Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
MANAGEMENT OF MEDICATION INCIDENTS

Document Reference	SOP19-015
Version Number	1.2
Author/Lead **Job Title**	Kerry Finch Medicines Safety Officer
Instigated by: **Date Instigated:**	
Date Last Reviewed:	25 January 2024
Date of Next Review:	January 2027
Consultation:	Clinical Risk Management Group Drugs and Therapeutics Group
Ratified and Quality Checked by: **Date Ratified:**	Drugs and Therapeutics Group 25 January 2024
Name of Trust Strategy / Policy / Guidelines this SOP refers to:	

VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*12/08/19*	*New SOP*
1.1	*01/04/20*	*Daily review meeting changed to Corporate Safety Huddle (throughout the document)* *Flowchart 6.3 changed wording from re-write to re-prescribe* *Mental Health Legislation section added*
1.2	*25/01/24*	*Reviewed. Addition of escalation of medication incident management via the Patient Safety Incident Response Framework. Approved at Drugs and Therapeutics Group (25 January 2024).*

Contents

1. INTRODUCTION

This standard operating procedure aims to ensure that all Humber Teaching NHS Foundation Trust staff understands how to manage medication related incidents.

It should be read in conjunction with the Incident Reporting Policy and Procedure.

The information recorded within Datix is reviewed in the following ways:

- With the staff involved with the incident to ascertain what happened, why it happened, the impact on the people involved, can we learn from the incident and implement improvements to reduce the possibility of the incident occurring again.
- The medicines safety officer reviews each medication incident within 30 days and may ask for further information. The information obtained may highlight if the team need extra support such as training or a piece of specialised equipment. It may also highlight a systems failure which can be improved/rectified. Any medication errors which cause serious harm may trigger a CQC notification and will need to be reviewed and uploaded as per the CQC notification process timeline.
- At the daily Corporate Safety Huddle.
- At the weekly Clinical Risk Management Group (CRMG).
- Any controlled drug incidents will be reviewed with the Controlled Drug Accountable Officer.

2. SCOPE

This SOP applies to all Humber Teaching NHS Foundation Trust staff, including substantive, temporary and locum, of all grades and disciplines, involved in any aspect of medicines optimisation including: prescribing, dispensing, checking and administration.

3. PURPOSE

The key objectives of this SOP are to:

- Ensure immediate and long-term patient safety
- Identify any factors that may have contributed to the incident (example: staffing, equipment etc.)
- Offer support and training to staff involved with medication incidents to minimise such errors occurring
- Offer support to managers dealing with staff involved with medication incidents
- Ensure that as an organisation we learn from our errors

4. DUTIES AND RESPONSIBILITIES

Clinical/Non-clinical Staff
It is the responsibility of all clinical/non-clinical staff to:

- Practice in line with this SOP and any other associated policies and procedures.
- Take immediate action following an incident to ensure patient/staff safety in line with this SOP and any other associated policies and procedures.
- Complete a Datix to enable learning, where an incident occurs.
- Take immediate and proactive action to prevent similar incidents from reoccurring.
- Ensure patients are informed where an incident involves them, i.e. to support being open with patients and service users if mistakes are made or accidents happen.

Unit Managers and Clinical Service Leads
It is the responsibility of unit managers and clinical service leads to:

- Practice in line with this SOP and any other associated policies and procedures.
- Take responsibility for the local management of medication incidents in a fair and consistent manner.
- Encourage a culture where incident reporting is seen as a positive.
- Support staff and take an active lead in being open with patients when incidents have occurred or patients have been harmed.

Medicine Safety Team
It is the responsibility of the Medicine Safety Team to:

- Review all reported medicines incidents/near misses to identify any themes or trends.
- Review managers actions entered into the incident forms, seeking assurance on actions and learning when required.
- Escalate any trends/themes/concerns to relevant management teams and/or the Clinical Risk Management Group.
- Collate a monthly report detailing incidents in each care groups.
- Inform the Controlled Drug Accountable Officer (CDAO) of the incident.

5. DEFINITION

Medication Error – "*Medication errors are any Patient Safety Incidents (PSIs) where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines. These PSIs can be divided into two categories; errors of commission or errors of omission. The former include, for example, wrong medicine or wrong dose. The latter include, for example, omitted dose or a failure to monitor, such as international normalised ratio for anticoagulant therapy.*" MHRA Patient Safety Alert, stage 3: Improving medication error incident reporting and learning.

6. MEDICATION INCIDENT

6.1. What Constitutes a Medication Incident?

This is not an exhaustive list.

Prescribing:

- Incorrect or incomplete patient or medication details on the MAR chart
- Allergy status incomplete
- Inappropriate medicine, dose, route, rate
- Additional instructions incomplete (if appropriate)
- Inappropriate indication
- Length of course not indicated
- Transcription error
- Medication monitoring/follow-up incomplete/not actioned
- Medication prescribed that the patient is allergic to
- Prescription not signed and dated

Dispensing:

- Patient dispensed the wrong medication/strength/form/formulation/quantity
- Pharmacy label states the wrong patient name(s)
- Medication label is incorrect (for a different patient) or not labelled

Administration:

- Administering medication without a valid prescription
- Patient administered the wrong medication, strength, form, formulation, dose, route
- Patient administered expired medication
- Medication administered to the wrong patient
- Medication omitted without a clinical rationale
- Medication prepared incorrectly
- Inappropriate use of 'PRN' medication
- Medication administered early/late
- Non annotation of the patients MAR chart

Mental Health Legislation:

- There is no S58 (T2, T3 or Z08) paperwork in place where a detained patient has been **administered medication** for a mental disorder for longer than 3 months after first receiving treatment.
- Medication prescribed does not match the details outlined within the T2,T3,Z08 or CTO11 (if patient is CTO recall and within 72hrs of a period of recall)
- T2,T3, Z08 or CTO11 has not been completed correctly

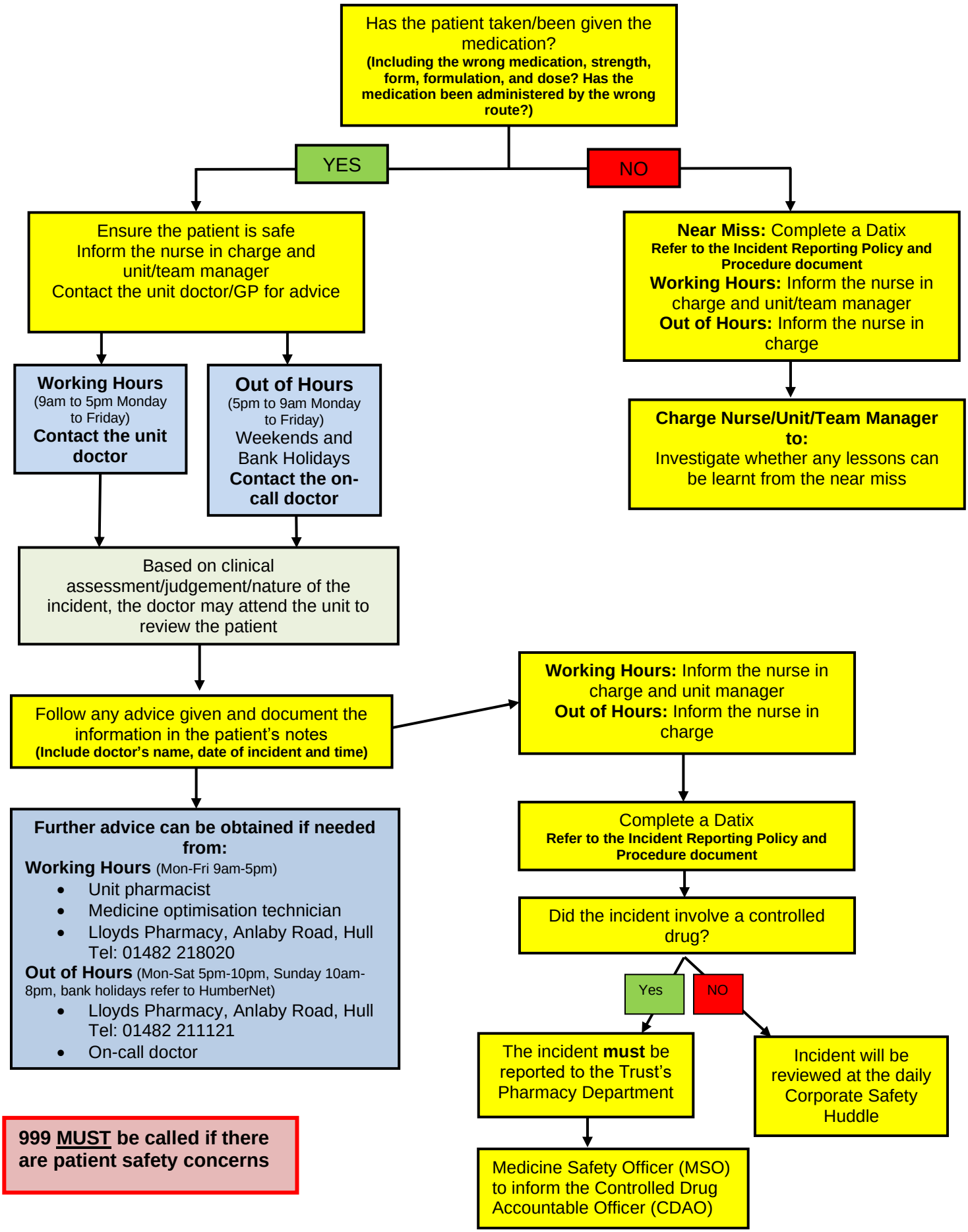
Monitoring:

- Incomplete/inappropriate follow-up
- Failure to monitor therapeutic levels
- Failure to monitor self-administration

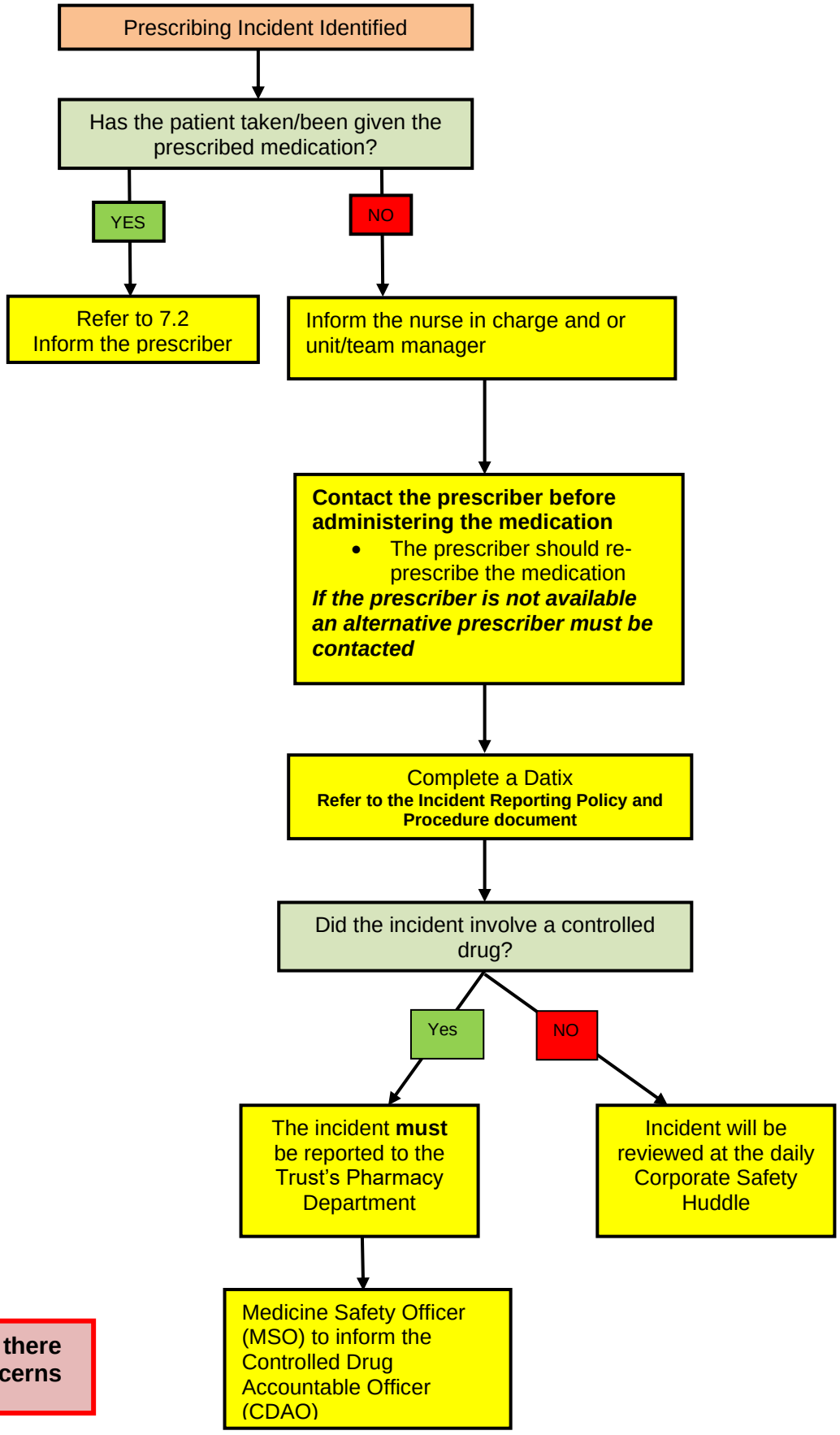
6.2. Escalation process of Medication Incident datix

- Medication Incident datix reviewed in daily patient safety huddle, escalation to an Initial Incident review discussed and agreed by Patient Safety Team lead.
- Initial Incident review investigation reviewed at weekly Clinical Risk Management Group and further escalation if required agreed via a 'Swarm huddle' 'PSIA' or 'PSII', following the Patient Safety Incident Response Framework.
- When a medication Incident has caused a level of harm to a patient the escalation and further investigation process should incorporate a review from Medicines Safety, involving review of the post medication incident care plan and both physical and mental health review. Clinical Risk Management group agreement of identified designated lead within the team involved in the incident and consideration given to the benefit of external medic (external to team) involvement for support, oversight, and contribution to explore if further specialist physical health review is required. Also giving the opportunity for the patient involved to discuss any concerns with a non-immediate team member if required.

6.3. Immediate Action to be taken when an Administration Incident has been identified

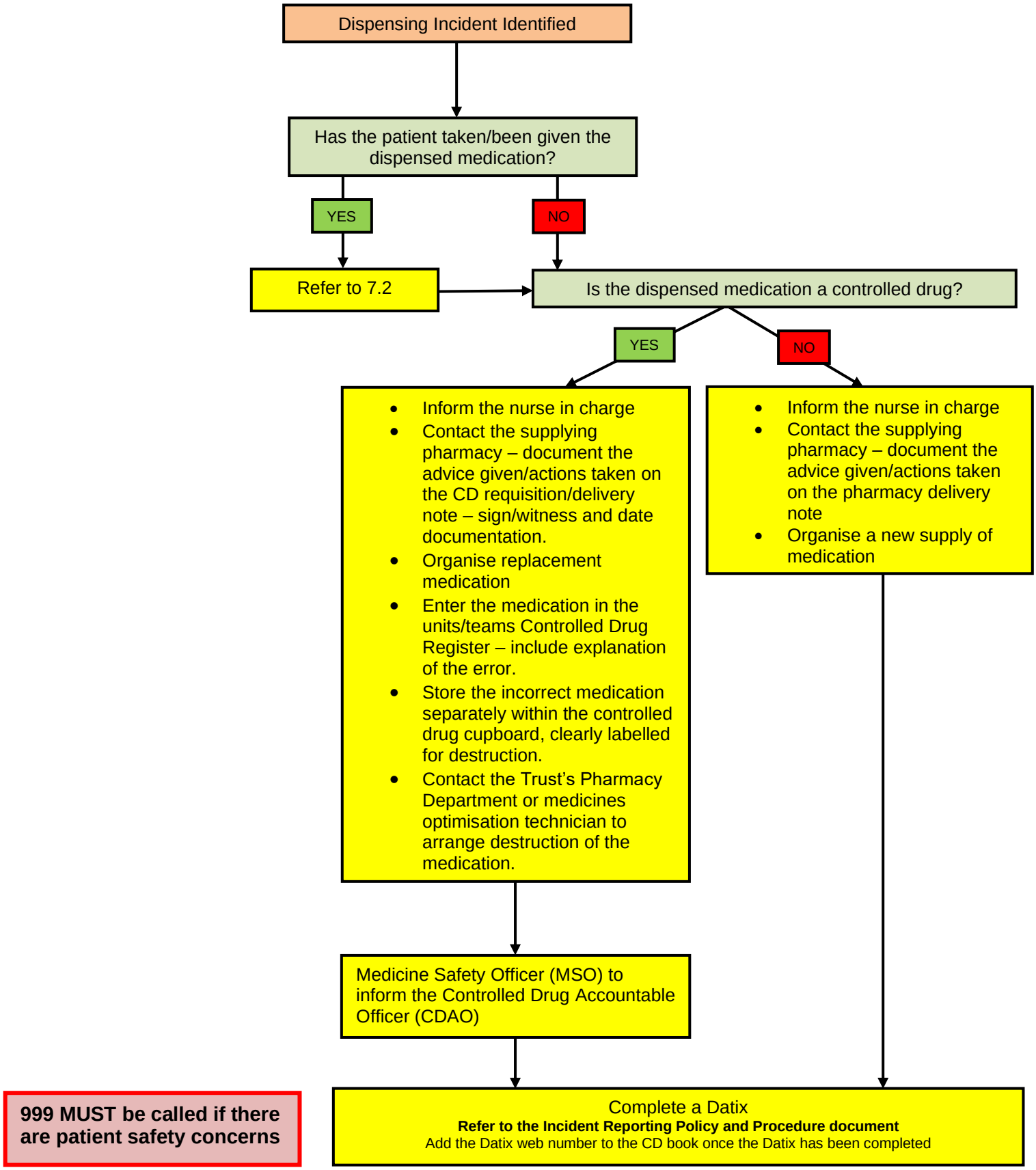


6.4. Immediate Action to be taken when a Prescribing Incident has been identified



999 MUST be called if there are patient safety concerns

6.5. Immediate Action to be taken when a Dispensing Incident has been identified



7. DATIX INCIDENT MANAGEMENT

Refer to the Incident Reporting Policy and Procedure.

8. LEARNING, FEEDBACK AND SUPPORT FOR STAFF

Refer to the Incident Reporting Policy and Procedure.

9. RELATED POLICIES AND PROTOCOLS

- Incident Reporting Policy and Procedure
- Serious Incidents and Significant Events Policy and Procedure
- Duty of Candour Policy and Procedure
- Incident Review Meeting SOP
- Mental Health Act Policy

Appendix 1: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. **Document or Process or Service Name**: SOP for the Management of Medication Incidents
2. **EIA Reviewer (name, job title, base and contact details):** Kerry Finch, Medicines Safety Officer
3. **Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?** Procedure

Main Aims of the Document, Process or Service
To improve the management of medication incidents.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	The SOP is consistent in its approach regardless of age.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory, Physical, Learning, Mental health (including cancer, HIV, multiple sclerosis)	Low	The SOP is consistent in its approach regardless of disability.
Sex	Men/Male Women/Female	Low	The SOP is consistent in its approach regardless gender.
Marriage/Civil Partnership		Low	The SOP is consistent in its approach regardless of marital status.
Pregnancy/ Maternity		Low	The SOP is consistent in its approach regardless of pregnancy/maternal status
Race	Colour Nationality Ethnic/national origins	Low	The SOP is consistent in its approach regardless of race.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The SOP is consistent in its approach regardless of religion or belief.
Sexual Orientation	Lesbian Gay men Bisexual	Low	The SOP is consistent in its approach regardless of sexual orientation
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	The SOP is consistent in its approach regardless of gender reassignment.

Summary

Please describe the main points/actions arising from your assessment that supports your decision. The SOP is consistent in its approach regardless to any of the target groups identified above.	
EIA Reviewer: Kerry Finch	
Date completed: 2nd January 2024	Signature: K.Finch