1. INTRODUCTION

1.1. The seven steps of patient safety

The seven steps to patient safety describe the steps that NHS organisations need to take to improve patient safety. Following these steps, will help ensure that the care provided is as safe as possible and that if things do go wrong, the right action is taken. The diagram below highlights continuous reporting and feedback on incidents and risks will provide organisations with evidence and the confidence that they are maximising safety.

![Diagram of the seven steps to patient safety]

1.2. Professional standards

<table>
<thead>
<tr>
<th>Step</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open and honest</td>
<td>Be open and honest when things go wrong</td>
</tr>
<tr>
<td>Report</td>
<td>Report patient safety incidents to the appropriate local (Datix) or national reporting programme (Yellow card scheme, NRLS, CQC)</td>
</tr>
<tr>
<td>Learn</td>
<td>Investigate and learn from all incidents, including those that cause harm and those that are “no harm” or “near miss”</td>
</tr>
<tr>
<td>Share</td>
<td>Share what you have learnt to make local or national systems of care safer</td>
</tr>
<tr>
<td>Act</td>
<td>Take action to change practice or improve local or national systems of care</td>
</tr>
<tr>
<td>Review</td>
<td>Review changes to practice</td>
</tr>
</tbody>
</table>

Figure 1 - Professional standards adapted from Royal Pharmaceutical Society (RPS)
1.3. **Getting the culture right**

There have been infamous examples across industries and organisations of the problems caused by the wrong culture. The wrong type of culture contributed to the unacceptable failings at Mid Staffordshire NHS Foundation Trust hospital between 2005 -2008, those at Orchard View Care Home and also the abuse at Winterbourne View private hospital. Underpinning getting the right culture is a 'just culture'. This is a culture based upon fairness and is achieved when attitudes, behaviours and practices are fair.

![Diagram showing steps from Just Culture to Learning Culture]

**Figure 2 - “Just Culture” adapted from RPS standards**

1.4. **Principles of a ‘Just Culture’**

1. Patient safety is paramount

2. Deliberate harm and unacceptable risk impacting on patient safety must not be tolerated

3. Patient safety is maintained by healthcare professionals being candid and raising concerns and learning from incidents to improve systems, standards, policies, legislation and people

4. Individual accountability must always be fair and proportionate and viewed in the context of root cause, system deficiencies, mitigating circumstances and the entirety of contributing factors

1.5. **Learning from errors and sharing best practice**

When applied to the provision of healthcare, a just culture means removing fears, increasing sharing and reporting of concerns, being able to learn from mistakes or incidents, being able to share lessons learnt and increasing this shared learning to reduce the likelihood of similar mistakes and incidents happening again. Learning from medication errors and near misses should take place at both an individual and systems level and that learning is shared and adopted across the trust.
The NHS has developed an incident decision tree based upon the work of Professor James Reason, an expert on patient safety. The decision making tool embodies just culture principles and uses a series of tests to decide on the appropriate course of action following an incident.

1.6. Medication safety

Medication is the most common intervention in medicine and is a critical component in modern healthcare, with over 1 billion prescription items dispensed in the community in 2016. Medication also represents a substantial total cost to the NHS, being the second largest outgoing in the NHS after staff costs (SLWG, 2018)

Medication has a huge potential to do good, but errors can occur at many points in the medication cycle – prescribing, dispensing, administering, monitoring and use. Such errors can include errors of omission and commission; however there is no universally agreed definition for a medication error.

In 2016 the (WHO) published a paper medication error: technical series on safer primary care which made reference to the definition of a ‘medication error’ as ‘any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of a healthcare professional, patient or consumer. Such events may be related to professional practice, healthcare products, procedures and systems, including prescribing, order communication, product labelling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use’ (SLWG, 2018)

The National Reporting and Learning system (NRLS, 2018) defines a ‘patient safety incident’ (PSI) ‘as any unintended or unexpected incident, which could have or did lead to harm for one or more patients receiving NHS care’

1.7. 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 (prescription, dispensing, preparation, administration etc.) has the potential for failure, to varying degrees.

The ideal system is comparable to a stack of slices of Swiss cheese. Each slice of cheese is a “defensive layer” in the process. Each hole is an opportunity for a process to fail (something happens that should not happen). 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.

For example an unsafe prescription is the problem that gets through one hole, but is then challenged by a nurse or pharmacist (the “defensive layer”). Each layer of cheese represents 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.

1.8. What are near misses?

The definition of a medication error also includes ‘near miss incidents’, i.e., ‘when an error would have occurred but for the intervention of something or someone’. The Trust recognises that it is as important to report a near miss as an actual error. Near misses act as a great opportunity for staff to work on systems, persons and processes before an error happens.

1.9. The Third (WHO) Global Patient Safety Challenge 2018: Medication Without Harm

Unsafe medication practices and medication errors are a leading cause of injury and avoidable harm in health care systems across the world. Globally, the cost associated with medication errors has been estimated at $42 billion USD annually.

Medication errors occur when weak medication systems and/or human factors such as fatigue, poor environmental conditions or staff shortages affect prescribing, transcribing, dispensing, administration and monitoring practices, which can then result in severe harm, disability and even death.

In response to this, WHO has identified a Medication without Harm campaign as the theme for the third Global Patient Safety Challenge. The focus of this

The main campaign is to reduce severe avoidable medication-related harm by 50%, globally in the next 5 years.

Everyone including patients and health care professionals have a role to play in ensuring medications safety. The video below is part of the WHO campaign in reducing medication related harm by improving practices and reducing medication related harm. [https://www.youtube.com/watch?v=MWUM7LIXDeA](https://www.youtube.com/watch?v=MWUM7LIXDeA)

### 2. REPORTING MEDICATION ERRORS AND INCIDENTS

![Diagram of Medication Incident Reporting Process](sample-do-not-use)

Figure 3 - Adapted from Medication Safety Officer Handbook 2016
3. **AIMS**

3.1. The aim of this procedure is to educate and provide guidance to staff on:

- The background of medication errors and patient safety
- Local and national drivers for improving medication safety
- Following an error, ensuring the immediate and long term safety of the patient
- Supporting the patient through the ‘Duty of Candour’ principles
- Supporting staff involved in making an error
- Identifying person/systems factors that may have contributed to the error/near miss
- Providing guidance for ward sisters/senior nurses/senior doctors and senior pharmacists with staff who have made an error/near miss;
- Providing a framework for assessing errors/near misses
- Learning from medication errors/near misses and sharing best practice

4. **IMMEDIATE ACTIONS FOLLOWING A MEDICATION INCIDENT**

4.1. **If patient HAS taken/been given the incorrect medicine**

- Assess the condition of affected patient(s), observe and monitor for any adverse effects and a review of the patient must be undertaken by medical staff as a matter of urgency
- The error must be reported immediately to the professional in charge of the clinical area (i.e. Nurse in charge) and the medical team in charge of the care for the patient(s). Out of hours, the on-call doctor and out of hours nursing service must be contacted immediately.

4.2. **If patient has NOT taken/been given the incorrect medicine**

- In working hours; inform the relevant professional in charge to which the error incident relates.
- Out of hours; wait until next working day and contact relevant professional in charge. Remove the medicine to avoid accidental administration at a later date, seeking advice from the on call pharmacist
4.3. **Expectation when notified of medication error or near miss**

- Based on clinical assessment/judgement/nature of incident, a clinician may attend to review the patient or give advice.

- Where relevant, advice must be sought from a clinical pharmacist and prescriber regarding the possible outcomes of the medication error.

- Inform the patient as soon as appropriate in line with the Trust’s Duty of Candour Policy. See CP36 “Being open policy”.

4.4. **For prescribing errors**

Where incident is due to poor prescribing the prescribing Doctor must cancel the incorrect prescription and re-prescribe. If they are unavailable another doctor from same team/on call doctor must do this.

- No administration of this medicine must occur until re-prescribed correctly.

- A pharmacist should be contacted for advice where appropriate.

4.5. **For dispensing errors**

A dispensing error may originate from either a hospital pharmacy or outside community pharmacy.

- Immediately withdraw the medication from use.

- Inform the site pharmacy team immediately and make arrangement for re-dispensing, if needed.

- Retain the medication and all packaging to give to the pharmacy. This is important for effective investigation to be undertaken by the site or community pharmacy.

- No administration of this medicine must occur until re-dispensed correctly.

4.6. **For errors involving administration/preparation of medicines**

The manager should ensure that any implicated medication that may be useful in the investigation is retained (syringes, labels, medication etc.). These details may be important to help identify root causes of the incident.

No administration must occur until medicine is determined safe beyond doubt (or replacement obtained).
4.7. **For errors involving medical devices**

Where the incident involves a problem with a medical device, this must be notified to the medical equipment team immediately, and the device removed from service.

4.8. **For incidents involving monitoring**

Where there is any concern that the monitoring or interpretation of monitoring of a patient’s treatment has been erroneous, seek advice immediately from senior medical, senior nursing or senior pharmacy staff if unsure.

Where the incident is attributed to a resource or skill/knowledge issue this must be reviewed immediately, reassigning staff if deemed necessary.

No further administration must be undertaken until authorised by senior medical staff.

4.9. **Documentation**

The Nurse in charge, in conjunction with the most senior medical staff present (if appropriate) should take any necessary copies of charts and obtain statements from the staff involved.

4.10. **Once the patient is safe, report the incident**

- Always complete an incident report on Datix
- Always complete an incident report for near-misses, as these provide useful information for improvement and awareness of risks.
- Document the incident in the patient healthcare record, including the outcome.

5. **INFORMING THE PATIENT**

5.1. The organisation acknowledges that when things go wrong, honest and open communication with the patient and/or relatives is fundamental to the ongoing partnership between them, those providing their care, and the organisation.

5.2. Following the introduction of Duty of Candour legislation in 2015 the organisation must inform, and apologise, to patients if there have been mistakes in their care that have led, or could have led, to significant harm. Where moderate severity harm or above has occurred, there are additional legal requirements. This is detailed in the Trust Adverse Incident Policy and “Being open” policy.

5.3. The patient (parent/guardian/next of kin) must be informed by nurse in charge (or equivalent), line manager and the doctor in charge of the patient’s care at that moment in time. If appropriate an apology should be given and documented, acknowledging that an apology is not an admission of liability.
6. STAFF INVOLVED IN INCIDENTS

6.1. 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 incident.

6.2. However for an error to occur an important step in the process would have to be omitted, or not carried out as intended. There is potential for this to reoccur, 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 and how and take steps to rectify this.

6.3. Staff welfare must be considered during the error/near miss management/investigation process. Appropriate support must be offered and made available, regardless of the severity of the incident. This may include establishing support from a named buddy or referral to the occupational health service. Staff support is available from a range of sources and this is given in the trust adverse incident management policy or from human resources.

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

6.5. Effective learning from incidents happens in an environment where an individual is comfortable in opening up and being honest about the situation. It is unacceptable for any initial incident management meetings to be framed as a formal reprimand. Only a thorough investigation in line with this document can determine if further action is warranted involving the individual.

6.6. Once the initial facts have been gathered, staff should be invited to undertake reflection (See appendix 1).

6.7. An incident review meeting to discuss reflective practice and the incident must be undertaken between the line manager and staff member within 2 weeks (See appendix 2).

6.8. Where **Agency Nurses** are involved in an error/near miss, the specific agency manager must also be told about the error/near miss and be involved in the management of the incident as soon as an error is identified.

6.9. Where **Bank Nurses** are involved in an error/near miss, the bank nurse manager must also be informed about the error/near miss and be involved in the management of the incident as soon as an error is identified.

6.10. Where pre-registration students are involved in an error/near miss the University may need to be informed. The lead education and training professional for each group of pre-registration staff should be consulted in this regard, to determine the appropriateness of this and action going forward.
7. MINOR MEDICATION ERRORS

7.1. Medication incidents vary considerably in terms of potential for harm, learning opportunity and appropriateness of extensive Root Cause Analysis (RCA) investigation.

7.2. Medication incidents of a minor nature; those where the remedial action is quick, usually limited to one individual and an isolated incident; may be managed without a full reflection and review meeting. It is important to recognise that some minor errors have potential to cause serious harm and these should be dealt with more formally in line with this document. If in doubt staff, should seek advice from a senior pharmacist.

7.3. Minor errors may include:
   • Prescribing errors (e.g. poor legibility / failure to print clearly);
   • Administration errors (e.g. omission of a non-critical medicine stocked on ward);
   • Dispensing errors (e.g. spelling error on label);
   • Corrected pharmacist interventions which may be recorded elsewhere.

7.4. Minor Prescribing errors
   • Most errors are intercepted before they lead to harm and it is noted that new prescribers may develop a degree of complacency around prescribing. Therefore it is important that these errors are fed back to individual or teams of doctors/ non-medical prescribers on an ad-hoc basis.
   • Minor prescribing errors where remedial action is performed by the pharmacist may be entered into the incident report as ‘immediate actions’, at the point of incident report submission. Where this is clearly sufficient to allow final approval and close the incident, this may be done so with agreement from the pharmacist.
   • Nurses can also feedback to doctors in the same way though are encouraged to escalate prescribing errors to pharmacists to deliver the feedback where they feel unable to, or require further advice as part of the prescribers learning
   • Errors can be pointed out to the member of staff, including any advice on how to avoid in the future. Repetitive errors of this kind should be reported to the line manager with consideration of reflection/review undertaken as below to increase the learning from errors and promote patient safety
8. REFLECTION BY STAFF

8.1. Written reflections are a useful tool to 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.

8.2. The purpose of preparing a reflective account is developmental and not punitive; however, this documentation may be referred to as evidence of previous support/action/learning should repeated errors of the same or similar nature occur.

8.3. Reflections should be undertaken as soon as possible after the event and be submitted to the line manager within 7 working days.

8.4. Reflections are recommended to be undertaken for all incidents, however it is recognised that this may be of limited value in some cases. As such, it is the line manager’s discretion to request a reflection, except in defined situations (see below).

8.5. It is expected written reflections are always undertaken for incidents where any of the following apply:
   - Medication reaches the patient, or care area involved (e.g. ward);
   - Patient harm severity is risk scored moderate, high or extreme;
   - Involves an actual or near-miss serious incident/never Event incident;
   - Member of staff has been involved in more than one medication incident in the past two months or more than two in the past six months.

8.6. All staff involved in a medication error incident, regardless of grade, profession, or non-registration, are expected to reflect on the event. This should be documented using the multidisciplinary incident reflection record (Appendix 1) and also documented in the staff members supervision records. These demonstrate that effective management and support has taken place and that effective professional development and learning has been identified and facilitated.

8.7. Where staff are struggling with the reflection process, this should be treated sensitively and reference to the fishbone root causes tool may be useful (see appendices 3 - 8). Staff should be invited to review their reflection if there are any deficiencies or unanswered sections which may be useful to the investigation.

9. MEDICATION INCIDENT REVIEW MEETINGS

9.1. An incident review meeting is one carried out between the staff member and their manager. It is influenced by the severity of harm (or potential risk of harm) and the extent to which the individual has been involved previously in any other error incidents or near misses.
9.2. Utilise the **NHS Just Culture guide** as a structure for the conversation. A record of the review is documented using appendix 2.

9.3. The investigation activities and discussion must cover the following:

- Identification and agreement of the root cause factors. Consult the medication error incident RCA checklists / fishbone (appendices 3-8) to ensure all root causes are identified and the main root cause/s are established;
  - For human factors, also see section 11.
  - For weak medication systems factors, also see section 12.
- Determine any staff support required and agree this;
- Determine knowledge gaps with respect to policy, procedure or accepted practice needs;
- Identify learning opportunities for the individual;
- Determine the safe-to-practice status of the individual;
- Identify learning within the team and consider where to involve the medication safety officer for wider learning.

9.4. It must be clear who is responsible for taking what actions, and in what timescale. An action plan must be completed on the incident review record. Where actions are identified for others, these must be agreed before finalising to ensure they are realistic and achievable.

9.5. Following the investigation, a copy of the incident reflection record and review record **must** be placed in the staff member’s supervision records within the department.

9.6. These records demonstrate effective management and support has taken place; and that effective professional development and learning has been identified and facilitated.

9.7. This record may be removed after a defined time if deemed appropriate by the senior manager. This record should be reviewed in line with the Trust appraisal process confirming positive change has occurred.

9.8. A copy of the reflection is generally not submitted to the staff member’s human resources record unless recommended by a senior manager (i.e. in cases where escalated via the disciplinary procedure HRPG27A).

9.9. The electronic incident report should be updated and completed in line with the Trust adverse Incident Policy (or equivalent policies) and training given by the
respective site. This should state clearly what learning and action have taken place on the back of the incident

**10. HUMAN FACTORS ANALYSIS**

10.1. Human factors analysis explores how staff relate to the situation around them, the environment, the people around them and their capabilities and limitations. Identifying these factors can be used to improve performance and safety.

10.2. **Solutions to human factors in medication errors**

This may include the following:

- **Training individuals** – to better prepare them for work/conditions and situations, such as being ‘busy’. This may involve strategies to ensure they remain safe in a situation where it is continuously very busy (e.g. ways of checking medicines before prescribing dispensing, administering);

- **Environmental design** – can this be improved where medicines are prescribed, dispensed, prepared and administered. This can include how we reduce the risk of mis-selections (e.g. look-alike and sound-alike drugs) from the shelf, reduce distractions, and if the work space allows the individual to concentrate.

- **Equipment design** – tools and automation, therefore exploring if the system (where used) can be optimised or whether something can be automated for tasks currently undertaken manually.

- **Task design** – changing what staff do rather than just the device they use. This could be assigning tasks to other workers/professionals or to automate the process (e.g. ePrescribing, electronic ordering of medicines, robotic dispensing etc.)

**11. SYSTEMS REVIEW**

11.1. **Systemic / organisational factors**

In the event that a clear systemic or organisational factor is identified, the Medical Director, Chief Pharmacist, Director of Nursing, and Medication Safety Officer should be consulted without delay. They will evaluate the best way to manage this, which may include escalation to the Medicines Management Group.

Changes in practice may be required alongside learning which is co-ordinated by the Chief Pharmacist and Medication Safety Officer (MSO). This may also involve other stakeholders in the organisation. Examples of changes in practice may include:

- System changes (e.g. implementing changes to procedural documents, and actual system in practice)
- Elimination of the risk (e.g. change medication practice, stop medication reaching patient permanently)
- Revised teaching sessions and eLearning training on medication safety for all relevant staff.

11.2. Suitability of policy / procedures / accepted practice

The incident may identify a problem with the documented process for how a task is carried out. This may be how it is interpreted (i.e. wrongly leading to error or differences in practice), omissions in the documented process, or an identified need for a documented process. It is important to recognise that implementing changes to documents in itself does not prevent errors.

12. REPEATED ERRORS

12.1. Staff who make more than one medication error may require additional training, supervision and support.

12.2. It is important to establish themes with the repeated errors to understand if there is a particular issue with carrying out a process or whether a broader range of concerns apply.

12.3. Line Managers should reflect on the medication process in which these errors are occurring and keep an open mind as to whether there is a medication system review also required (see section 12).

12.4. Managers can approach pharmacists to support learning and consider requesting staff to undertake the medicine management training again where appropriate.

13. SAFE TO PRACTICE STATUS

13.1. Where repeated errors occur despite training and support, it is likely that the line manager will need to consider more formal actions. This will be in line with the Trust Disciplinary Procedure (HRPG27A)

13.2. Upon undertaking a root cause analysis the line manager may feel it is appropriate to review the duties of the member of staff (i.e. suspension) until a critical incident reflective exercise is undertaken.

13.3. There may be occasions where the employee wishes to stop themselves from continuing a specific duty. This should be respected and addressed within the Medication Incident Review. There must be a clear rationale documented for this with clear actions to determine when that person can return to those duties, where appropriate.
13.4. Supervised practice can provide assurance that staff who made the error are following correct procedures. The method and length of supervised practice will depend primarily on the severity of the error and/or potential for harm.

13.5. Other factors to consider include:

- availability of support staff to supervise;
- insight of the member of staff as detailed in their reflective account;
- circumstances surrounding the medication error,
- confidence of the member of staff;
- any previous incidents raising concern (e.g. themes).

13.6. The method and length of supervised practice should ideally be decided in partnership between the line manager and staff member 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.

14. ROLE OF THE MEDICATION SAFETY OFFICER (MSO)

14.1. This role is a requirement of the NHS England Patient Safety Alert - Stage Three: Directive Improving medication error incident reporting and learning.

14.2. The MSO is integral to improving medication error incident reporting and learning within the Trust. One of the MSOs’ key roles is to promote the safe use of medicines across the organisation and act as an expert in this field. This is through various work streams i.e. analysis of medication errors and trends and implementation of strategies to reduce errors.

14.3. The MSO serves as an essential link between the identification and implementation of (local and national) medication safety initiatives and operational services to improve patient safety with the use of medicines.

14.4. The Patient Safety Domain at NHS England and the MHRA support the MSO in the form of the National Medication Safety Network.

14.5. MSO’s attend conferences/workshops, regular online Webex meetings, email discussion groups and online information forums to discuss topics identified at local and national level. These include the identification of new risks and best practice to minimise these risks, implementing patient safety guidance and improving incident reporting quality and learning.
15. INCIDENT THEMES, TRENDS AND SHARED LEARNING

15.1. Learning from errors and near misses must be shared across all services.

15.2. The medication safety officer (MSO), based in pharmacy, identifies any themes and trends within errors / near miss incidents.

15.3. Theme analysis details include:

- Incident numbers
- Incident type & breakdown by drug or system processes
- Location and comparables (e.g. to other sites, where possible)
- New or emerging themes and identified root causes (e.g. new process).

15.4. Theme analysis is provided by a quarterly report sent to directorates/divisions via the medicines management group.

15.5. Directorates will be expected to engage with the pharmacy team in terms of identifying actions and how to manage the situation to drive an improvement in patient safety.

15.6. Shared learning is delivered in the following ways:

- Regular Medication Safety Bulletins
- Pharmacist cascading of mini-teaching to ward-based teams e.g. messages of the day/week
- Trust safety alerts
- National/Local medication communications and alerts
- Pharmacist 1:1 Junior Doctor teaching at ward level as appropriate
- Induction training and Directorate-specific medicine safety sessions to medical staff
- Safety initiatives such as ‘Medication Safety Week’

15.7. The Medication Safety Sub-Group will focus on the key incident themes and specific risk reduction strategies. These will form recommendations that are taken to relevant governance groups for approval. Where appropriate, arrangements may be made for policies, guidelines and procedures to be developed or amended.

15.8. Concerns where learning is not happening or is ineffective will be escalated by exception reporting via the Medicines Management Group.
16. REFERENCES


- General Pharmaceutical Council (2017). *Standards for pharmacy professionals*. Available at [https://www.pharmacyregulation.org/sites/default/files/standards_for_pharmacy_professionals_may_2017_0.pdf](https://www.pharmacyregulation.org/sites/default/files/standards_for_pharmacy_professionals_may_2017_0.pdf)


v1


Multidisciplinary Medication Incident Reflection Record

<table>
<thead>
<tr>
<th>Incident No</th>
<th>Date of incident</th>
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<tbody>
<tr>
<td>Reflectors Name</td>
<td>Line Manager Name</td>
</tr>
<tr>
<td>Date Reflection written</td>
<td>Date discussion held</td>
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You may find the ‘FISHBONE’ diagram in policy helpful with your reflection.
Tell us briefly about the incident (max 1-2 sentences)

Tell us your thoughts on any agreed trust protocols/procedures & accepted practice related to this incident. Do they exist? One needed? Is it clear? Is it achievable? Are they right? If not, why not?

What information did you and could you have used to influence your decisions/actions? (Think about your professional code/standards or expected standard of practice)

What factors may have influenced you (or the team) with respect to this incident? (E.g., work based, home based, your physical / mental health, environment working in etc.)

Tell us what you learnt from the incident?

How will you prevent this incident happening again (what could we do differently?) And how would you like this learning to be shared?

Comments from discussion with your line manager:

Staff signature | Line manager signature

One copy to be kept by employee and one to retain in staff supervision record
# Multidisciplinary Medication Incident Review of Reflective Practice

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<th>Reflector’s Name</th>
<th>Line Manager Name</th>
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## To be completed by Line manager with the staff member involved

This must be completed AFTER reflective practice has been completed

- Reflection has been read, reviewed, comments added and signed by line manager.

Discuss and agree (between line manager and individual) what are the **main root causes**. (This should involve use of the reflective practice, fishbone / RCA checklists in Medication Incident Policy)

Please summarise outcomes, and comment where needed

a) Is a referral to staff support services needed?
   - Practice/Educational Facilitator
   - Occupational Health
   - Other (please state):

b) Has there been a breach of policy/procedure/accepted practice?
   - Policy or Procedure Breach (state documents to be reviewed in action plan)

c) Is there a basis for review of any policy/procedure/accepted practice?
   - Yes (if so, discuss with Medication Safety Team in pharmacy via line manager)

d) Has any specific training / learning need been identified?
   - Yes (state in action plan)
   - No (state reason why here):

- Other

Please confirm safe-to-practice status for individual

- YES – safe to practice unsupervised
- YES – safe to practice with 1:1 supervision
- NO - (please state reason):
  - For no, reassessment of competency is likely (state in action plan, e.g. workbook / eLearning/)

## Personal Development Plan

<table>
<thead>
<tr>
<th>Learning Need</th>
<th>Specific Action to address learning need</th>
<th>Date due</th>
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## Staff signature

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<th>Line manager signature</th>
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Please ensure you update the incident report to ensure consistency in documentation

One copy to be kept by employee and one to retain in staff supervision record
Root Cause Analysis Checklist for Prescribing Errors

Use this checklist to undertake a systematic review of the error. It will help pinpoint where things went wrong & identify areas for action/improvement.

1. Was the prescription written in accordance with medicines policy?  
   - **No**

2. Were all pertinent details recorded and correct?  
   - **Yes**

3. Were the prescribed medication details correct?  
   - **No**

4. Did the prescriber have sufficient prescribing information?  
   - **Yes**

5. Which was incorrect?  
   - **Not signed & dated**
   - **Generic**
   - **Abbreviations**
   - **Units**
   - **Totally illegible**

6. Was the data missing?  
   - **Yes**

7. Was the data inaccurate?  
   - **Yes**

8. What was missing/inaccurate?  
   - **Communication**
   - **Verbal**
   - **Written**
   - **Other**

9. Why did it happen?  
   - **Allergy status**
   - **Medication history**
   - **Weight**
   - **Blood results**
   - **Transcription**
   - **Wrong Pt**

10. Other Root Causes Identified?

This form may be useful for investigating medication incidents - Please contact the Medication Safety Team for further support.
Root Cause Analysis Checklist for Preparation / Dispensing Errors

Use this checklist to undertake a systematic review of the error. It will help pinpoint where things went wrong and identify areas for action/improvement.

- Dispensed incorrectly
  - Was there a problem with storage of the medication?
    - Yes
      - Incorrect Medication
      - Incorrect Strength
      - Labelling
      - Expired medication
    - No
  - Were there packaging issues?
    - Yes
      - Similar Packaging
      - Calculation error
        - Incorrect dilution
          - Process error
            - Spilled
          - Incorrect rate
            - Process error
              - Type error
            - Equipment failure
            - Lack of information
          - Incorrect packaging
            - Medication is unclear
            - Different product/
              Manufacturer from normal
        - Inappropriate package
          - Skill mix
          - Competency
          - Knowledge
          - Distractions
            - Interference
          - Equipment failure
          - Staffing levels
      - Incorrect strength
        - Process error
          - Type error
          - Setting up
        - Equipment failure
        - Lack of information
        - Incorrect packaging
      - Incorrect labelling
        - Process error
          - Type error
          - Setting up
        - Equipment failure
        - Lack of information
        - Incorrect packaging
      - Expired medication
    - No
- Was there a Manipulation error?
  - Yes
    - Calculation error
      - Inappropriate package
      - Incorrect rate
      - Incorrect dilution
      - Similar packaging
    - No
- Due to an individual?
  - Yes
    - Inappropriate package
      - Skill mix
      - Competency
      - Knowledge
      - Distraction
        - Interference
      - Equipment failure
      - Staffing levels
    - No
- Any environmental issues?
  - Yes
    - Inappropriate package
      - Poor lighting
      - Inadequate facilities
      - Preparatory
        - Storage
      - Staffing levels
      - Noise
    - No

Other Root Causes Identified:

This form may be useful for investigating incidents – Please contact the Medication Safety Team for further support.
Root Cause Analysis Checklist for Administration Errors

Use this check list to undertake a systematic review of the error. It will help pinpoint where things went wrong & identify areas for action/improvement.

1. Were there issues with the equipment?
   - Yes
   - No

2. Was there a process failure?
   - Yes
   - No

3. Was the medication not given or given late?
   - Yes
   - No

4. Due to an individual?
   - Yes
   - No

5. Were there Environment issues?
   - Yes
   - No

Inappropriate device used:
- Pump
- Syringe
- Line
- Connectors
- Equipment failure
- Appropriate Equipment unavailable
- Equipment set up incorrectly

Guideline not followed
- Policy not followed
- Lack of monitoring
- Lack of recording
- Labelling incorrect
- Incomplete/missing
- Lack of information
- Available
- Prepared in advance

Medication unavailable
- Was Pharmacy open?
- If pharmacy closed:
  - In emergency cupboard?
  - On another ward?

Competency
- Knowledge
- Distractions/interuptions
- Staffing levels
- Skill mix

Noise
- Lighting
- Surface
- Space

This form may be useful for investigating incidents – Please contact the Medication Safety Team for further support.
Root Cause Analysis Checklist for Monitoring Errors

Use this check list to undertake a systematic review of the error. It will help pinpoint where things went wrong & identify areas for action/improvement.

Were there issues with the equipment?
- Yes
  - Equipment failure
  - Inappropriately set up
  - Incorrect equipment

Issues with blood tests/results?
- Yes
  - Communication
  - Documentation
  - Incorrect patient
  - Incorrectly taken
  - Misinterpretation

Lack of monitoring?
- Yes
  - Incorrect test requested
  - No test requested
  - Do guidelines exist?

Due to an individual?
- Yes
  - Competency
  - Knowledge
  - Distractions/Interruptions
  - Staffing levels
  - Skill mix
  - Environment

Other Root Causes Identified:

This form may be useful for investigating incidents – Please contact the Medication Safety Team for further support.
Annex 7:

Fishbone Diagram of Contributory Factors

- **Patient factors:**
  - Clinical condition
  - Social factors
  - Physical factors
  - Psychological / mental factors
  - Interpersonal relationships

- **Individual (staff) factors:**
  - Physical issues
  - Psychological
  - Personality
  - Social / domestic

- **Task factors:**
  - Guidelines / procedures / protocols
  - Decision aids
  - Task design

- **Communication factors:**
  - Verbal
  - Non-verbal
  - Written
  - Electronic

- **Team + social factors:**
  - Role congruence
  - Leadership
  - Support + cultural factors

- **Education + Training Factors:**
  - Competence
  - Appropriateness
  - Availability
  - Accessibility
  - Supervision

- **Equipment + resources:**
  - Equipment supplies
  - Visual display
  - Integrity
  - Positioning
  - Usability

- **Working condition factors:**
  - Environment
  - Design of physical environment
  - Administrative
  - Staffing
  - Time / workload

- **Organisational + strategic factors:**
  - Organisational structure
  - Policy, standards, goals
  - Externally imported risks
  - Safety culture
  - Priorities

**Problem or issue**
(Care Delivery Problem (CDP)/Service Delivery Problem (SDP))

Annex 8

Blank Template Fishbone Diagram of Contributory Factors

Use appendix 7 to prompt.

- **Patient factors:**
- **Individual (staff) factors:**
- **Task factors:**
- **Communication factors:**
- **Team + social factors:**

- **Education + Training factors:**
- **Equipment + resources:**
- **Working condition factors:**
- **Organisational + strategic factors:**

SAMPLE - DO NOT USE