PROCEDURE FOR MANAGING AND SUPPORTING STAFF FOLLOWING A MEDICATION ERROR

(BESS: Bennion Error Scoring System)

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	tbc

ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Medicines Management Nurse

Circulated to the following for Consultation

Date	Role / Designation
13/02/18	Interim Nurse Director
	Executive Director for Community Care and Mental Health Services
	Assistant Director of Nursing
	Head of Clinical Education
26/03/18 14/08/18 circulated for virtual endorsement	Heads of Nursing / Midwifery
	Integrated Clinical Team Managers
	Head of Physiotherapy
	Acting Head of Pharmacy
10/04/18	Interim Medical Director

Evidence Base
Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area? The National Patient Safety Agency (2009) Medicines Management Standards: Nursing Midwifery Council (2010) Medicines Procedure: Powys THB (2018) Bennion Error Scoring System (BESS) (1986)

1 Introduction (Mandatory Heading)

A review of medication error incidents reported to the National Reporting and learning systems (2010) highlighted 525,186 incidents that had been reported over the previous 5 years. Of these 16% of medication incidents had caused actual patient harm, 0.9% resulted in death or severe harm.

The National Patient Safety Agency (NPSA) 2009 stated that reporting within the NHS had improved and that the majority of reported incidents had resulted in low or no harm to patients.
The analysis of this data provides a real opportunity to reduce the risk of further incidents occurring.
Powys Teaching Health Board (PTHB) recognises the need to learn from mistakes made but also the importance of supporting and educating staff following a medication error, omission or near miss, this should also be within a fair culture, unless deliberate actions are identified.
It is the manager's responsibility to ensure consistent, fair and equitable management of all staff in response to a drug error or near miss. The support provided to staff members should be evidenced, a reflective account undertaken and lessons learnt to avoid or reduce identified risk factors.
The Medicines Procedure and the Medicines Management Standards (Nursing Midwifery Council 2010) to be superseded by the Royal Pharmaceutical Society (RPS) Competency framework for all Prescribers, should be adhered to, repeated errors or deliberate non compliance to the procedure and standards must be managed appropriately and in a timely manner.

The National Reporting and Learning Systems (NRLS) defines a patient safety incident as "any intended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care". This can occur in the process of dispensing, prescribing, preparing, administering, monitoring or through the provision of medicines supply, storage and advice. An error includes omissions.

2 Objective (Mandatory Heading)

This procedure aims to

- Ensure timely reporting of all medication errors, omissions or near misses.
- To encourage an open culture of timely reporting.
- To outline the support to be provided to staff members.

That after reading the procedure staff will be aware of :

- Management and Employees responsibilities

- Actions to be followed with reference to an incident involving a medicines related error.
- The advantages in using the BESS Error reporting system, to ensure safe outcomes for the patient and staff member.

3 Definitions (Mandatory Heading)

- **PTHB**: Powys Teaching Health Board
- **NMC** : Nursing Midwifery Council
- **NPSA**: National Patient Safety Agency
- **NRLS**: National Reporting and Learning Systems
- **BESS**: Bennion Error Scoring System

4 Responsibilities (Mandatory Heading)

All Health Board staff must adhere to the procedure and procedures for managing and supporting staff following a medication error.

Service and Clinical managers
All managers, operationally responsible for service delivery, must facilitate implementation of the procedure within their own specific area. Thus ensuring that staff are aware of the procedure and how to comply with its content. The Medicines Management team will assist by providing the appropriate training.

Employees
All employees who are in the process of dispensing, prescribing, preparing, administering, monitoring or through the provision of medicines supply, storage and advice, must familiarize themselves with the procedure in order to understand their individual responsibilities when a medicines error, omission or near miss occurs.

4.1	**Staff Group or Specific Role**
	All employees who are in the process of dispensing, prescribing, preparing, administering, monitoring or through the provision of medicines supply, storage and advice,

5 Purpose

This procedure clearly sets out the actions to followed in relation to an medicines related error, omission or near miss:

1. As soon as the error, omission or near miss is identified, if there has been any suspected harm to the patient as a consequence of the incident, assess the patient's condition to establish whether there are any

immediate life threatening risks. If harm has occurred, call for help and take the appropriate immediate life support actions:
   a. Airway obstruction
   b. Breathing problems
   c. Cardiac arrest / CNS depression / severe hypotension / hypovolemia / hypoxia / bleeding / circulatory problems i.e. bradycardia. Continue to monitor the patient as required.
2. Report the incident immediately to the General Practitioner / Consultant responsible for the patient's care and ensure that appropriate next steps treatment is taken as appropriate.
3. Ensure the patient /carer is informed that a medication error, omission, near miss has occurred, an apology to be made if appropriate, prior to the investigation which will determine the next steps of the "putting things right" process.
4. Document the nature of the medication error in the patient's notes.
5. Report the incident as soon as is practically possible to the person in charge/ line manager and record the error on datix. The datix report will be reviewed by the Primary Care Drugs and Therapeutics committee, remedial action will be taken where required.
6. Ensure that support has been offered to the member of staff involved in the medication error, omission, near miss.
7. An investigation of the incident should be carried out by the senior line manager, using the Bennion Error Scoring System (BESS) to review the causal factors.
8. Depending on the level of risk and findings from the initial investigation, take necessary actions. This process should be carried out sensitively and with necessary support offered to the member of staff, i.e. Clinical Supervision and the Occupational Health Service.
   However, it must be noted that, where incidents are found to involve gross carelessness, criminal, deliberate or malicious actions, any immediate disciplinary issues will be addressed in line with the All Wales Capability or Disciplinary procedures. Consider whether a safeguarding referral should be made
9. At the appropriate time, allow the member(s) of staff involved in the medication error, omission, near miss to reflect on the circumstances and identify their own learning, using the error reflection form.
10. Identify any training or performance issues and put an action plan in place to address these.

6 Resources

The BESS (Bennion Error Scoring System) is usefully applied to medication errors, omissions or near misses. It is a simple and easy to follow process derived from the El Dorado Medication Error Tool produced by D. Cobb and M. Davis in 1986). Where possible, this process should be undertaken by the line manager in the presence of the member of staff who has made the error, omission or near miss. It is essential that confidentiality is maintained at all times.

7 Training

Staff will need to be made aware of how to use the BESS system. All instructions are contained within this procedure.

Complete the BESS Error Reporting Form (below):

- Date, time and location of incident
- Date and time incident reported
- Record who identified the error and other staff on duty at the time of the incident
- Provide a brief overview of the incident
- Document if patient was seen by a doctor following identification of the incident, record any direction from this.
- Record the:
    - Error category
    - Route
    - Drug
    - Reporting time
    - Outcome for the patient.

Add the scores to determine the outcome and action outcomes

8 Implementation

Divisional implementation of this procedure with ownership by the different professional group.

Further Information Clinical Documents

Clinical policies which should be read in conjunction with this include:

- All Wales Procedure for Medicines Administration, Recording, Review, Storage and Disposal.
- Procedure for the Management of Controlled Drugs
- NMC Standards for Medicines Management.

This procedure is underpinned by the professional codes of practitioners involved in medicines management activities.

Standards for Health Services Wales

This procedure contributes to compliance with the Standards for Health Services Wales, activity is specifically linked to three areas: timely safe and effective care.

9 Monitoring Compliance, Audit & Review

Incidents reported through the DATIX system will be reviewed and BESS score and adherence to action planning and lessons learnt, documented post BESS investigation will be monitored

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

10 References / Bibliography

- Aneurin Bevan University Health Board Procedure for managing and supporting staff following a medication error (2017 Draft)
- Calderdale and Huddersfield NHS Foundation Trust. The Medicine Code: Section 19 – Medication Errors: Version 7.2 (December 2016)
- Cardiff and Vale University Health Board. The Medicines Code: Version 1 (2017)
- The National Patient Safety Agency (NPSA) (2009) Tackling medication incidents and increasing patient safety (Online).

Available at: http://www.npsa.nhs.uk/corporate/news/tackling-medication-incidents-and-increasing-patient-safety/

- The Royal Orthopaedic Hospital NHS Foundation Trust Management of a drug error / near miss: Standard Operating Procedure Version 5 (2016)

Appendix 1

BESS Error Reporting Form

Area incident occurred / discovered:

Date of Incident: / /	Time of Incident: :
Location:	
Date incident reported: / /	Time incident reported: :
Error reported by (circle): SELF	OTHER

Staff involved: Identify number(s), bands/grades and whether staff are permanent or
agency / bank:

Total number of staff involved in error	

Name	**Profession / qualification i.e. nurse / student nurse / HCSW / Doctor / Pharmacist**	**Grade/band**	**Permanent / bank / agency**

Staff level at time of incident:

Number of Qualified staff	
Number of Unqualified staff	

Did staffing levels have an impact on the incident / situation (circle) **YES** **NO**

If 'Yes' explain why:

……..

……

……

Additional Information:

Patient seen by medical staff (circle)?	YES	NO
Discussed on the phone with medical staff (circle)?	YES	NO

Brief description of nursing / medical action recommended / taken:

……

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……

……

……

Prescription / authorisation clear and legible (circle)? If 'No' enclose a copy.	YES	NO
Pharmacy label clear and legible and matches prescription / authorisation (circle)?	YES	NO
Drug name, dose and formulation identifiable from manufacturer's box (circle)	YES	NO
Is the patient wearing a wrist band (circle)? (Hospital setting only)	YES	NO

Form completed by (Name and Signature)	**Date**

Bess Rating Scale

ERROR CATEGORY	**Points awarded**
Wrong time	**1 Point**
Wrong date	**1 Point**
Wrong patient	**3 Point**
Wrong route	**2 Point**
Wrong medication	**3 Point**
Wrong dose	**2 Point**
Extra dose	**2 Point**
Medication omitted	**2 Point**
Medication given when allergy stated	**3 Point**
Medication given against an unsigned prescription	**1 Point**
Wrong formulation	**1 Point**
Expired drug	**2 Point**
Presence of a known contraindication	**3 Point**
Failure to double pump appropriately (ITU / CCU only)	**3 Point**
Medication administered without a prescription	**3 Point**

Medication Classification

(if in doubt of what classification a drug belongs to, please look up in the BNF)

i	ii	iii	iv	v
Topical drugs & ENT Antacids. Anti-motility medicines Antidiarrhoeal agents Laxatives. Vitamins & Minerals Peripheral vasodilators Anti-platelets Lipid-regulators Sodium cromoglycate Leukotriene receptor antagonist anti-histamines Mucolytic Cough preparations Orlistat Paracetamol Acamprosate NRT	Antidementia drugs. Non-MAOI Antidepressants Anti-inflammatory agents Endocrine system drugs (not listed elsewhere) Hypnotics and anxiolytics Ulcer healing drugs Diuretics Nitrates/anti-anginals Dihydopyridine Calcium channel blockers Inhaled broncodilators and steroids Oral salbutamol Pseudoephedrine CNS stimulants Disulfuram Oral penicillin, cephalosporin and trimethoprim Contraceptives Allopurinol/colchicine Eye preparations	Eye preparations. Antibiotics/anti-infectives.(not listed elsewhere) Antipsychotic agents Barbiturates Narcotic antagonists Oral antidiabetic agents Steroids Glucose 50%/glucagon Management of inflammatory bowel disease Beta-blocker Centrally acting vasodilators & anti-hypertensive Alpha-blockers ACE and ARB Diltiazem Non-antihistamine anti-emetics Drugs for genito-urinary disorders Vaccines	Oral anti-cogulants (except warfarin) LMWH Thrombolytic agents. Cardiovascular drugs Antiarrythmics including digoxin, verapamil Narcotic analgesics Electrolytes Any IV agents MAOIs Anti-epileptics Parkinsons medication Aminoglycosides Anti-virals Penicillinamine/gold Ciclosporin, Leflunomide and tacrolimus Cytokine modulators	Warfarin & Heparin Blood & blood components Chemotherapeutic & Antineoplastic agents Insulin Clozapine Lithium
1 point	**2 points**	**3 points**	**4 points**	**6 points**

Add 4 points if under 18 years old

Route Given	Points awarded
IV, IM or SC	**3 Point**
Oral	**2 Point**
PEG administration	**2 Point**
Topic / Transdermal	**1 Point**
Inhaled	**1 Point**
PR or PV	**1 Point**
Sublingual / buccal	**1 Point**

Following Discovery, error reported within:	**Points awarded**
0 – 30 mins	**0 Point**
31 – 59 mins	**1 Point**
1 hour – 6 hours	**2 Point**
6 hours – 24 hours	**3 Point**
24 hours +	**4 Point**

Outcome to patient	**Points awarded**

Level of monitoring required by medical staff at time of error	
Minimal monitoring – little or minimal actions requested i.e. BP & pulse once only.	**0 Point**
Close monitoring – observations to be continued over a period of time i.e. BP & pulse over next 6 hours, BM hourly for 3 hours etc.	**1 Point**
Complex monitoring & medical intervention – extended nursing & medical observations, blood tests. Need for further medical opinion. Possible transfer to a District General Hospital.	**5 Point**
Intensive monitoring & medical intervention – transfer to HDU/ITU for emergency intervention. If already in ITU area a need for more intensive intervention.	**10 Point**

Total points scored (if more than one error in 12 months accumulate score)	**Outcome**
Minor severity Score 1-15	Staff member involved in error can continue to prescribe / dispense / administer / advise on medicines. Score retained on practitioners file for 12 months. NB through reflection the practitioner must demonstrate they are a safe practitioner. If there is any doubt the line manager can ask the member of staff to undertake a supervised practice, even though the points fall in the 'monitor severity category.
Moderate severity Score 16-24 **Major severity Score 25+ points**	Staff member involved in error **MUST NOT** prescribe / dispense / administer / advise on medicines, without further training and supervision. • **Carry out reflection** • **Action plan (moderate / major score will determine detail of action plan) to include: Supervised practice & Competency assessment** • Score retained on practitioners file for 12 months.

Appendix 2

Recording chart for supervised practice following a medication error
To be retained in practitioners personal file

Administration of Medicines – Record of Supervised Practice

Episode Number	Date	Medication	Route	Supervisors signature	Competent	Not Competent
					Tick which applies	

Appendix 3

Powys Teaching Health Board
Reflection on Medication Errors Reflection Tool (Form 3)

This form should be completed by all professional groups in the event of a medication error or near miss.
A copy should be retained by the professional completing the form for revalidation purposes.

Date of error & Time	Area of work:	Datix incident No:	BESS score **Must be added to DATIX report**	BESS score in last 12 months **Must be added to DATIX report**
Brief description of error (please attach any relevant information, e.g. copy of labels, prescription, etc.)				
What factors may have contributed to this error?				
What are the implications of this error for the patient?				
What have you learnt from this error?				

What steps will you take to limit this error occurring in the future?

Further action / training / support required:

ALL ACTIONS TO BE UPDATED ONTO THE RELEVANT DATIX REPORT

What is your understanding of the severity of this error?

Minor or no risk ☐
Moderately serious risk ☐
Serious effect risk ☐
Very serious/fatal risk ☐

Discussion & Review Comments: Line manager / Prescribing lead / Clinical lead

Can the practitioner resume their role without further supervision? YES NO
(Practitioner to provide rationale if this decision differs from the 'interpretation of score and outcome)

Name_____ Reviewers name _____

Signature _____ Signature _____

Date:_____ Date: _____