Good Practice Guidance 10: Handling of medication errors, incidents and near misses in Care Homes

Advice for care home staff only

Key Points

- Medication errors can be defined as patient safety incidents involving medicines in which there has been an error in the process of prescribing, dispensing, preparing, administering, monitoring, or providing medicine advice, regardless of whether any harm occurred.

- Care homes are required to have “arrangements for reporting adverse events, adverse drug reactions, incidents, errors and near misses.”

- If a resident is unwell as a result of the medication error or incident, medical assistance should be sought immediately.

- All notifiable incidents should be reported to the Care Quality Commission (CQC).

- Care home medication policies should include how to deal with medication errors, incidents and near misses.

- Care homes should have a clear reporting system for medication errors, incidents and near misses.

- There should be a regular method for investigating and reviewing medication errors, incidents and near misses by a designated member of staff with learning points and actions shared with all staff members involved with medicines.

What is a medication error?
The National Patient Safety Agency’s (NPSA) definition of medication errors is:

“Medication errors can be defined as patient safety incidents involving medicines in which there has been an error in the process of prescribing, dispensing, preparing, administering, monitoring, or providing medicine advice, regardless of whether any harm occurred”.

Care staff should be clear as to the definition of a medication error, incident and ‘near miss’. Errors may result in an incident or an adverse event or where averted, they can be classified as a ‘near miss’.
Examples of medication errors are given below:

1. **Omissions** – any prescribed dose not given
2. **Wrong dose administered**, too much or too little
3. **Extra dose given**
4. **Un-prescribed medicine** – the administration to a resident 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. **Wrong time for administration**
8. **Not following ‘warning’ advice when administering** e.g. Take with or after food.
9. **Administration of a drug to which the resident has a known allergy**
10. **Administration of a drug past it’s expiry date**

All medicines have inherent hazards. Most medicines are toxic in overdose or have the potential to cause harm if used inappropriately or incorrectly. Usually, medication errors happen because the safeguards and defences intended to prevent medication errors from happening are inadequate or fail.

**Why reduce medication errors?**
- reduces the risk of a patient being harmed;
- can prevent unnecessary hospital admissions or re-admissions
- can prevent prolonged hospital stays - medication errors during a hospital stay can delay discharge.
- reduce unnecessary costs to the NHS.
- Increase staff confidence and morale.
- reduces risk of litigation for clinical negligence.

**What are the statutory requirements around reporting medication errors?**
From 1 October 2010, all adult social care providers must notify the Care Quality Commission (CQC) under the Health and Social Care Act 2008 about specific incidents including medication errors and incidents. The law requires these notifications to be submitted within certain timescales – further guidance is available on what should be reported, how and in what timescales via the CQC guidance on Statutory Notifications.

The notification must be made in writing and the CQC provide template forms to simplify the notification process. Further information and guidance is available on the ‘Notifications’ section of CQCs website [www.cqc.org.uk](http://www.cqc.org.uk).
What does ‘best practice’ look like when dealing with medication errors?

As part of the CQC Essential standards care homes 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”.

- When care staff are made aware that a resident has been the victim of a medication error or if a resident is unwell as a result of a medication error or incident, medical assistance should be sought immediately. The resident and their relatives should be notified of any medication errors or incidents in a timely fashion.

- Care homes should have a medication error policy in place and all staff should be very familiar with this policy. The medication policy should include how to deal with medication errors, incidents and near misses with clear step by step instructions.

- All medication errors, incidents and near misses should be reported to the duty manager to inform them what has happened and also what action has been taken to rectify the immediate situation and what has been done to prevent it happening again. All notifiable incidents should be reported to the CQC.

- There should be a regular method for investigating and reviewing medication errors, incidents and near misses by a designated member of staff. A home 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.

- The results of these regular investigations should be recorded including any actions taken such as offering training to individuals or reviewing existing procedures.

- Regular meetings should be held with all staff involved with handling or administering medication to review the outcomes and investigations of errors/incidents/near misses, share learning points and prevent reoccurrence of similar errors, incidents or near misses.

- A care home should also log any incidents that occur as a result of errors made as part of the prescribing or dispensing process, for example, by GPs or community pharmacists. Such errors should be discussed with the GP or community pharmacist.

- To help reduce administration errors, the Care Home Use of Medicines Study (CHUMS) recommends a robust system for constant review of accuracy of medicine administration records. This could be in form of a regular audit or review. It could focus on, for example, reasons for omitted doses, coding of refusals, and administration of PRN (when required) medicines.
What can be done to reduce errors?
The National Patient Safety Agency seven step plan to reduce all types of medication errors:

1. Increase reporting and learning from medication incidents
2. Implement safer medication practice recommendations
3. Improve staff skills and competences
4. Minimise dosing errors by introducing a ‘double check’ culture
5. Ensure medicines are not omitted
6. Ensure the correct medicines are given to the correct patients
7. Document patients’ medicine allergy status

MAR charts should be completed and all relevant codes used even when medication is refused or if not required when offered with ‘PRN’ medicines.

Care staff should ensure that medication is being reviewed and monitored by GPs where possible.

Care staff should ensure that allergy status for all residents is regularly checked and updated.

Care staff should also be aware of the types of medicines or specific medicines that have reports where repeated serious errors have occurred and particular effort needs to be made to improve medication safety. These include:

- Oral anticoagulants e.g. warfarin
- Anti-platelets e.g. aspirin
- Diuretics e.g. furosemide
- ACE inhibitors e.g. lisinopril
- NSAIDS e.g. naproxen, diclofenac
- Methotrexate
- Opiate analgesics e.g. morphine

This list is not exhaustive and serious errors have occurred with other drugs for example, insulin.

Further information

What resources can help me to deal effectively with medication errors?
Further information on Notification of other Incidents in care homes is available in Outcome 20 of the CQC Essential Standards of Quality and Safety

Further information on managing medicines in care homes is available in Outcome 9 of the CQC Essential Standards of Quality and Safety

CQC website with further information about the statutory notifications;

The Royal Pharmaceutical Society of Great Britain has produced professional pharmaceutical guidance ‘The handling of medicines in Social Care’ also provides information on managing medication errors: http://www.rpharms.com

The Nursing and Midwifery Council (NMC) provides guidance and advice on a number of topics which is available on their website; http://www.nmc-uk.org


The National Patient Safety Agency also contains information on medication incidents and errors related to medicines; http://npsa.nhs.uk/


Good Practice Guidance documents are believed to accurately reflect the literature at the time of writing.