Medication related incidents and near misses - Care setting Reporting Guidance

A practical guide to support care settings to report medication related incidents via the Ulysses Incident Reporting System

NHS Shropshire Telford and Wrekin, Care Settings Governance Team, Medicines Management Team May 2023 – Review May2025

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Document Control Sheet

Document Amendment History

Version No.	Date	Brief Description
2	28/02/23	Version 2, Update for roll out across STW following completion of six week pilot – MSG approval for further roll out.
3	02/05/23	Version 3, Insight user guide updated, to include additional field to include text “GP Practice of person affected” on page 6, this is now a separate appendix. N2N guidance also removed.

Contents

MEDICATION RELATED INCIDENTS/NEAR MISSES - REPORTING GUIDANCE and Frequently Asked Questions (FAQs)

The Care Homes use of medicines study (CHUMS), (Barber ND et al 2009) and subsequent report was published following an extensive research study into the prevalence, causes and potential harm of medication errors in care homes for older people.

The report revealed an unacceptable level of medication errors relating to older people in care homes. The study showed that care home residents take an average of eight different medicines every day. On any one day, seven out of ten residents experience mistakes with their medications. These errors range from doses being missed or given incorrectly, to the wrong medicines being given. In some cases, these errors have the potential to cause very serious harm.

Although this study was specific to Care Homes for older people, the principles and findings of the study should be considered when thinking about medicines administration across all care settings.

To ensure a joined up integrated care system (ICS) approach to medication related incidents and system learning, in addition to establishing any required support for care organisations with medicines management, the Medicines Management Team encourage the reporting of relevant information around medication related incidents and near misses.

When a medicines related incident occurs, but any potential harm/impact of this incident has been prevented (near miss/no harm caused), please ensure this is reported internally and to the appropriate person(s)/organisation(s). A report of these incidents should be completed quarterly to the Medicines Management Care Settings Governance team at stw.carehomeenquries@nhs.net. (Please refer to Appendix 2 for reporting template).

This information will be used to monitor trends and themes, which will inform training, education and further support where required. This will also allow for themes and trends to be shared within the ICS to allow for identification of any actions required by system partners and outside care providers.

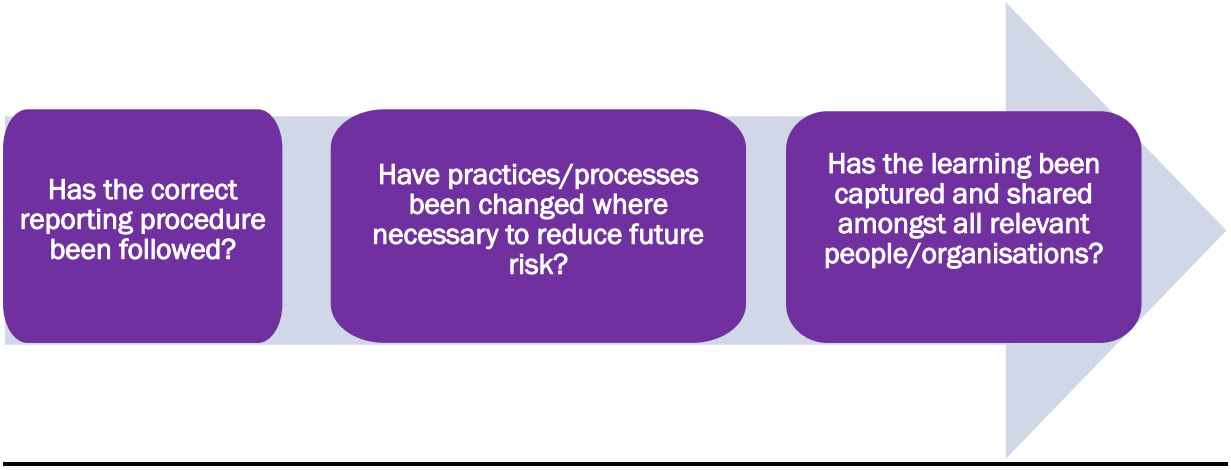
When a medicines related incident occurs that results in harm (any severity), please ensure this is reported internally and to the appropriate person(s)/organisation(s) and logged on to the Ulysses incident reporting system via the web-based link, below, as an **N2N medication concern**.

https://ulysses.midlandsandlancashirecsu.nhs.uk/Incident.aspx?link=D0155A368A63EBE15F

This includes any **LOW- SEVERE** medication related incidents which take place within all areas of the care sector, including care homes (both nursing and residential), domiciliary care and supported living facilities.

Please ensure that any controlled drug medication incidents are reported to the Controlled Drugs Accountable Officer (CDAO) at www.cdreporting.co.uk as well as via the Ulysses reporting system.

What to consider following a medication related incident



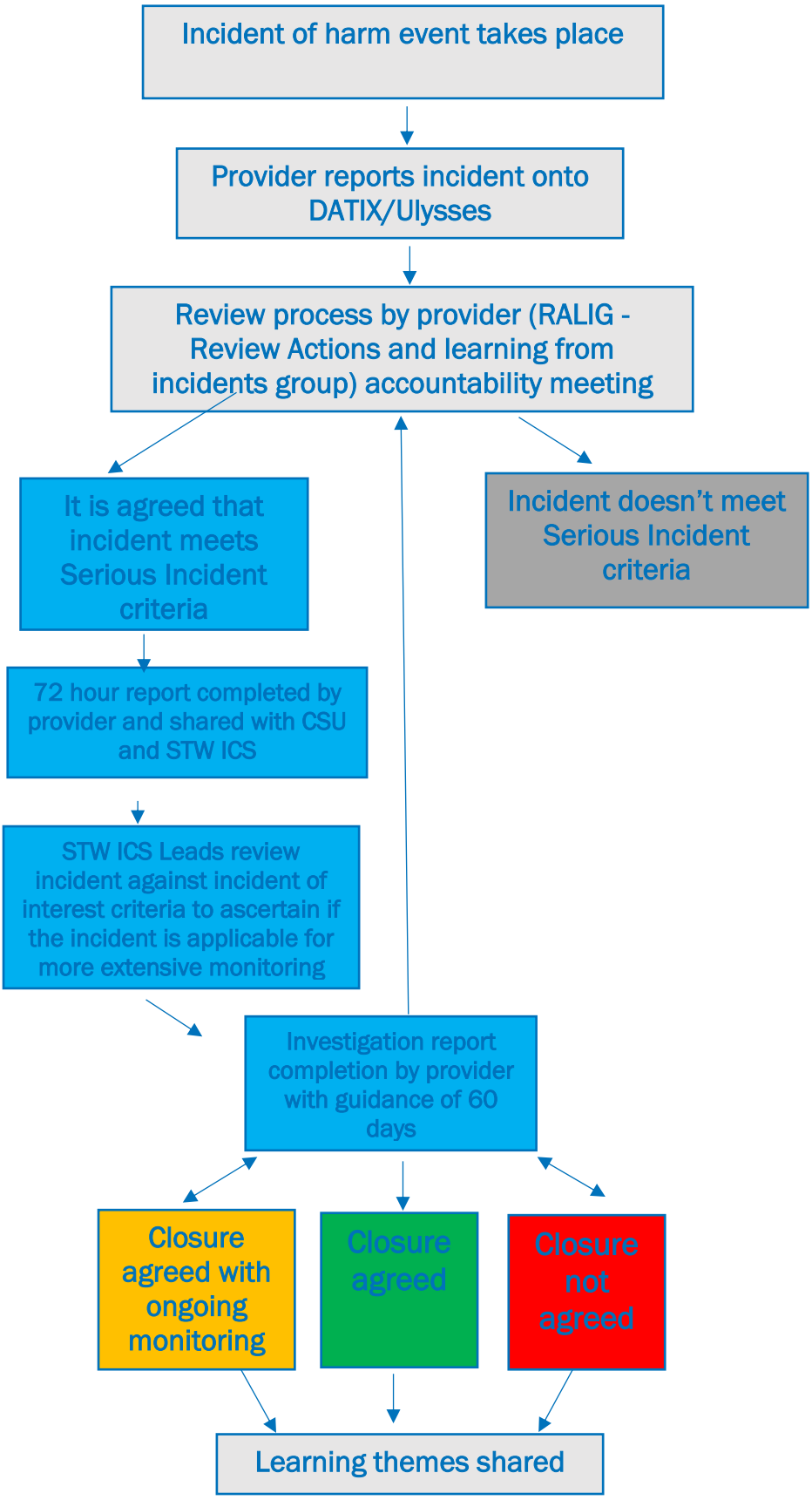
Guidance - SEVERITY RATINGS of medication related incidents:

SEVERITY RATING	EXAMPLE OF (NOT EXHAUSATIVE)
NEAR MISS (NO HARM CAUSED, BUT POTENTIAL TO CAUSE HARM)	Amoxicillin prescribed, individual has a Penicillin allergy, prescribing error identified prior to administration and new prescription issued for alternative. Strength of medication dispensed does not match strength on dispensing label, potential for over or under dose, dispensing error identified prior to administration and medicine re-dispensed. Or similar ADVERSE IMPACT PREVENTED
NONE (NO HARM)	Missed dose of emollient/cream. Administration of eye drops for dry eyes FOUR times a day, when prescribed FOUR times a day PRN. Or Similar ADVERSE IMPACT PREVENTED
LOW (MINIMAL HARM)	Incident resulted in extra observation or minor treatment being required e.g., Missed pain medication resulting in a temporary increase in pain and/or function impairment Delayed or omitted medicine e.g., Vitamin B12 injection. MINIMAL ACTUAL HARM CAUSED **These incidents should be reported to the Medicines Management Team for Monitoring/Trending purposes only - MMT operate a fair blame culture.**

MODERATE (SHORT-TERM HARM)	Any medication related incident resulting in a moderate increase in treatment e.g., Discharged from hospital without stock of newly initiated medicines and no discharge information, resulting in treatment delay, including pain controlling medication. Administering an antihypertensive medicine e.g., Ramipril that was withheld or stopped, resulting in a low BP which then leads to a fall. **SIGNIFICANT, BUT NOT PERMENANT ACTUAL HARM CAUSED** **These incidents should be reported via Ulysses for Medicines management review, monitoring and trending purposes only.**
SEVERE (PERMENANT/LONG TERM HARM)	Colecalciferol 20,000 units initiated by specialist and recommended as a TWICE weekly dose, when prescribed, prescribed TWICE daily and administered incorrectly, TWICE daily as prescribed resulting in Vitamin D toxicity. **ANY SERIOUS MEDICATION RELATED INCIDENT WHICH REULTS IN ACTUAL HARM/ HAS THE POTENTIAL TO RESULT IN PERMENANT HARM.** **These incidents should be reported via Ulysses for Medicines management review, monitoring and trending purposes only.** **Please see serious incident framework review process below.**
DEATH RELATED TO EVENT	**ANY PATIENT MEDICATION SAFETY INCIDENT THAT HAS/HAD THE POTENTIAL TO CAUSE DEATH** **These incidents should be reported via Ulysses for Medicines management review, monitoring and trending purposes only.** **Please see serious incident framework review process below.**

As per the NHS Shropshire, Telford and Wrekin serious incident (SI) framework, the following process should be followed:

Serious Incident/Never Event Review Process Flow Chart



Defining a medication incident/error/near miss

What is a medication ERROR?

- The Care Quality Commission (CQC) defines a medicines error as 'any patient safety incident, where there has been an error, while prescribing/preparing/dispensing/administering/monitoring/providing medicines advice. Medicines errors occur when weak medication systems or human factors affect processes e.g., fatigue, environmental conditions, staffing levels.

What is a NEAR MISS?

- The Care Quality Commission (CQC) defines a near miss as a 'prevented patient safety incident'. 'It is an event that has not caused harm but has the potential to cause injury or ill health.' Reviewing near misses can provide useful learning and areas for improvement.

Do I have to report every medication related incident via the Ulysses incident reporting system?

- It is not a legal requirement to report all medication related incidents resulting in harm to the Medicines Management team via the Ulysses incident reporting system
- However, the Medicines Management team encourage reporting medication related incidents so that the information can be used to inform education and learning in order to improve patient safety across Shropshire Telford and Wrekin.
- This is achieved by trending the incidents which are discussed and monitored (anonymously) at the ICB Medicines Safety Group, quarterly meetings. It is important to stress that a fair blame culture exists and learning from each of the reports is paramount to ensure measures can be implemented to avoid future harm.
- Although there is no requirement to notify CQC about medicines related incidents, there is a legal obligation to inform CQC if a medicines error has caused/resulted in:
- A death, an Injury, abuse, or an allegation of abuse, or if it is an incident reported to or investigated by the police.
- Where relevant, it should be made clear that a medicine related incident was a known or possible cause or effect of these incidents or events being notified.

The Ulysses reporting system can also be used to report these incidents into the medicines management team.

What is **Ulysses**?

- Ulysses Incident Management Database provides a straightforward and easy to use web-based solution for the reporting of all Clinical and Non-Clinical Incidents and Accidents.

How do I report using the Ulysses system?

When a medicines related incident occurs that results in harm (any severity), please ensure this is reported internally and to the appropriate person(s)/organisation(s) and logged on to the Ulysses incident reporting system via the web-based link, below, as an **N2N medication concern**.

https://ulysses.midlandsandlancashirecsu.nhs.uk/Incident.aspx?link=D0155A368A63EBE15F

The details required to report an incident are:

- A clear and full description of what has happened (remember that a person that has not been involved in the incident needs to be able to understand exactly what happened).
- If medication was involved, which medications (there may be several medications, so it is important to list them all)
- Where did the incident happen (was this in hospital and the care home have picked up the incident for example)
- What was the immediate action taken by care staff (remember that a person not involved in the incident needs to understand what happened next)
- What is the status of the individual now (has the individual been transferred back to secondary care or are they still at the care service, if so are they recovering, has the incident been resolved e.g. prescription corrected or medicines supplied)
- Has the individual's GP been informed and involved in this individual's care before reporting to the Medicines management team (if they have been involved have they also reported the incident via the Ulysses system?)

Reporting medication related incidents and near misses in a care setting

Incident identified by reporter and risk assessed as per below indicators

NONE /NO HARM /NEAR MISS
Report internally and to the appropriate person(s)/organisation(s)

Follow internal medication incident reporting process, including notification of all person(s)/organisation(s) following an assessment of the risk

Complete any necessary process changes in order to reduce the risk of future medication related incidents/near miss

Submit quarterly no harm/near miss medication incident report to the Care Settings Governance Team via: stw.carehomeenquiries@nhs.net
(please see appendix 2 – Reporting Template)
Identified trends and themes to be shared with the Medicines Safety Group and across care settings in Shropshire Telford and Wrekin.

LOW HARM/
MODERATE HARM/SEVERE HARM/DEATH
Report internally/appropriate person(s)/organisation(s) and logged on to the Ulysses incident reporting system via the web-based link. (Please refer to Care Settings Ulysses guide provided).
https://ulysses.midlandsandlancashirecsu.nhs.uk/Incident.aspx?link=D0155A368A63EBE15F

Complete any necessary process changes in order to reduce the risk of future medication related incidents/near miss

Reported incident reviewed by Quality/Medicines Management team, NHS Shropshire, Telford and Wrekin in order for support, advice and guidance to be given and for education, learning and patient safety purposes.
Identified trends and themes to be shared with the Medicines Safety Group and across care settings in Shropshire Telford and Wrekin. Feedback will be shared with care settings via the care settings governance team newsletter and medicines management education and training sessions.

Appendix 2: QUARTERLY REPORTING TEMPLATE FOR NEAR MISS AND NO HARM MEDICATION RELATED INCIDENTS
Quarterly Medication Incident Report For: - Insert Name of Care Setting completing the report

Please refer to the supporting medication incident/near misses reporting guidance for further information and for guidance. Please return completed template to stw.carehomeenquries@nhs.net. A reminder email will be circulated to request completed templates to be submitted each quarter for review
Q4 = January – March Q1 = April – June Q2 = July – September Q3 = October – December

Number of medication related incidents by Quarter within review period INSERT YEAR e.g., 2022/2023					
CATEGORY	No of Incidents – NEAR MISS OR NO HARM				
	Q1	Q2	Q3	Q4	Running Total
Medication - Administration Incidents					
Medication - Prescribing Incidents					
Medication – Poor Transfer of care					
Medication – Storage					
Medication – Supply					
Medication – Documentation					
Medication – Other Incidents					
Grand Total					