**Medication Errors**

Below is an excerpt from CQC website:

Medicines error

Errors can occur at different stages of the medication use process.

A medicines error is any patient safety incident, where there has been an error while:

* prescribing
* preparing
* dispensing
* administering
* monitoring
* providing advice on medicines.

Medicines errors are not the same as adverse drug reactions.

Medicine errors occur when weak medication systems or human factors affect processes.

Human factors to consider:

* fatigue
* environmental conditions
* staffing levels.

Medicine errors can result in severe harm, disability and death.

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Errors may result in an incident or an adverse event or where averted they can be classified as a ‘near miss’.

Examples of administration errors can include the following:

1. Omissions – any prescribed dose not given

2. Wrong dose administered, too much or too little

3. Extra dose given

4. Unprescribed medicine – the administration to a client of any medicine not authorised for them

5. Wrong dose interval

6. Wrong administration route – administration of a medicine by a different

route or in a different form from that prescribed

7. Administration of a drug to which the resident has a known allergy

8. Administration of a drug past it’s expiry date

**What does ‘best practice’ look like when dealing with medication errors?**

As part of the CQC Essential standards Care Companies are required to have “arrangements for reporting adverse events, adverse drug reactions, incidents, errors and near misses. These should encourage local and, where applicable, national reporting, learning and promoting an open and fair culture of safety”.

If a client is unwell as a result of the medication error or incident, medical assistance should be sought straight away.

All notifiable incidents should be reported to the CQC.

However, a care company should not ignore other errors, incidents or near misses but should encourage a culture that allows their staff to report incidents without the fear of an unjustifiable level of recrimination. It is clear that the more evidence that is reported the more information is available about what could possibly go wrong.

A medication policy should include how to deal with medication errors, incidents and near misses.

Staff should be clear as to the definition of a medication error, incident and ‘near miss’. Examples of medication errors are given above.

**Chapter Care procedure for medication errors is:**

1. **All** medication errors, incidents and near misses should be reported to the Care Manager on duty to inform them what has happened. This should be done through the on-call system immediately whilst you are still with the client. **DO NOT LEAVE THE VISIT UNTIL YOU HAVE SPOKEN TO THE CARE MANAGER ON DUTY.**
2. The Care Manager will advise you what action has to be taken to rectify the immediate situation.

1. The client and their relatives (if appropriate) should be notified of any medication errors or incidents.
2. You will be required to write a report stating the facts surrounding the medication error or incident.
3. There will be an investigation and review of the medication errors, incidents and near misses that have occurred. The results of these investigations should be recorded including any actions taken such as offering training to individuals or reviewing existing procedures.

Care Companies should have a clear reporting system, including the requirement for a written report describing what has happened, what was done to rectify the immediate situation and what has been done to prevent it happening again.

There should be regular audits or reviews around medication. Which focus on reasons for omitted doses, coding of refusals, Mar chart completion and administration of prn (when required) medicines.

Staff should have competency checks which include the administering of medications safely.

When investigating errors, incidents and near misses, companies should have a fair and just way of dealing with these. In essence the idea is not to play the “blame game” but to look at what happened, why it happened and how can the chances of this happening again be reduced. The outcomes from an investigation may include –

1. Re-training the staff member who has made the error
2. Reviewing the systems in place and changing them if it is identified as a cause
3. Staff members may have a member of the management team come out to observe them to check they are following the correct procedures and to show them the correct way to administer medication safely