Caring for Care Homes

How to record and review a significant incident

It is important that all medicines-related safety incidents, including all 'near misses' and incidents that do not cause any harm are recorded and reviewed to understand and share the learning from them.

Why is it important to record safety incidents?

The recording and review of incidents provides valuable learning to make the NHS safer. Only a small percentage of incidents result in actual harm, but no harm and low harm incidents provide an opportunity to learn and develop strategies to minimise the risk of preventable harms.

What would be considered a safety incident?

A safety incident is any event (positive or negative) which is important or unusual and provides an opportunity to identify an area for learning, improvement or the sharing of good practice. Significant events could relate to clinical, organisational or communication issues or they might be a combination of these. This guidance sheet will focus on incidents related to medicines.

What would be considered a medication incident?

Definition of a medication error[1]: "A medication error is any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professional, resident, or consumer". Please see over the page for examples of scenarios where medication errors can occur.

What actions should be taken after discovering an incident?

1. After discovering an incident, the priority is to ensure the resident is safe. This may require contacting the resident's GP or other healthcare professional.
2. When you are satisfied that the resident is safe consider the following:
   - Could the incident be a safeguarding issue? If so, report to safeguarding through your usual route
   - Did the incident result in a death, an injury, abuse or allegation of abuse, or was it reported to, or investigated by the police? If yes, report to Care Quality Commission and your Local Authority commissioners.
   - Did the incident involve a Controlled Drug? If yes, report to NHS England CD Accountable Officer using the online CD Reporting Tool at: **www.cdreporting.co.uk**
3. Complete details of the incident as soon as possible after the incident. This form should be retained in the care home.

How should I use the form?

1. Details of the incident should be completed as soon as possible.
2. Do not include the names of people involved, the report should be anonymous to allow sharing with the wider team.
3. You should then take time to reflect on what happened and identify what went well and what did not go well and to make appropriate changes to practice. This approach will enable you to concentrate on learning and improving systems and processes to manage risk more effectively.
4. Following a full evaluation, you should use the form to facilitate discussion and reflection at your team meetings to ensure that any learning is shared with the wider team.

The following list gives examples of scenarios where medication errors can occur. Near misses in any of the sections below should also be recorded and then reviewed when appropriate.
The definitions have been divided into sections according to the National Patient Safety Agency (NPSA) Safety in doses: medication safety incidences in the NHS (2007):

Prescribing Errors

- Resident prescribed the wrong medication, dose, route or rate
- Incomplete information e.g. no strength or route specified
- Medication omitted from prescription
- Medication prescribed to the wrong resident
- Transcription errors, this would include errors when hand-writing a Medication Administration Record (MAR) Chart
- Prescribing without taking into account the resident's clinical condition
- Prescribing without taking into account resident's clinical parameters e.g., weight

Pharmacy/Dispensing Doctor Dispensing Errors

- Resident dispensed the wrong medication or dose or route
- Medication dispensed to the wrong resident
- Resident dispensed an out-of-date medicine
- Medication is labelled incorrectly

Preparation and Administration Errors

- Resident administered the wrong medication, dose or route
- Resident administered an out-of-date medicine
- Medication administered to the wrong resident
- Medication omitted without a clinical rationale
- Medication incorrectly prepared
- Unauthorised administration e.g., disguised in food
- Medication administered late or early
- Medication deliberately not administered without good reason
- Administration of medication recorded incorrectly or not recorded

Monitoring Errors

- Resident known to be allergic to medication, but the medication was prescribed and/or dispensed and/or administered
- Failure to provide the resident with correct information regarding their medication e.g. when to take, what it is for, side effects
- Failure to monitor therapeutic levels
- Failure to monitor resident who is undertaking self-medication
- Failure to react appropriately to signs of ill health, pain or requests for help due to being unwell – associated with medication administration

Other Errors

- Poor or inadequate communication
- Poor, inadequate or incorrect recording/documentation
- Inappropriate or inadequate disposal of medicines
- Inappropriate administration of medication to chemically manage a resident's behavior that has not been prescribed or giving additional doses to sedate resident
- Deviation from local policy and guidelines relating to medicines management