SOP FOR MANAGING AND SUPPORTING STAFF FOLLOWING A MEDICATION ERROR

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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	Nov 2022
2	• Link the Being Fair Tool (NHS England) • Medication Incident Investigation tool • Risk Ratio and Action table • Reflective accounts and additional links for other healthcare professionalisms • Outline Fair Blame culture • Objective risk and action outcome	

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Cara Bruton, Medicines Management Nurse

Circulated to the following for Consultation

Date	Role / Designation
26/07/2024	Head of Nursing
	Head of community Services, Medicine Management
	Medicines Management Nurse & NMP Lead
	Head of Safeguarding
	Head of Quality and Safety
10/01/2025	Community Service Managers
	Mental Health Modern Matron
	Head of Mental Health Nursing, Quality and Safety
	Head of Therapies & Professional Lead for Occupational Therapy
02/06/2025	Ward managers
	Deputy ward managers

1 Introduction

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.

It is important that an open culture exists to encourage the immediate reporting of errors and incidents in the administration of medicines. Incidents rarely occur because of one single factor and a policy of learning from events is essential to risk management.

Errors in medication prescribing, dispensing and administration can result in serious harm to patients, and it is therefore essential to ensure that all possible steps are taken to minimise the risk for their occurrence.

The terms error, medication error, medication incident and medication related incident are used interchangeably throughout this document.

2. Objective

This procedure aims to:

- Reduce the risk of harm to patients and staff
- Ensure lessons are learnt from each clinical incident
- Adopt a proactive and fair approach with staff
- Ensure timely reporting of all medication errors, omissions or near misses,
- Encourage an open culture of timely reporting,
- Outline the support to be provided to staff members involved in a medication error.

After reading this procedure, staff will be aware of:

- Management and employees' responsibilities
- Actions to be followed with reference to an incident involving a medication related error.

3. Definitions

- **AHP –** Allied Healthcare Professional
- **DoC –** Duty of Candour
- **NMC-** Nursing and Midwifery Council
- **NRLS-** National Reporting and Learning System
- **NSPA-** National Patient Safety Agency

- **PTHB** – Powys Teaching Health Board
- **TSU-** Temporary Staffing Unit

4. Role / Responsibilities

This policy applies to all staff involved in the prescribing, dispensing, administration, preparation, supply, storage, transcribing, and disposal of medicines. These include

- Allied Healthcare Professionals (AHP)
- Registered nurses/midwives/nurse associates/assistant nurse practitioners, and healthcare support workers.
- Pharmacists/pharmacy technicians and pharmacy support staff
- Unregistered healthcare staff who handle medicines as part of their role (e.g., transport, porters)
- Physicians Associates
- Medical and dental staff

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

4.1 Service and clinical managers

All managers operationally responsible for service delivery must facilitate the implementation of this procedure within their own specific area, thus ensuring that staff are made aware of this procedure and how to comply with its contents. Ward/unit managers and deputy ward/unit managers are responsible for ensuring the performance of their staff is managed in relation to medication processes including administration, preparation, storage, disposal and the relevant documentation.

The Medicines Management team will assist by providing appropriate training and advice.

4.2 Employees

All employees who are involved in the process of dispensing, prescribing, preparing, administering, monitoring, transcribing or through the provision of medicines supply, storage and advice, must familiarise themselves with the procedures in order to understand their individual responsibilities when medicines error, omission or near miss occur.

4.3 Medicines Management Nurses

Medicines management nurses will support managers and staff involved in medication errors and incidents by:

- Supporting the implementation and interpretation of this procedure.
- Supporting investigations
- Supporting supervised practice where the Healthcare Professional has made previous medication errors
- Liaising with national peers re: national direction around errors
- Providing medicines related training
- Recommending changes in practice where learning from incidents suggests that this is required.
- Supporting the implementation of any changes in practice and policy and procedure updates.

4.4 Professional Heads of Service

Professional Heads of Service will support any professional elements arising from medication errors.

5. Procedures and guidance

5.1 Examples of medication errors

Although not exhaustive, the following errors by either the prescribing, supply and/or the administration of a medicine are examples of the type of incident that **must** be reported:

- The wrong medicine
- The wrong dose
- The wrong patient
- The wrong route
- Administering a medication late or early without justifiable reason
- Omitting a prescribed medicine without sufficient explanation as to why, e.g., prescriber instruction to withhold the medicine.
- Failure to follow up, or act upon the reasons why a medicine has not been administered, e.g., medication not available; patients unable to take medication.
- Failure to address safeguarding issues according to health board policy, e.g., lack of capacity to consent or refuse treatment.
- Failure to comply with specific instructions for the administration of a medication, i.e., to be given with food.

- Failure to observe or ascertain the allergy status of a patient or the incorrect documentation of an allergy or allergy status.
- The administration/prescription of a medication to a patient with a contraindicated allergy
- Administration/supply of a medication that has expired (including shortened expiration).
- Administration of a medication that has been discontinued.
- Administration of a medication without a valid prescription.
- Administration of a medication that belongs to another patient.
- Administration of a medication without undertaking required physical health monitoring e.g., INR prior to warfarin, gentamicin levels prior to gentamicin administration
- Lost medication/keys/charts
- Given without patient or parental consent (for school age children in the community)
- Administering a medication where correct storage requirements have not been adhered to and pharmacy have not agreed use e.g. fridge/cold chain excursion
- Incorrectly or ambiguously transcribing a medication or transcribing without authorisation.

5.2 Contributing factors

In considering the incident, it is important to identify any other important contributing factors such as:

- Ambiguous prescription
- Communication failures
- Documentation problems
- Interruptions
- Packaging of a product (look-a-likes)
- Policy/procedure/SOP not available/unclear
- Product storage e.g. room and fridge temperature excursions, storage space.
- Similar patient names
- Similar looking medicine names
- Similar sounding medicine names
- Skill mix
- Space to prepare product for administration
- Staffing levels
- Urgency of situation
- Individual personal distractions

	5.3 Safeguarding If any safeguarding concerns or significant risk factors are identified for a child or vulnerable adult, practitioners must follow Wales Safeguarding Procedures (2019) and the PTHB Safeguarding Policy. Advice and support concerning any safeguarding issue can be sought from PTHB Safeguarding Team via the Safeguarding Hub on 01686 252806 or email PowysTHB.Safeguarding@wales.nhs.uk (Monday-Friday 09:00-17:00, excluding Bank Holidays). Outside of office hours, Local Authority can be contacted on 0345 0544 847 or contact Silver on Call. All registered practitioners should access appropriate safeguarding supervision and training as per guidance. Safeguarding Supervision (sharepoint.com)
	5.4. Controlled drugs All errors including controlled drugs must be reported via DATIX and investigated immediately and the CD Incident SOP followed Controlled Drugs - Powys Teaching Health Board (nhs.wales). Any discrepancies must be investigated in accordance with the above CD Incident SOP and Dealing with Discrepancies.
	5.5 Actions All medication incidents must be reported through PTHB clinical incident reporting system, DATIX and an investigator assigned. It is the responsibility of the staff member who initially made the medication error (if aware) or the staff member who discovers the medication incident/error to report the medication incident/error via DATIX. The process for managing and supporting staff following a medication error is outlined in Appendix A. If the investigator is unsure whether a staff member involved in a medication incident requires specific individual review, the Being Fair Tool may be used to help assess the incident. **Please note – the Being Fair Tool should only be used when concerns about an individual's conduct or fitness to practice are raised during a patient safety learning response. It is not for routine use.**

	Ward/department managers dealing with and investigating medication related incidents and errors must utilise the Medication Error Investigation tool (appendix B), the Risk Ratio (appendix C) to appropriately investigate errors and incidents related to their severity. The Action Table (appendix D) must be referred to when putting together an action plan for the healthcare professional involved in the medication related incident or error.

	5.6 Reporting mechanism for a medication error Following a medication error, the immediate priority is to ensure the safety of the patient involved. The following actions should include: 1. Report the incident immediately to the person in charge of the shift (escalate through management or professional channels as required, including silver on-call if out of hours) as well as the GP/Shrop-Doc if appropriate 2. Any emergency action required, either ward based or acute, should be initiated and if appropriate the GP/ Shrop-Doc should be called to access the patient or give advice on clinical management of the patient. 3. The error must be documented fully via DATIX, including the medication functionality and, if appropriate, within the patient's notes along with any actions or monitoring required. 4. A full handover of the event, actions, monitoring, and outstanding issues must be given to all subsequent shift leaders until the clinical needs of the patient are fully met. 5. Where appropriate, the patient or next of kin must be informed of the error within 7 days for low/no harm and 5 days for Duty of Candour, and any subsequent monitoring or remedial action must be fully explained (for moderate to severe incidents, please refer to PTHB Duty of Candour guide for NHS staff. 6. Where appropriate, medicines, containers, syringes, infusions, administration sets, and medical devices must be retained safely for examination by the person investigating the incident and only disposed of if the person investigating the incident is satisfied that all necessary information has been gathered. 7. Where a device is involved in a medication error, the type of device, the manufacturer and the serial number must be recorded in the DATIX report. The Datix report will be referred to the medical devices team as appropriate.

All staff must be familiar with the DATIX reporting system when completing an incident report in the event of a medication error. In addition to the required information, the following must be included:

- Patient identifiable information and location of incident
- Name of medication(s) involved
- Where appropriate, dose, route, formulation, frequency of medication as prescribed and as administered i.e. medication prescribed orally but administered intravenously
- Where appropriate, when and number of times the medication was omitted, delayed, or given in error
- Where appropriate, describe the type of allergic relation/adverse reaction experienced by the patient
- Where appropriate, serial numbers of medical equipment involved
- If documentation is illegible or ambiguous – attach photocopies of documents to the incident report
- If known, the name of the healthcare professional involved in the medication error (in the relevant area of the DATIX reporting form)
- If a student practitioner has been involved in a medication error or incident, the Practice Education Facilitator or designated supervisor must be informed. This is to ensure the relevant university is made aware and the student can receive appropriate training and support as required
- If bank staff have been involved, the Temporary Staffing Unit must be informed
- If agency staff have been involved, the Temporary Staffing Unit must be notified and will inform the relevant Agency

5.7 Fair process

It is known that fear of investigations, disciplinary action and subsequent sanctions discourages staff from reporting incidents including incidents involving medicines.

The purpose of this document is to identify process issues, areas for improvement and learning opportunities from medicines related incidents, and errors to reduce harm to both patients and PTHB staff.

However, where it is deemed that a medication incident is serious, or concerns are raised regarding an individual's conduct or fitness to practice, the Being Fair Tool may be utilised to help decide appropriate actions. A professional

	investigation and/or a patient safety investigation may need to be conducted and if it is identified the incident is a result of possible negligent practice, the incident will be dealt with using the PTHB Disciplinary Policy and Procedure. **The Being Fair Tool should only be used when concerns about an individual's conduct or fitness to practice are raised during a patient safety learning response. It is not for routine use.**
	5.8 Management of staff involved in a medication error Each professional group will need to follow this procedure as well as their own Professional Code of Conduct/Practice. Different actions will need to be taken, and processes followed depending on the severity of the medication-related incident. In all cases, medication incidents and any related actions/recommendations/competency investigations are recorded and held on healthcare professionals' personal file for a minimum of 12 months. If a member of staff has been involved in 3 or more incidents in a rolling 12-month period or is currently under investigation, these must be kept in the staff members' personal file for a minimum of 3 years.
	5.9 Documentation The Medication Administration Performance Review Documentation (Appendix E) is to be retained by the individual's ward/department manager within the individual's personnel file.
	5.10 Medications error process **5.10.1 First error** In the event of a healthcare professional making a first error the recommendation will be to provide support, guidance and/or supervision to the staff member by their ward/department manager (directly or deputised). This will involve reinforcement of the PTHB Medicine Policy and any other relevant policies/procedures and professional guidance. A reflective account (Appendix F) of the incident and lessons learnt will be completed by the healthcare professional/s involved in the medication incident. The ward/department manager will record the incident and keep a copy of the reflective account; to be added to the DATIX report and held in the healthcare professional's personal file for 12 months.

The ward/department manager may decide that the healthcare professional will benefit from the Medication Administration Performance Review Documentation (Appendix E). This is dependent on the nature and severity of the medication incident.

The ward/department manager should also at this point ensure that the healthcare professional is up to date with all relevant medicines training e.g., MARRS, PGD training, Discretionary/homely, Medicines training, Vaccination and Immunisation training.

Each medication incident is to be judged individually. A first medication error involving a high-risk medicine or a procedure involving a high-risk medicine which have a heightened risk of causing significant patient harm when they are used in error (NHS England), may be serious enough for the healthcare professional to refrain from prescribing, dispensing, or administering medicines or other medicines processes until the investigation and actions are fully completed. Suspension from medication related practices would be a collective decision involving at least the practitioner, line manager, professional lead and medicines management.

5.10.2 Subsequent errors

Subsequent medication errors whilst the healthcare professional is under a monitoring period will be supported using this procedure and the healthcare professional, if needed, will be provided with guided supervision, and may be expected to undertake re-training relevant to the type of medication incident. During this time, the healthcare professional may have to refrain from prescribing, dispensing, or administering medicines or other medicines processes. This may include a formal training session relevant to their area of work. Other processes can include competency-based training and assessment relating to the administration, prescribing, or dispensing of medicines or other medicines processes as appropriate.

There may be incidents where use of the PTHB Disciplinary Policy and Procedure, is more appropriate for example, when a healthcare professional deliberately chooses to deviate from PTHB, All-Wales policies and procedures and/or professional expectations with no acceptable mitigating circumstances the Being Fair Tool may help support this assessment.

	The incidents will be recorded in personal files for a minimum period of 12 months. In the event that a member of staff has been involved in 3 or more incidents in a rolling 12-month period or is currently under investigation, these must be kept in the staff members' personal file for a minimum of 3 years. A Professional Concerns Investigation or Root Cause Analysis (RCA) might be needed for serious or subsequent medication errors.
	5.11 Temporary staff involved in medication errors **5.11.1 Bank staff** Where a member of bank staff is involved in a medicine error/incident during a bank shift, the relevant ward/department manager will notify the Temporary Staffing Unit (TSU) immediately. If the bank staff member also holds a substantive post within PTHB, this can be jointly managed by their ward/department manager and the TSU. The above process will then apply; taking into consideration any temporary restrictions in practice that are appropriate until the relevant training and support has been assessed and implemented. **5.11.2 Agency staff** If agency staff make an error, TSU must be made aware, and they will refer to their Agency for review and any necessary training or other updates. Evidence of action will be required by the TSU if the agency staff member is re-engaged in working for PTHB again. If any subsequent errors are made, consideration will be given as to whether placement within PTHB remains appropriate.
	5.12 Performance review **5.12.1 First time medicine related incident/error** The Medication Administration Performance Review (Appendix E) should normally be completed as soon as possible and must be within two weeks of the error. It is important to give clear time scales and regular reviews to ensure that time scales are met, and progress is made in reaching the expected objectives within the set time scales. **5.12.2 Serious or subsequent medicine related incident/error**

	For more serious medication incidents, or subsequent incidents, it may be necessary to consider suspending the healthcare practitioner from carrying out medicines related tasks.

6. Monitoring Compliance / Audit

Incidents reported though the DATIX system will be reviewed along with the risk ratio (Appendix C) and action implementation.

7. Review and Change Control

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

8. References / Bibliography

Being Fair Tool, NHS England
Northen Lincolnshire and Goole NHS Foundation Trust. Policy and Procedure for the Management of Staff Involved in a Medication Related Incident: Version 1.4. (July 2021)

Should you require any assistance please contact the Corporate Governance Officer – Policies & Procedures. (ext.) 2933.

Appendix A – Managing and Supporting Staff Following a Medication Error Flow Chart

FIRST ERROR

Use the Medication Investigation Tool (Appendix B) to define type of incident and contributing factors

Use the tables in the Risk Ratio (Appendix C) to ascertain the actions required from the Action Table (Appendix D).

Provide support, guidance and/or supervision by ward manager (directly or deputised) using the Performance Review (Appendix E). Reinforce the PTHB Medicines Policy and other relative policies/procedures.

Staff member/s to complete a reflective account (Appendix F) to be kept in their personal file for a minimum of 12 months. Ensure that the member of staff is up to date with all relevant medicines training.

If further support or training is required, refer the member/s of staff to the Medicine Management Nurse

Consider use of Being Fair tool – if concerns about an individuals conduct or fitness to practice are raised.

SUBSEQUENT ERRORS

Use the Medication Investigation Tool (Appendix B) to define type of incident and contributing factors

Use the tables in the Risk Ratio (Appendix C) to ascertain the actions required from the Action Table (Appendix D).

Provide support, guidance and guided supervision by ward manager or MM Nurse using the Performance Review (Appendix E). Reinforce the PTHB Medicines Policy and other relative policies/procedures.

Staff member/s to complete a reflective account (Appendix F) to be kept in their personal file for a minimum of 12 months/ 3 years if more than 3 incidents in a rolling 12-month period.

Refer to MM Nurse for retraining relating to the type of medicines incident, MARRS, PGD etc. Consider use of Being Fair tool – if concerns about an individuals conduct or fitness to practice are raised.

Staff member/s to refrain from all medicines processes if suggested by the Action Table (Appendix D). Consider capability or the PTHB Disciplinary Policy if required.
Refer to professional lead to agree action plan.

Consider use of Being Fair tool – if concerns about an individuals conduct or fitness to practice are raised.

Appendix B – Medication Incident Investigation tool

MEDICATION INCIDENT INVESTIGATION TOOL	
NAME:	NHS NUMBER:
DOB:	LOCATION:

This form is designed to be used for supporting information for the manager investigating incidents involving staff ensuring a fair and consistent approach.

Where was the incident discovered?	**Ward/department:**	**Date and time of incident:**

Type of incident -Please mark **X** in the appropriate description(s).	
ϒ Patient has known allergy to treatment	ϒ Mismatching between patient and medicines
ϒ Omitted medicine/ ingredient	ϒ Contraindication of medicine in relation to drug or condition
ϒ Wrong drug/ medicine	wrong/unclear dose or strength
ϒ wrong quantity	ϒ Wrong formulation
ϒ wrong frequency	ϒ Wrong route
ϒ wrong method of preparation/ supply	ϒ Wrong storage
ϒ wrong/ passes/omitted expiry date	ϒ Wrong/omitted patient information leaflet
ϒ Wrong/transposed/omitted medicines label	ϒ Wrong/omitted verbal patient directions
ϒ Calculation error	ϒ Wrong/ambiguous/incomplete advice
ϒ Delay in treatment	ϒ Documentation ambiguous/unclear/incomplete
ϒ Capacity (limited/impaired/fluctuation) – consider safeguarding referral	ϒ If RCA/SI investigation, what was the outcome?
ϒ Other (please specify):	ϒ Adverse reaction when the medicine was used as intended?

Where there any other important contributing factors? Mark **X** in the appropriate choice	
ϒ Ambiguous prescription	ϒ Product storage
ϒ Checking problems	ϒ Similar name (patient)
ϒ Communication failures	ϒ Similar looking name (medicine)
ϒ Software/ hardware/ Wi-Fi problems	ϒ Similar sounding name (medicine)
ϒ Documentation issues	ϒ Skill mix
ϒ Interruptions	ϒ Inadequate space
ϒ Packing of a product (look-a-like)	ϒ Staffing levels
ϒ Procedure not available/ unclear	ϒ Urgency of situation
ϒ Other (please specify):	

NAME:	NHS NUMBER:
DOB:	LOCATION:

Summary of incident and actions taken at the time
Medicines involved: State name(s), strength(s), and formulation(s) of medicines involved. Please attach a copy of the All-Wales Medicines Administration Record to this form.

	Class of error: Mark a **X** in the appropriate choice.				
Medication Process – At what stage did the incident occur?	**Lack of knowledge of product**	**Lack of knowledge of procedure**	**Knew what to do, but did something else**	**Knew what to do but forgot or omitted to do it**	**Other**
Prescribing/prescription process	ϒ	ϒ	ϒ	ϒ	ϒ
Administration/supply of medicines from a clinical area	ϒ	ϒ	ϒ	ϒ	ϒ
Advice/information	ϒ	ϒ	ϒ	ϒ	ϒ
Monitoring/follow-up of medicine	ϒ	ϒ	ϒ	ϒ	ϒ
Dispensing/supply/preparation from DGH pharmacy	ϒ	ϒ	ϒ	ϒ	ϒ
Dispensing/supply/preparation from community pharmacy	ϒ	ϒ	ϒ	ϒ	ϒ
Patients' reaction to medicine	ϒ	ϒ	ϒ	ϒ	ϒ
Other (please specify):	ϒ	ϒ	ϒ	ϒ	ϒ

Investigation finding/actions to be taken
•
•
•
•
•
•

NAME:	NHS NUMBER:
DOB:	LOCATION:

Pharmacy/Medicines Management comments/action taken
• • • • • •

Lessons learnt/information disseminated to
• • • • • •

NAME OF PERSON COMPLETEING INVESTIGATION:
SIGNATURE:
DATE:

Additional copies available here.

Appendix C – Risk Ratio

The following risk ratio and table should be utilised to ascertain the actions that should be taken.

Incidents should be graded using the Risk Grading Matrix (Table 1) and using the information in Tables 2 and 3.

Table 1 – Risk Grading Matrix

Severity/Impact/Consequence

Likelihood of recurrence	None/Near Miss (1)	Low (2)	Moderate (3)	Severe (4)	Catastrophic (5)
Rare (1)	**1**	**2**	**3**	**4**	**5**
Unlikely (2)	**2**	**4**	**6**	**8**	**10**
Possible (3)	**3**	**6**	**9**	**12**	**15**
Likely (4)	**4**	**8**	**12**	**16**	**20**
Certain (5)	**5**	**10**	**15**	**20**	**25**

NONE/ NEAR MISS	VERY LOW	LOW	MODERATE	HIGH
1	2-3	4-6	8-12	15-25

Table 2 – Definitions for likelihood of occurrence

Descriptor	Description
Certain	Expected to occur at least daily
Likely	Expected to occur at least weekly
Possible	Expected to occur at least monthly
Unlikely	Expected to occur at least annually
Rare	Not expected to occur for years

Table 3 – Definitions of severity/impact on affected person and consequence to organisation

(A) Level	(B) Descriptor	(C) Actual impact on affected person/s (examples only)	(D) Actual or potential consequence of organisation
5	Catastrophic (including death)	Death (including single or multiple fatalities)	• International adverse publicity/severe loss of confidence in the organisation • Significant lost staff working days • Definite notification to strategic HA, NSPA /other external agencies (e.g. HSE, police, coroner etc.) • Probable external investigation/interventions/sanctions by HCC, HSE etc. • Public enquiry • Safeguarding Adults: pattern of recurring incidents or deliberate maladministration that results in ill health or death
4	Severe	Permanent or long-term harm	• National adverse publicity/major loss of confidence in the organisation • Complaint • Increased length of stay >15 days • Increased level of care >15 days • Significant lost staff working days • Definite notification to strategic HA, NSPA /other external agencies (e.g. HSE, police, coroner etc.) • Possible external investigation/intervention/sanctions/prosecution by HCC, HSE, police etc. • Loss of major civil case • Loss of Human Rights Act (HRA) or Disability Discrimination Act (DDA) case • Critical CHI report Safeguarding Adults: Deliberate maladministration of medicine or covert administration without proper authorisation
3	Moderate	Moderate/serious effect on care and wellbeing of any person Short-term harm requiring further treatment or procedure	• Local adverse publicity/moderate loss of confidence in the organisation • Probable complaint • Increased length of stay 8-15 days • Increased level of care 8-15 days • Lost staff working days • Probable notification of strategic HA, HPSA etc. • Persistent same issue complaints • HRA or DDA claim Safeguarding Adults: recurring missed medication or administration errors that cause harm or affect more than one adult

2	Low	Minor effect on care or wellbeing, health, and safety of any person. Non-permanent harm requiring observation or minor treatment	• Possible complaint • Increased length of stay 1-7 days • Increased level of care 1-7 days • Possible lost staff working days • Minor civil care • Safeguarding Adults: recurring missed medication or administration errors that cause no harm
1	None/near-miss	No obvious harm/injury	• Minimal impact/no service disruption • No or low financial loss • No lost staff working days • No litigation • No loss of reputation • No loss of equity • Safeguarding Adults: missed or wrong dose of medication on one occasion – no harm

Appendix D - Action Table

Identified risk ratio	1 None/Near-Miss	2-3 Very Low	4-6 Low	8-12 Moderate	15-25 Severe	Violation
Action Plan	• Reflective learning • Discuss incident • Ensure knowledge • Retain signed records	• Reflective learning • Discuss incident • Ensure knowledge • Retain signed records	• Reflective learning • Discuss incident • Ensure knowledge • Retain signed records • Assessment or reaccreditation if necessary	• Reflective learning • Discuss incident • Ensure knowledge • Retain signed records • Assessment or reaccreditation if necessary	• Reflective learning • Discuss incident • Ensure knowledge • Retain signed records • Assessment or reaccreditation if necessary	• Check relevant policy • Gather information •
Managed by	• Line manager • Support from relevant education training e.g. Meds management	• Line manager • Support from relevant education training e.g. Meds management	• Line manager • Support from relevant education training e.g. Meds management	• Line manager • Support from relevant education training e.g. Meds management • Consider band 8 involvement	• Line manager • Support from relevant education training e.g. Meds management • Consider band 8 involvement • Consider HR involvement	• Line manager • Senior support (band 8 or above) • HR support

Appendix E -Performance Review

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

DRUG ADMINISTRATION PERFORMANCE REVIEW DOCUMENTATION

Supervisor of practice

The 'supervisor of practice' must be a senior staff member within the same clinical area, a Practice Education Facilitator or a member of the Medicines Management Team. Ideally, in the first instance, this should be either the line manager or senior practitioner with proven competencies i.e. up to date with relevant learning and competencies and must also hold a relevant practice assessor/supervisor qualification.

Aims of the performance review

To ensure that the standards of practice within medication administration and the safe management of medicines are delivered by the professionals recommended, as per PTHB policies and procedures, for example, the Medicine Policy.

This performance review is designed to maximise the competencies and knowledge of the PTHB employee in the administration and safe management of medicine, thus ensuring the safety and best interests of patients at all times. It is intended to support staff involved in medication incidents within PTHB and provide evidence of further professional training and development, improving competency, skills, and knowledge.

Record of completion

A completed and signed copy of this document will be kept in the practitioner's personal file by their line manager. In the event of the practitioner moving clinical area, a copy will be forwarded to the appropriate manager along with their personal file.

This document should be shared with the practitioner and action plans and objectives mutually agreed between the practitioner and the mentor. A completed copy should be given to the practitioner for their own learning portfolio.

Practitioners Name:
Area of practice:

Supervisor:

Medication Administration Review start date:

Medication Administration Review interim date:

Medication Administration Review finish date:

Learning Objectives and Training Needs

Give a description of the incident and any contributing factors as identified in the Medication Incident Investigation Tool:

Identified performance issue(s) raising concerns:

Training/learning needs identified by mentor:

Training/learning needs identified by practitioner:

Signature of practitioner: Date:

Signature of Mentor: Date:

Interim discussion

As part of the ongoing learning process, those practitioners undergoing more than 4 weeks of development must have an interim interview at 2 weeks.

Points for discussion:

Progress made so far:

Further development required:

Signature of practitioner: Date:

Signature of Mentor: Date:

Training required (one or more aspects of training but not necessarily all of them might be required)

Name of training	Date last attended/ completed	Training required	Booked by	Date, time & venue	Both mentor and practitioner signature when completed
Medicines management 1:1					
IV therapy study date (classroom session)					
Medical Gases training					
Insulin training (e-Learning)					
Oral medication administration assessment					
PGD Training					
Vaccination/immunisation training					
Homely/discretionary medicines					

Supervised practice record

Practitioners might need to undertake a number of supervised practices (to be determined by their line manager) in medication administration (either IV or Oral administration), use the PTHB assessment of practice documents along with the following records

Supervised practice (state IV or PO)	Date of assessment	Assessed by	Comments

Lessons learnt to prevent re-occurrence:

Appendix F – Nursing and Midwifery Council Reflective Account

All practitioners must undertake a piece of reflective practice as part of their performance review. The reflection should outline the practitioner's experiences during the incident, how actions can affect patient safety and their reflection upon their professional practice following the review. The practitioner may use templates provided by their regulatory body (links below).

Nursing & Midwifery Council

REFLECTIVE ACCOUNTS FORM

You must use this form to record five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code. Please fill in a page for each of your reflective accounts, making sure you do not include any information that might identify a specific patient, service user, colleague, or other individuals. Please refer to our guidance on preserving anonymity in the section on non-identifiable information in *How to revalidate with the NMC*.

Reflective account:
What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?
What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?
How did you change or improve your practice as a result?
How is this relevant to the Code? Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

For additional copies of Reflective Account templates
NMC Reflective Account
GPhC Reflective Account
GMC Reflective Account
HCPC Reflective Account