Medication errors- practice review

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Starting point for today:

- Open discussion- context of the services represented

working **together**…

Confidentiality

respect

diversity of opinion can be enriching

cameras on

look for the benefits of an alternative opinion

positive challenge

naïve questions are valuable

go “off piste”……

enjoy ourselves

aims

To review the occurrence of medication errors in your service, look at causes , audit practice and carry changes forward

Focus areas

- the standards and regulations
- common errors
- why they occur
- factors influencing culture
- Self / your service - audit
- review and findings- part 2.

Definition:

- A medication administration error (MAE) is defined as "any difference between what the patient received or was supposed to receive and what the prescriber intended in the original order/ prescription."
- Medication errors are any Safety Incidents where there has been an error in the process of prescribing, preparing, dispensing and administering, recording, monitoring or providing advice on medicines. Medication errors can occur at many steps in children's care, from ordering the medication to the time when the child is administered the drug. (*adapted from NHS Resolution Site 2022*)

- The BMJ estimated that more than **237 million medication** errors are made every year in England.
- Errors are made at every stage of the process, with over half (54%) made at the point of administration and around 1 in 5 made during prescribing (21%). Dispensing accounts for 16% of the total.
- Error rates are highest in care homes (42%), despite covering fewer patients than the other sectors.
- The researchers estimated that nearly 3 out of 4 medication errors (72%) are minor, while around 1 in 4 (just under 26%) have the potential to cause moderate harm; just 2% could potentially result in serious harm.
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Annex A Questions

- Have staff received specific training since the last inspection in relation to children's healthcare needs?
- Do you have systems in place to ensure that the administration of medication is accurate?
- Have you had to take any action as a result of any medication error?

Guide to Childrens' Homes regulations and standards

Administration of medicines

7.15

Care must be taken to ensure prescribed medicines are only administered to the individual for whom they are prescribed.

Medicines must be administered in line with a medically approved protocol.

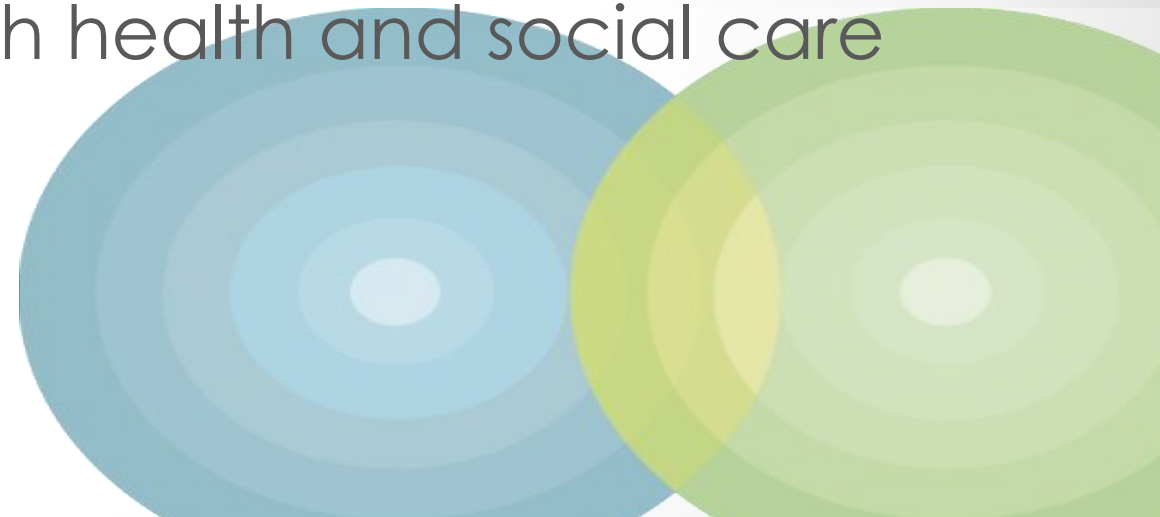
Records must be kept of the administration of all medication, which includes occasions when prescribed medication is refused. Disposal (Health Technical Memorandum 07-01: Safe and sustainable management of healthcare waste)

Regulation 23 requires the registered person to ensure that they make suitable arrangements to manage, administer and dispose of any medication.

These are fundamentally the same sorts of arrangements as a good parent would make but are subject to additional safeguards. Where the home has questions or concerns about a child's medication, they should approach an expert such as a General Medical Practitioner, community pharmacist or designated nurse for looked-after children.

Children's Homes regulations and standards

- 7.16 Children who wish to keep and take their own medication should be supported to, if they are able to do so safely.
- Staff should be mindful that children holding their own prescribed medication must only use it for themselves in accordance with the prescription.
- 7.17 Managing medicines in care homes (March 2014) is a guideline that applies across both health and social care



Regulation 23

- **23.**—(1) The registered person must make arrangements for the handling, recording, safekeeping, safe administration and disposal of medicines received into the children's home.
- (2) In particular the registered person must ensure that—
- (a)medicines kept in the home are stored in a secure place so as to prevent any child from having unsupervised access to them;
- (b)medicine which is prescribed for a child is administered as prescribed to the child for whom it is prescribed and to no other child; and
- (c)a record is kept of the administration of medicine to each child.
- (3) Paragraph (2) does not apply to medicine which—
- (a)is stored by the child for whom it is provided in such a way that other persons are prevented from using it; and
- (b)may be safely self-administered by that child.

Regulation cont'd

- (4) In this regulation, "prescribed" means—
- (a)ordered for a patient, for provision to the patient, under or by virtue of the National Health Service Act 2006 or section 176(3) of the Health and Social Care (Community Health and Standards) Act 2003(1); or
- (b)in a case not falling within sub-paragraph (a), prescribed for a patient in accordance with regulation 217 of the Human Medicines Regulations 2012(2).

(Managing medicines in care homes

Social care guideline [SC1]Published: 14 March 2014. Last fully reviewed 2017. Coronavirus updates 2020)

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8/9 or 6 R's

- Right person
- Right medication
- Right dose
- Right route
- Right time
- Right documentation
- Right reason
- Right to decline
- ? Right response

- right person
- right medicine
- right dose
- right route
- right time
- person's right to decline

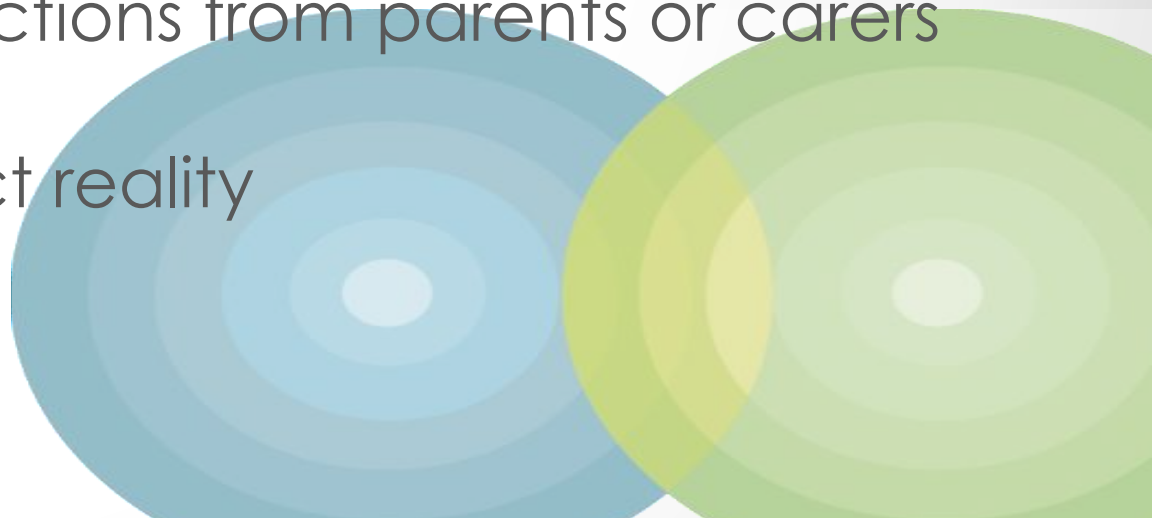
Discussion:

- Where are your medications kept?
- What are your processes for dispensing on site / off site?
- How often are your staff trained – to what level?
- Management of controlled drugs?
- Homely remedies?
- What goes wrong ?

- Let's discuss……

Common contributing factors to errors:

- Adequate space
- Shifts-staff tiredness, poor planning
- Capacity
- Time ?poor planning again?
- Interruptions
- Not enough staff
- Staff not trained
- Overwriting by staff
- Taking telephone changes or instructions from parents or carers
- Poor oversight and monitoring
- Policy not fit/unclear, doesn't reflect reality
- Anything else??



Most common errors- findings from root cause analysis

- **Doseage error:** This usually happens when either a doctor prescribes a new medicine or asks to stop the old one. This confusion can result in either overdose or underdose.
- It can also come from human error
- How does it happen in your service?

Most common errors- findings from root cause analysis

- **Lack of knowledge about drug interaction:** Different drugs interact with each other differently. This is why some medicines are not prescribed along with others. However, a lack of knowledge about drug-drug interaction can have a serious consequence. Whenever a new medicine is prescribed staff should be aware of what the child is already taking and possible problems with new drugs.
- An overall review of medication can help avoid this problem.

Recording errors

- Transcribing
- Areas not completed
- Incorrect/incomplete information
- Missing recordings
- Incorrect Recordings
- Illegible recordings
- Incorrect balance records

Most common errors- findings from root cause analysis

- Wrong person…… surprisingly common .
- How can this occur?

Most common errors- findings from root cause analysis

- Omission- drug missed at the right time.
- Wrong time - delay, missed drug given too late.

- Issues that can arise?

Most common errors

- PRN medicines not offered or usage monitored.

- Issues that can arise?

Most common errors- findings from root cause analysis

- Prescribing- wrong drug , wrong dose, wrong type .

- Would staff have the knowledge to identify this from a prescribing point of view?

Most common errors- findings from root cause analysis

- Unauthorised drug.

- Administration errors including the incorrect route of administration, giving the drug to the wrong child, extra dose or wrong rate.

Thinking ahead to session 2……

- TASK TO TAKE AWAY:

review the range of medication errors which have occurred in your service over the last year. Carry out an audit to see if recommended actions from any investigations have ALL been consistently implemented

Observe administrations

speak with several members of your team separately and ask them to describe the processes to you- do they describe them to be the same or do each describe them differently?

bring back your findings to the next session as part of a reflective process.

Any queries?

- Please let me know of any questions or queries before we meet again.

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