Medication Error Investigation and Reporting Process for SNEE Medicines Optimisation Team Errors and Near Misses

Introduction

Investigating patient safety incidents will enable the Medicines Optimisation Team to understand what led to the incident or near miss, and provides an opportunity to introduce changes in practice and reduce the likelihood of recurrence. The investigation also facilitates learning and enables managers to provide support for the individual (s) involved in an incident. It is key that all incidents involving the Medicines Optimisation Team are reported irrespective of the type of error and its potential or actual impact.

Scope

The policy will apply to the Medicines Optimisation Team for medication or device related incidents occurring as a result of any activity from a member of the Medicines Optimisation Team.

Aim

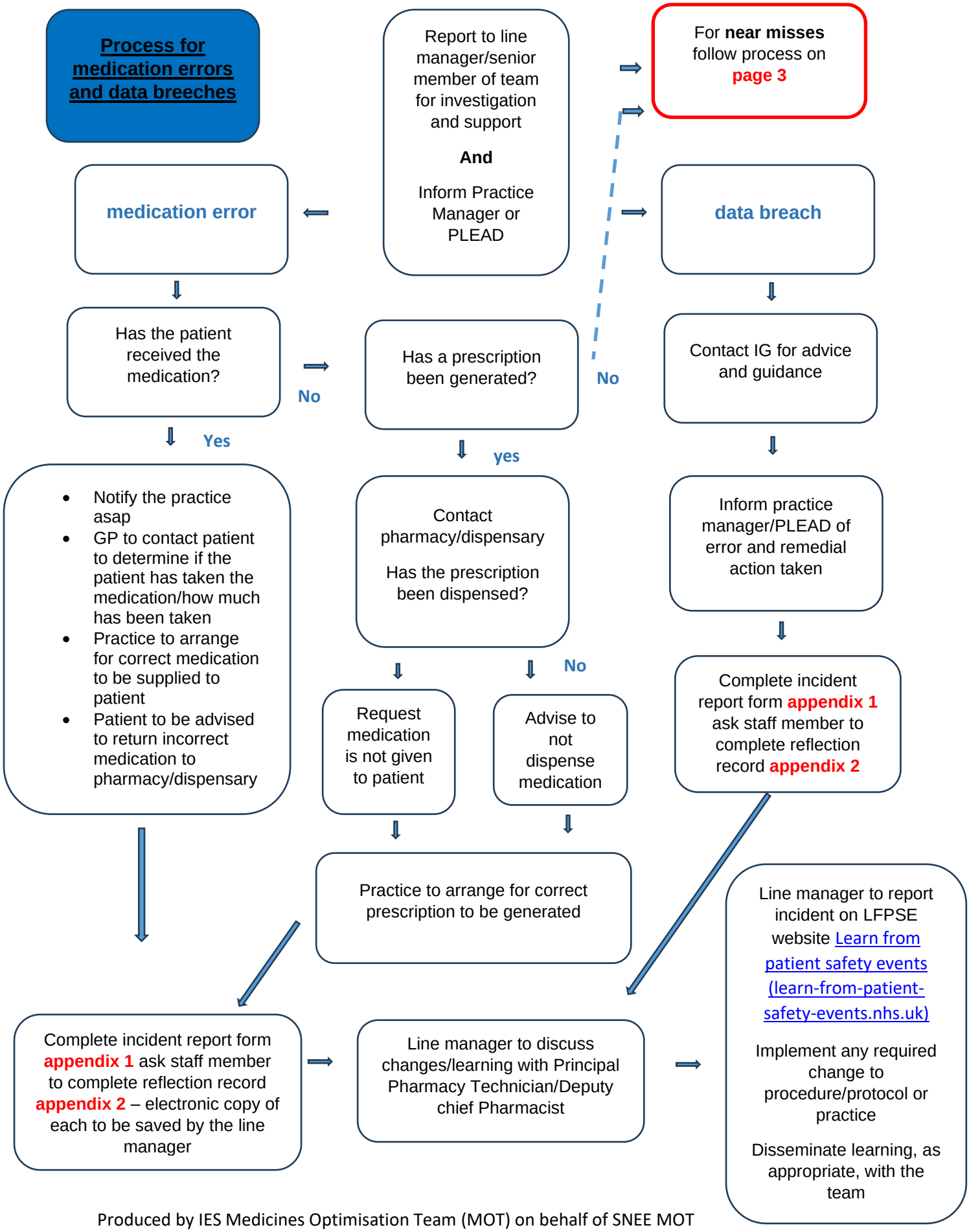
The purpose is to provide members of the Medicines Optimisation Team with information on how to report an incident

- Report an incident
- Immediate action to remove harm

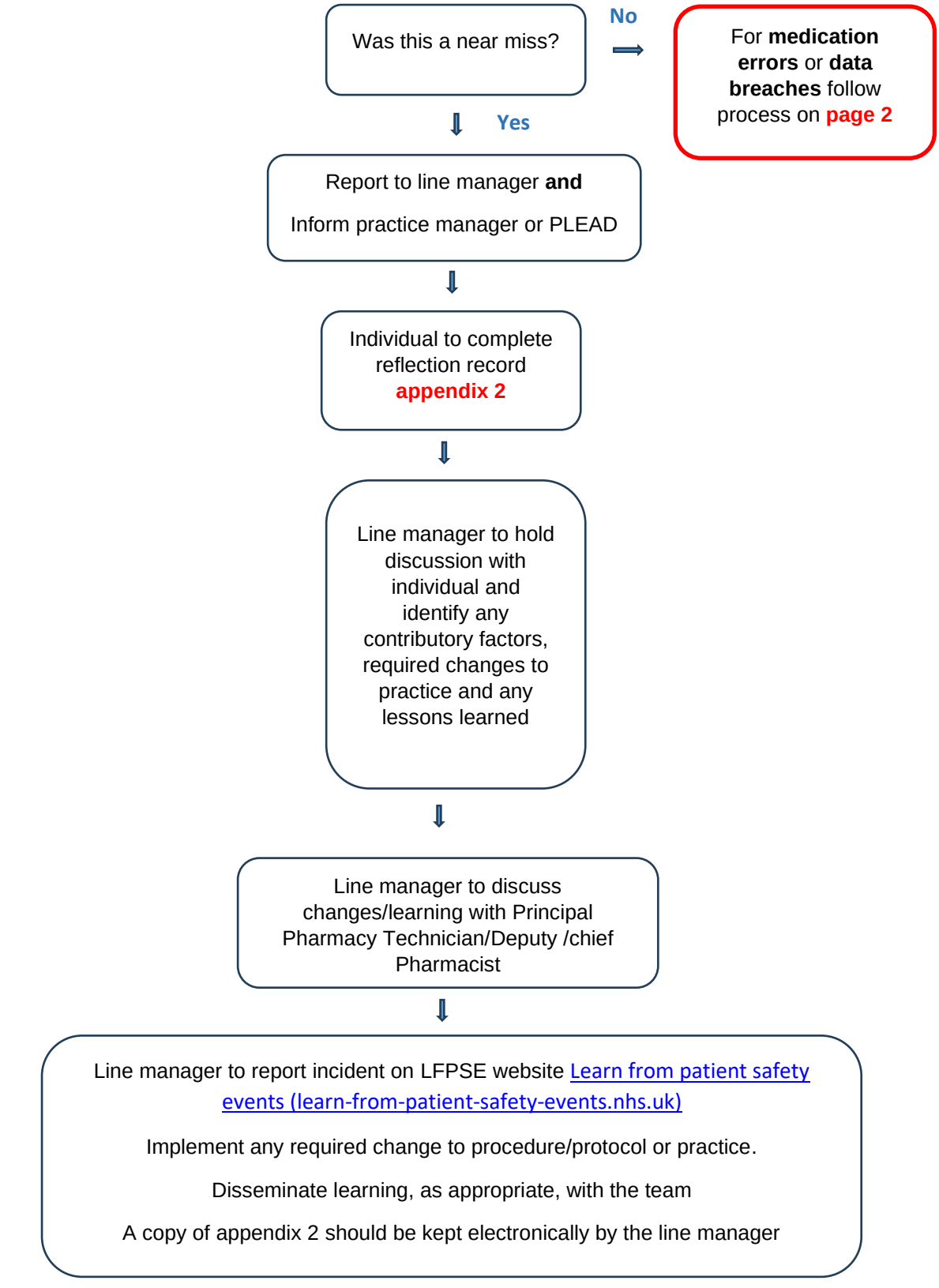
Process

- For medication errors and/or data breaches follow flowchart on page 2
- For near misses follow flowchart on page 3

Contact a senior colleague if you require support with any stage of this process


Process for medication errors and data breeches
Report to line manager/senior member of team for investigation and support
And
Inform Practice Manager or PLEAD
For near misses follow process on page 3
medication error
data breach
Has the patient received the medication?
No
Has a prescription been generated?
No
Contact IG for advice and guidance
Yes
yes
Notify the practice asap
GP to contact patient to determine if the patient has taken the medication/how much has been taken
Practice to arrange for correct medication to be supplied to patient
Patient to be advised to return incorrect medication to pharmacy/dispensary
Contact pharmacy/dispensary
Has the prescription been dispensed?
Inform practice manager/PLEAD of error and remedial action taken
No
Request medication is not given to patient
Advise to not dispense medication
Complete incident report form appendix 1 ask staff member to complete reflection record appendix 2
Practice to arrange for correct prescription to be generated
Complete incident report form appendix 1 ask staff member to complete reflection record appendix 2 – electronic copy of each to be saved by the line manager
Line manager to discuss changes/learning with Principal Pharmacy Technician/Deputy chief Pharmacist
Line manager to report incident on LFPSE website Learn from patient safety events (learn-from-patient-safety-events.nhs.uk)
Implement any required change to procedure/protocol or practice
Disseminate learning, as appropriate, with the team

Protocol for near misses



Appendix 1

Medicines Optimisation Incident reporting from

Name of individual reporting incident	**Location of the incident**
Date of the incident	**Name of medication(s) or device(s) involved**
Staff member(s) involved in the incident.	
Description and details of the error	
Has the reflection record been completed? **Yes ☐** **No ☐**	
Detail all actions taken to resolve the matter	
What support has been provided for staff involved	
Identify any lessons learnt or changes to practice required	
Is there any follow up required (detail if yes)	
How will the learning be shared with the team?	
Report completed by	**Date**
Recorded on LFPSE website by:	**Name:** **Date:**

The completed form should be saved electronically by the line manager

Appendix 2

Medication Incident Reflection Record

To be filled out by the individual following any medication incident and is to be followed by a discussion with their line manager

Date of incident			
Reflector's Name		Line Manager Name	
Date Reflection written		Date discussion held	
Tell us briefly about the incident (max 1-2 sentences)			
Were there any contributory factors in respect to this incident? (E.g., work based, home based, your physical / mental health, environment working in etc.)			
Tell us your thoughts on any agreed protocols/procedures & accepted practice related to this incident. (E.g. Do they exist? Were they followed? Have you had training in them? Are they clear? Are they achievable? Are they right?: If not please tell us why not)			
Tell us what you learnt and what good emerged from the incident to improve your practice and others?			
How will you prevent this incident happening again and how would you like this learning shared?			
Would you like any additional help or support?			
Comments from discussion with your line manager:			
Staff signature		Line manager signature	

The completed form should be saved electronically by the line manager