MEDICINES – MANAGEMENT OF ERRORS, INCIDENTS OR NEAR MISSES.

1.0 Preamble

1.1 The Hospice Clinical Governance Committee supports the guidance regarding error management that is found in The Nursing and Midwifery Council (NMC) document “Standards for Medicine Management October 2007 – Standard 24 Management of Adverse Events (Errors or Incidents)” and General Medical Council (GMC) Guidance for Doctors Good Medical Practice November 2006: providing good clinical care (paragraphs 3,14,30,31,43,44,45).

1.2 It is important that an open culture exists in order to encourage the immediate reporting errors, incidents or near misses in the administration/prescribing/management of medicines. This in combination with thorough investigation and proper analysis should in turn lead to a reduction in errors and reduce risk to patients.

1.3 Many factors can contribute to the severity of a medicine error. Each medicine error, incident or near miss will be considered and investigated. Consideration being given to:

1.3.1 It’s clinical significance, actual or potential
1.3.2 The previous practice of the member of staff involved
1.3.3 Any previous medicine errors by the member of staff concerned
1.3.4 The events which precipitated the error
1.3.5 Any other factors that were felt to influence practice on the occasion concerned

1.4 Patient related Errors Incidents or Near Misses will be graded according to the following scale:

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>error prevented by staff surveillance (i.e. near miss)</td>
</tr>
<tr>
<td>Level 1</td>
<td>error occurred but there was no patient harm</td>
</tr>
<tr>
<td>Level 2</td>
<td>error occurred: increased monitoring was required but there was no change in clinical status</td>
</tr>
<tr>
<td>Level 3</td>
<td>error occurred: change in clinical status +/- increased laboratory monitoring but no ultimate harm</td>
</tr>
<tr>
<td>Level 4</td>
<td>error occurred: extra treatment required or increased length of hospice stay/ Community patient or Day Services patient required admission into hospice or hospital</td>
</tr>
<tr>
<td>Level 5</td>
<td>error occurred: permanent harm resulted</td>
</tr>
<tr>
<td>Level 6</td>
<td>error occurred resulting in death of patient</td>
</tr>
</tbody>
</table>
1.5 Grading level may change with time as actual level of harm to patient becomes apparent.

1.6 Non patient related Errors Incidents of Near Misses would generally be treated as level 1 however incidents such as missing controlled drugs would be treated more seriously as determined by the Accountable Officer.

1.7 Each error will be investigated, the nature of the error and the events surrounding it will be considered. Patient safety is the primary concern. It is recognised that errors are rarely only due to an individual, and it is often a combination of events or systems failure. The organisation will share lessons learnt, with the aim of improving patient safety. However, where following a full investigation there is clear evidence of gross misconduct disciplinary proceedings will be instigated, and the respective professional/registration body may be notified.

1.8 Whilst acknowledging that errors do occur it must be everyone’s aim to keep such events to an absolute minimum.

1.9 All new RN’s will complete a medicine assessment and be given time to read all the medicines policies during their orientation period before they commence single nurse medicine administration or offer medication advice to external professionals. The medicine assessment will be carried out by an ANP for clinical area or ward manager or community team manager.

1.10 All new Drs will spend time with the Pharmacist during their induction and the Ward Doctor will have regular meetings with the Pharmacists. The Drs also receive an induction booklet which includes prescribing guidelines.

1.11 When collating errors, incidents or near misses and cascading action plans in response to errors all data will be rendered anonymous.

1.12 This policy applies to all staff involved in medicine management and focuses primarily on errors incidents and near misses directly involving St Gemma’s staff members.

2.0 Policy

2.1 If any of the events listed on the IR1 form medicines section take place they are classified as medicine incidents.

2.2 All medicine errors/incidents/near misses are reported and recorded on an IR1 form as per procedure. See flow chart 1
2.3 The IR1 form must include both a factual account of the error, incident or near miss and a reflection that covers contributing factors, actual/potential implications and any possible measures to reduce the risk of errors occurring in the future.

2.4 Any supporting information is attached e.g. copy of drug chart, copy of medication label, reflective sheet.

2.5 All medicine errors/incidents/near misses are investigated and a course of action is determined as per procedure. See flow chart 2

2.6 ANP for each clinical area carries out initial investigation for all errors/incidents/near misses that occur in their area.

2.7 Advanced Nurse Practitioner (ANP) for IPU who has overall responsibility for error management follows specific procedure if staff member(SM) makes three errors within six months or the medicine error is judged to be serious. This will involve liaison between the SM, ANP and Head of Department(HOD) for the SM’s clinical area.

2.8 The Director of Nursing (DoN) and Medical Director (MD) are responsible for reviewing the errors and action plans within the professional groups they are responsible for and advising on further action to be taken.

2.9 All medicines errors incidents and near misses are reviewed by the pharmacy group.

2.10 ANP for IPU collates errors for the whole hospice and produces a quarterly report for analysis of trends in conjunction with the hospice pharmacist. This report includes recommendations for practice and is submitted to the Clinical Governance Committee.

2.11 Where the error is identified as the individual’s failure to uphold good practice, and this occurs 3 times in less than 6 months, a review of their practice by the Advanced Nurse Practitioner (ANP) responsible for error management, the ANP responsible for the clinical area and Head of Department will be undertaken with input from a pharmacist as appropriate. The review will encompass a period of supervised practice and a medicines assessment. If indicated by the review, formal proceedings – be they disciplinary or competence based may be initiated.

2.12 If a single incident, upon investigation, is found to warrant practice review this will be conducted on recommendation of ANP responsible for error management, the ANP responsible for the clinical area and hospice pharmacist in consultation with respective Head of Department and appropriate actions taken.
3.0 Procedure

Reporting of drug related errors, incidents and near misses.

3.1 Staff members (SMs) follow procedure in flow chart 1 – Drug related IR1 reporting

Investigation and action planning stemming from drug related errors, incidents and near misses.

3.2 SMs follow procedure in flow chart 2 – Drug related IR1 investigation and action planning

3.3 ANP for Day Services and Community will investigate incidents/errors detected by CNS’ and Day Services Staff that were made by staff not employed by St Gemma’s Hospice and liaise with PCT teams to ensure appropriate external documentation is completed.

3.4 ANP responsible for error management takes further action if criteria outlined in 2.10 and 2.11 are met.

Original Validation Date: October 2010

Review Date: October 2013

Responsibility of: Director of Nursing
Flow Chart 1 - DRUG RELATED IR1 REPORTING

Error/incident/near miss detected

Person detecting error/incident/near miss reports to senior nurse in charge of area

Registered Nurse (RN) assesses patient or if patient in the community arranges for GP or DN to assess patient

Senior Nurse in charge of area informs Nurse in Charge (NIC) if patient on IPU

RN informs Doctor immediately if Grade 1–6 or at next contact if Grade 0

Doctor assesses patient and makes any necessary changes to management plan

Person detecting error initiates IR1 form

Doctor completes medical section on IR1 form

In office hours

NIC informs Advanced Nurse Practitioner (ANP)

If Grade 0-3 NIC e-mails ANP & Director of Nursing (DoN)

If Grade 4-6 NIC contacts manager on-call.
Manager on-call contacts DoN +/- Director of Medicine (DoM)

Out of office hours

RN/Doctor informs patient and/or relative within 24 hrs

RN & Doctor document incident in patients notes by the end of shift

Staff involved in occurrence to complete IR1 form

If on duty
Before the end of shift

If Grade 0-3 staff member to complete when next on duty

If Grade 4-6 staff member to be contacted at home by NIC, DoN or DoM

SM gives form to Head of Department (HOD) to review

HOD alerts ANP for In-Patient Unit (IPU) that error has occurred

HOD gives form to ANP for clinical areas for investigation and action
**Flow chart 2 - DRUG RELATED IRI INVESTIGATION AND ACTION PLANNING**

ANP discuss error with those involved; to establish circumstances of error, to encourage reflection and to support the individuals involved.
- if grade 0-3 the next time the member(s) of staff is / are on duty
- if grade 4-6 as soon as possible

ANP may ask Individuals to complete Practice Reflection Form. Appendix 1

**Pharmacists**
- Liaise with Lloyds / PCT / LTHT If error/incident occurred external to Hospice
- Request External Agency to provide additional information if necessary to complete IR1 form
- Pharmacy Complete Relevant Section of IR1 Form.

**ANP responsible for clinical area where error occurred**
- liaises with:
  - Medical Staff
  - HOD / line manager responsible for staff involved in error/incident
  - Sign IR1 form
  - ANP for IPU responsible for error monitoring

**Director of Nursing (DON)**
- Notifies CQC if grade 4-6 via regulation 28 by next working day
- Director of Nursing / Accountable Officer Reports CD Errors with shared learning to Local Intelligence Network (LIN) at 3 monthly meet

**Action Plan Agreed**
- Level 0-3 within 7 days by ANP/Ph +/- Dr. as appropriate
- Level 4-6 Immediate Action by ANP/Ph/Dr/DoN

Investigating ANP gives completed form to ANP for IPU to log details

ANP for IPU discusses completed form with DON who signs IR1 form, files form and retains it for 8 years

ANP for IPU Completes Monthly Error / Incident Tally
ANP for IPU reports Error / Action Plan to Wards and other ANPs at Monthly Meeting

DoN/ANP/Ph Meet 3 Monthly to Review Incidents and Implementation of Action Plan

ANP Completes 3 Monthly Drug Error / Incident / Near Miss Report and circulates to Pharmacy Group, Risk Management and Clinical Governance Committee

Director of Nursing/ANP/Pharmacists Complete Yearly Report to Board and retain a copy for CQC self inspection
Appendix 1: Practice Reflection Form

Staff Name:

IR1 Form Number:

Please complete all sections using supplementary sheets as required

Describe the context of the incident (e.g. shift, time of day, staffing levels etc.)

Who else was involved in the incident?

Give a detailed description of what happened

What do you think were the contributing factors?
What were you thinking about as it was taking place?

What were you feeling during and after the incident?

What did you learn from the situation?

What changes in your practices (if any) can be made as a result of the learning outcomes of this situation?

What organisational changes should happen as a result of the incident?