, accumulate score from past 12 months)	OUTCOME
LOW SEVERITY CATEGORY (3 – 7 POINT)	**Staff member involved in error can continue to administer medication.** **NB: Through their reflection and meeting, staff member must demonstrate that they are a safe practitioner. If there is any doubt, the manager can ask the member of staff to undertake supervised practice, even though their points score falls in the 'low severity' category.** • Completion of 'Reflection on Incident' form and BESS meeting with line manager. • Score retained on file for 12 months.
HIGH SEVERITY CATEGORY (8 POINTS OR MORE)	**Staff member involved in error must not continue to administer medication.** • 'Reflection on Incident' Form and BESS meeting must be completed • Supervised practice i.e not to administer medication without supervision from another qualified nurse • Score retained on file for 12 months.

Reflection on Incident (Form 2)
(completed on paper and taken with you for your BESS meeting)

Describe the context of the error (e.g shift, time of day, staff resources, activity levels etc)

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Provide a detailed description of the circumstances surrounding the error i.e describe the period immediately before and during the error. Continue on a separate sheet if required.

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Do you feel there were any personal issues that were affecting you on the day of the incident?

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What factors did you feel contributed to the error (e.g. distraction, interruption, fatigue, workload, lack of support, stress, patient disturbance)?

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How do you feel a similar error could be avoided in the future?

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What have you learnt from this error?

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Staff name and signature:	Date: / /

BESS Meeting and Outcome (Form 3) – to be completed on Ulysses only by the person conducting the BESS interview

Staff name:

BESS score:
Total of BESS score accrued in last 12 months (where applicable):

Any comments on the 'Reflection on Incident' (Form 2)? E.g. Anything missing from form, anything not supported by other data

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Good practice areas identified/ required

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Agreed action to be taken by individual

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Action points identified for care environment/service/trust

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Can the practitioner resume their role without further supervision/assessment of competence (look at 'Interpretation of Score and Outcome', consider reflection and information/observation in meeting)?

Yes ☐ No ☐

Line manager to provide rationale if above outcome differs from 'Interpretation of Score and Outcome'

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Form Completed by (name and signature):	Date: / /

Name and signature of staff member:	Date: / /

Appendix 3

Administration of Medicines - Record of Supervised Practice

Name of staff:……

Episode No	Route	Date	Medication	Supervisors Signature	Competent	Not competent

Appendix 4a

PRESCRIBER ERROR MONITORING FORM

This form is only to be used for prescribing errors that are detected before administration of incorrect medication to a patient. In cases where incorrect medication has been administered, the standard Trust incident form (IRF) should be completed. The doctor should be informed that a potential error has occurred and accept that a mistake has been made before completion of the form. The form is not to be used to record disagreements about drug choice, dosage etc. where the prescriber has written a correct and legally valid prescription.

Prescription Type	
Clozapine escalation chart	
Depot card	
Detox chart	
Discharge Prescription	
Electronic Prescription (Inpatient)	
Electronic Prescription (Outpatient)	
Standard Trust Prescription (Five day emergency card)	
Warfarin chart	

Error	
Conflicting dose information	
Drug contra-indicated due to allergy	
Drug Interaction	
Drug not discontinued	
Drug prescribed as PRN but should be regular	
Duplicate prescription	
Incomplete PRN details	
Incorrect dose	
Incorrect dose time	
Incorrect drug	
Incorrect duration of treatment	
Incorrect formulation	
Incorrect frequency	
Medication not covered by T2/T3 MHA Forms	
Medication omitted	
Misdated prescription	
Missing route of administration	
Therapeutic duplication	
Other (please state)	

Prescriber	Detected by
Name:	Name:
Signature:	Signature:
Date:	Date:

Action suggested by eP Technician to minimise occurrence i.e. system defaults

Once complete the form should be returned to Anthony Oxley, Pharmacy Department, Glenfield Hospital

Appendix 4b

GRADING PRESCRIBING ERRORS

Prescribing Error Grade = Medication Classification X Type of Error

Medication Classification (if in doubt of what classification a drug belongs to, please look up in the BNF)

Topical drugs & ENT Antacids. Anti-motility medicines Antidiarrhoeal agents Laxatives Vitamins & Minerals Peripheral vasodilators Anti-platelets Lipid-regulators Leukotriene receptor antagonist Anti-histamines Mucolytic Cough preparations Orlistat Paracetamol Acamprosate NRT	Antidementia drugs. Non-MAOI Antidepressants Anti-inflammatory agents Endocrine system drugs (not listed elsewhere) Hypnotics and anxiolytics Ulcer healing drugs Diuretics Nitrates/anti-anginals Dihydopyridine Calcium channel blockers Inhaled broncodilators and steroids Oral salbutamol Pseudoephedrine CNS stimulants Disulfuram Oral penicillin, cephalosporin and trimethoprim Contraceptives Allopurinol/colchicine Eye preparations	Antibiotics/anti-infectives.(not listed elsewhere) Antipsychotic agents Barbiturates Narcotic antagonists Oral antidiabetic agents Oral steroids Glucose infusion/glucagon Management of inflammatory bowel disease Beta-blocker Centrally acting vasodilators & anti-hypertensive Alpha-blockers ACEI and ARB Diltiazem Non-antihistamine anti-emetics Drugs for genito-urinary disorders Vaccines	Oral anti-coagulants (except warfarin) LMWH Thrombolytic agents. Antiarrythmics including digoxin, verapamil Narcotic analgesics Electrolytes Any IV agents MAOIs Anti-epileptics Parkinsons medication Aminoglycosides Anti-virals Penicillinamine/gold Ciclosporin, Leflunomide and tacrolimus Cytokine modulators	Warfarin & Heparin Blood & blood components Chemotherapeutic & Antineoplastic agents Insulin Clozapine Lithium
1 point	**2 points**	**3 points**	**4 points**	**6 points**

Type of Error

Examples of Type of Prescribing Error	Potential or actual impact	Grade
Legal/Procedural Error		
Incomplete information (e.g. no dose, frequency, route, time)	Potentially problematic	1
Mis-spelt drug name		
Incorrect formulation (e.g. tablet prescribed instead of liquid, ordinary tablets prescribed instead of controlled release)		
No indication on prn medication		
Errors with little chance of being carried out (e.g. digoxin 250mg prescribed instead of micrograms)		
Medication prescribed at the wrong time of the day (e.g. zopiclone prescribed in the morning)		
No maximum dose for prn medicines	Mild/moderate	2
Unintentional duplicate therapy (e.g.2 drugs with the same mode of action/from the same family/with the same effect)		
"black dot" interaction without justification, appropriate monitoring or contingency in place (e.g. NSAID prescribed to a patient taking Lithium without plan to monitor levels)		
Drug – disease interaction without justification (e.g. NSAID in a patient with CKD level 4, LMWH in patient with bleed)		
Regular medication not prescribed unintentionally		
Sub-therapeutic dose (e.g. flucloxicillin 500mg BD)		
Incorrect dose(but within BNF limit)		
Incorrect frequency		
Inappropriate length of therapy (e.g with antibiotics)/failure to stop therapy		
Drug unintentionally prescribed as regular and prn		
Wrong route		
Completely incorrect drug prescribed	Serious	3
Incorrect dose (but above BNF limit)		
Drug prescribed which the patient has a documented SEVERE allergy to (e.g. Augmentin for a patient with penicillin allergy)	Severe or fatal	4
Weekly drug prescribed daily (e.g. methotrexate)		

Add 2 points if in under 18 year old.

Appendix 5

LEICESTERSHIRE PARTNERSHIP N.H.S. TRUST

DISPENSING INCIDENT FORM

This form is to be used for all dispensing incidents that have left the control of the pharmacy. Errors that have been picked up by the checking process should be recorded on the internal error form.

The member of staff who is notified of or discovers the error should complete Part A of the form as soon as possible. The form should then be passed immediately to the Associate Director: Medicines Management who will ensure that parts B and C are completed by the relevant individuals.

A copy of the completed form should be retained in the Associate Director : Medicines Management's office and details of the error entered in the dispensing error log.

Part A Your Name: Job Title:

Date when incident reported to pharmacy:

Date of Incident:

Name and Job Title of person reporting incident:

Description of Incident (patient's name, what was wrong, did patient receive incorrect medication, did patient suffer harm and initial response by pharmacy to the incident)
If possible retain the erroneous item with this form.

Part B Medication Dispensed by (Name and Job Title)

Comments by dispenser including circumstances of error

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Medication Checked by (Name and Job Title)

Comments by checker including factors contributing to error

Part C Comments by the Associate Director : Medicines Management

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Changes in procedures required:

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……

Category of Incident

Section A: Source of Patient

01 = INPATIENT
02 = OUTPATIENT
03 = TTO OR LEAVE

Section B: Outcome

01 = No risk to patient
02 = risk of under treatment
03 = risk of high dose within BNF limits
04 = risk of dose above BNF limits
05 = demonstrable harm to patient
06 = death of patient

Section C: Error Category

Contents Incorrect

01 = wrong drug
02 = wrong strength or dose form
03 = wrong quantity
04 = out of date stock
05 = item omitted

Label Incorrect

06 = wrong drug name
07 = wrong drug strength or form
08 = wrong directions
09 = wrong quantity
10 = wrong ward
11 = wrong expiry date
12 = wrong patient name

Other

13 = Drugs given to incorrect patient
14 = Incomplete/incorrect additional labelling

Appendix 6

HIGH RISK MEDICATIONS WITH RESPECT TO OMISSIONS

ALFUZOSIN
ANALGESICS
ANTI-ANGINA MEDICATION
ANTI-ARRHYTHMICS
ANTIBIOTICS
ANTI-DIABETIC MEDICINES INCLUDING INSULIN
ANTI-EMETICS
ANTI-EPILEPTICS
ANTI-HYPERTENSIVES
ANTIMUSCARINICS
BENZODIAZEPINES FOR DETOX PATIENTS
BUPRENORPHINE
CLOZAPINE
DRUGS FOR PARKINSON'S DISEASE
DUTASTERIDE/FINASTERIDE
ESTABLISHED ENTERAL FEEDS
EYE-DROPS FOR GLAUCOMA AND UVEITIS
HIV MEDICATIONS
HYPOSTOP/GLUCAGON
IV/SC FLUIDS
LOW-MOLECULAR WEIGHT HEPARINS
METHADONE
NEUTROPENIA TREATMENTS
ORAL CONTRACEPTIVES
OVERDOSE REVERSAL AGENTS
PHYTOMENADIONE
PYRIDOSTIGMINE
QUININE SULPHATE
ASTHMA TREATMENTS
SHORT COURSE / DAILY REPLACEMENT STEROIDS
VENLAFAXINE, PAROXETINE, SERTRALINE
VITAMINS B & C BPC INJECTION
WARFARIN

Appendix 7

LOSSES OR DISCREPANCIES – COMMUNITY

Controlled Drugs

When a discrepancy between the balance on the Controlled Drug Record Card (CDRC) and the actual stock is noticed this **must** be investigated by the registered nurse taking the following steps.

Step	Action required	Action completed (√)
1	Report to the line manager and request a second checker.	
2	**Check for the following :** • Additions/Subtractions recorded on the CDRC for accuracy	
	• Any missing records following administration by the nurse/GP/OOHs/other supporting services.	
	• Any breakage or spillage that has not been recorded	
	• That stock has not been put into the wrong box or misplaced.	
	• Consider the possibility of a pharmacy dispensing error if additional supplies have been received into the community setting since the last correct check and if appropriate contact the dispensing pharmacy for further information.	
3	Report the incident on Safeguard	
4	Inform line manager of the outcome to the investigation If the discrepancy is resolved – **no further action.**	
5	If the discrepancy is still unresolved the nurse or their line manager must also inform: • The patient • The Community Services Matron • The Local Police (& obtain a crime reference number) • The Head of Pharmacy • If OOHs the On-call manager and **on-call pharmacist (for discussion)**	
6	Any further requirements for investigation by the nurse will be agreed in conjunction with the Lead Nurse for Community Services.	

Other Medicines in the Patient Home

If the registered nurse is alerted by the patient, or by other means, to the **possible loss of medication which causes concern**, the nurse should make an incident report and inform the prescriber. The nurse should then discuss with their manager to decide if any further action is required.

Appendix 8

NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	☐✓
Respond to different needs of different sectors of the population	☐✓
Work continuously to improve quality services and to minimise errors	☐✓
Support and value its staff	☐✓
Work together with others to ensure a seamless service for patients	☐✓
Help keep people healthy and work to reduce health inequalities	☐✓
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☐✓

Appendix 9

Due Regard Screening Template

Section 1	
Name of activity/proposal	Medication Error Policy
Date Screening commenced	04/04/2017
Directorate / Service carrying out the assessment	FYPC
Name and role of person undertaking this Due Regard (Equality Analysis)	Tejas Khatau – Lead Pharmacist and Policy Author
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The purpose of this policy is ensure medication errors are managed promptly, safely and fairly.	
OBJECTIVES: The policy is intended to provide framework on how various medication errors are managed within the Trust	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	No negative impacts identified.
Disability	No negative impacts identified.
Gender reassignment	No negative impacts identified.
Marriage & Civil Partnership	No negative impacts identified.
Pregnancy & Maternity	No negative impacts identified.
Race	No negative impacts identified.
Religion and Belief	No negative impacts identified.
Sex	No negative impacts identified.
Sexual Orientation	No negative impacts identified.
Other equality groups?	No negative impacts identified.

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No ✓	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	✓

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
No negative impacts were identified with regards to the protected characteristics.			
Signed by reviewer/assessor	Tejas Khatau	**Date**	04/10/21
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

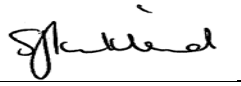
Appendix 10

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**Medication Error Policy**	
Completed by:	**Tejas Khatau**	
Job title	**Lead Pharmacist – FYPC Services**	**Date 7/10/2021**

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	N	If an error at any level is made, information will be collected and stored, either in the staff members' personal file or electronic database. This is not 'new' information as this process has been established for a number of years and only essential information pertaining to the incident is held. This would not be classed as excessive.
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	N	Following an administration error, staff will be asked to do a reflection on the incident. This would not be classed as excessive.
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	Y	Possibly yes. Information could be shared with individuals within LPT for the purpose of understanding themes and triggers for medication errors.
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	Y	As point 3 above
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	N	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	Y	It describes the thresholds and action to take following medication errors.
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	Y	Possibility. As part of the staff members' refection, they could highlight personal circumstances that contributed to the error
8. Will the process require you to contact individuals in ways which they may find intrusive?	N	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt.dataprivacy@nhs.net **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**	
Data Privacy approval name:	Sam Kirkland, Head of Data Privacy 
Date of approval	**07/10/2021**

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust