From St Christophers Hospice In-Patient Unit Drug Policy 2004

Section 3 ERRORS AND INCIDENTS INVOLVING DRUGS

"It is important that an open culture exists in order to encourage the immediate reporting of errors or incidents in the administration of drugs. If you make an error, you must report it immediately to your manger or employer"

Guidelines for the Administration of Medicines NMC 2002

3.1 Procedure following an error involving drugs

(i) The nurse must report the error/incident to the nurse in charge of the ward/department, senior nurse on call or Night Co-ordinator as soon as the error is realised, both monitoring any adverse effects.

(ii) The nurse in charge of the ward must report the error in administration to the Doctor immediately so that appropriate action can be taken if necessary to prevent the absorption of the drug.

(iii) The Nurse/s involved in the error or the nurse discovering the error must complete a drug error form, explaining how the error occurred and adding any reasons or extenuating circumstances they feel should be taken into consideration. This statement must be written during the shift/span of duty and before the nurse/s leave work.

(iv) The nurse involved in the error (or in her absence, the nurse in charge) should, wherever possible, inform the patient of the error. She should not do this if it is her belief (and that of the nurse in charge or doctor) that by doing so she will unduly distress the patient.

(v) The nurse involved in the error (or in her absence the nurse in charge) should, wherever possible, inform the patient's relatives/carers of the error. If they are not available, they should be informed on their next visit to the ward. The nurse should not do this if it is her belief (and that of the nurse in charge or doctor) that by doing so she will unduly distress them.

(vi) That the patient and relatives/carers have been informed, or the reasons for not informing them, should be recorded on the drug error form.

(vii) Following review of the drug error form, a team leader will meet with the nurse(s) at the earliest opportunity. If appropriate, the Matron may also meet with the nurse(s)

(viii) The completed drug error form should be sent to the pharmacist for review and filing. Drug errors will then be reviewed by the pharmacist every 6 months and discussed with the Matron, Team Leaders and Pharmacy Information Group. The pharmacist will produce a 6-monthly report.

(ix) The drug error must be reported in the evaluation sheet of the patient's case notes

(x) If any nurse makes an error of administration due to failure to abide by the regulations or guidelines in this policy, the Disciplinary Procedure may be invoked.

(xi) Any known error/incident not declared will invoke the disciplinary procedure.

3.2 Drug Errors involving Dose Omissions

Omissions are often only detected on a later shift once the nurses responsible have left the hospice. If an omission is detected, it should be discussed with the bleep holder and a decision should jointly be made on whether to contact the appropriate nurse from the previous shift and/or seek medical advice on giving the omitted dose subsequently.

3.3 Loss of a Controlled Drug

(i) The nurse in charge of the ward or department must immediately inform the Senior Registered Nurse on duty or Night Sister.
(ii) The Senior Registered Nurse should be routinely informed of any loss of Controlled Drugs.
(iii) The Pharmacist must be informed by the senior nurse or Matron as soon as possible.
(iv) A decision will be made by the Senior Registered Nurse, advised by the Pharmacist as to whether the police should be informed.
(v) A Drug Error Form should be completed as outlined in section "Procedure to be Carried Out Following an Error Involving Drugs" (above).
(vi) Full records must be made in the Controlled Drug register.
(vii) Additional checking and other procedures may be used if a loss remains unexplained. Decisions involving these procedures will be made jointly between the Senior Registered Nurse Team Leaders and Pharmacist, as appropriate.

3.4 Adverse Incidents involving drugs

If a patient suffers an adverse effect deemed to be caused by or related to drug use, it should be documented on the Drug Errors and Incidents form.
Examples of adverse incidents include;

- allergic reactions
- undesirable effects documented by the manufacturer
- undesirable effects previously unreported and potentially caused by a drug.

The forms may be completed by any member of the Multi-disciplinary team but should be sent to the hospice pharmacist once completed. The hospice pharmacist will inform the Medicines and Health Regulatory Authority.

ST CHRISTOPHER'S HOSPICE
REPORTING FORM FOR INCIDENTS AND ERRORS INVOLVING DRUGS

Report by: Dr Nurse Pharmacist ***Location:*** IPU (Ward .....) Home Other ***Date:***
(circle) ***(circle)***

Please tick the category of incident/error you wish to report

SUPPLY		**PRESCRIPTION**		**ADMINISTRATION**	
Stock inadequate/expired		Chart incomplete		Dose omission/delay	
Drug information problem		Incorrect dose		Incorrect dose given	
Labelling error		Incorrect frequency		Incorrect administration/route	
Dispensing error		Illegible/confusing		Other (please specify)	
Drug loss		Drug interaction			
Other (please specify)		Transcription error			
		Other (please specify)			
				ADVERSE INCIDENT e.g. allergic reaction to drug	

Details of incident/error (I/E)
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Factors contributing to I/E
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Staff reporting I/E	Staff involved in I/E	
Signature(s)		
Name of doctor informed (if applicable)	Date informed	Time informed
Patient informed YES/NO	Date:	Time:
Reason patient not informed:		
Relatives informed YES/NO	Date:	Time:
Name of relative informed:	Reason relative not informed:	
Recorded in patient's notes	Date:	Time:

Review by Line Manager:

Team Manager: (sign + date)	Matron/Director of Nursing/Med. Director (if appropriate) (sign + date)

Action taken to minimise this incident/error (To be completed by line manager)
Action planned to minimise risk of this incident/error recurring (To be completed by line manager)
Review by MD group (if required)
Classification of error (see below) *To be completed by pharmacist* Supply Prescription Administration Level 0 Level 1 Level 2 Level 3 Level 4 Level 5 Level 6

Explanatory Notes on Classification of errors

A Three broad categories: supply, prescription and administration

B Also classified as serious (capable of producing permanent organ damage or death) or not serious

Level 0: error prevented by staff surveillance (i.e. near miss)
Level 1: error occurred but there was no patient harm.
Level 2: error occurred: increased monitoring was required, but no change in clinical status
Level 3: error occurred: change in clinical status, or need for increased laboratory monitoring but no ultimate harm
Level 4: error occurred, extra treatment required, or increased length of hospice stay
Level 5: error occurred, permanent harm resulted
Level 6: error occurred resulting in the death of the patient

Ref: Wilson DG et al (1998) in Naylor R, Medication Errors, Radcliffe Medical Press, Oxford 2002

Instructions for completing error/incident forms

- Complete the front page of this report as far as bold line and then pass on to line manager for discussion and initial review and action plans.
- Line managers should decide whether further management input is required
- Line managers to complete review and action boxes where appropriate or request MD review via Pharmacy Information Group. Then send to pharmacist
- For anonymous reports and level 0 (near miss) reports – please send straight to pharmacist
- The pharmacist collates these forms and reports on them
- The pharmacist also reports adverse drug incidents to the MHRA (Medicines and Healthcare Regulatory Agency)