Medication related incidents Reporting Guidance

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

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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.
3 update	28/10/24	Information added to request secure email accounts to be used at all times. Update to quarterly reporting template to include STW Quality team, generic email address for reporting.
4	18/11/2024	Process change for reporting of no harm/near miss incidents to reflect STW Quality team PPF process and removal of quarterly reporting template. Update to SI flowchart, which is now the Patient Safety Incident Investigation (PSII)/Never Event Review Process Flow chart as per STW Quality team update. Contents page and footer updated.

Contents

Medication Related Incidents, 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 of ANY severity (including no harm and near miss incidents) (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.

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

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.

This includes any 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 NHSE Controlled Drugs Team at England.MidlandsCD@NHS.net as well as via the Ulysses reporting system, using the link above.

PLEASE ENSURE WHEN REPORTING AN INCIDENT VIA THE ULYSSES INCIDENT REPORTING SYSTEM, A SECURE EMAIL ADDRESS IS USED. PERSONAL EMAIL ACCOUNTS SHOULD NOT BE USED.

What to consider following a medication related incident

SEVERITY RATINGS of medication related incidents - Guidance

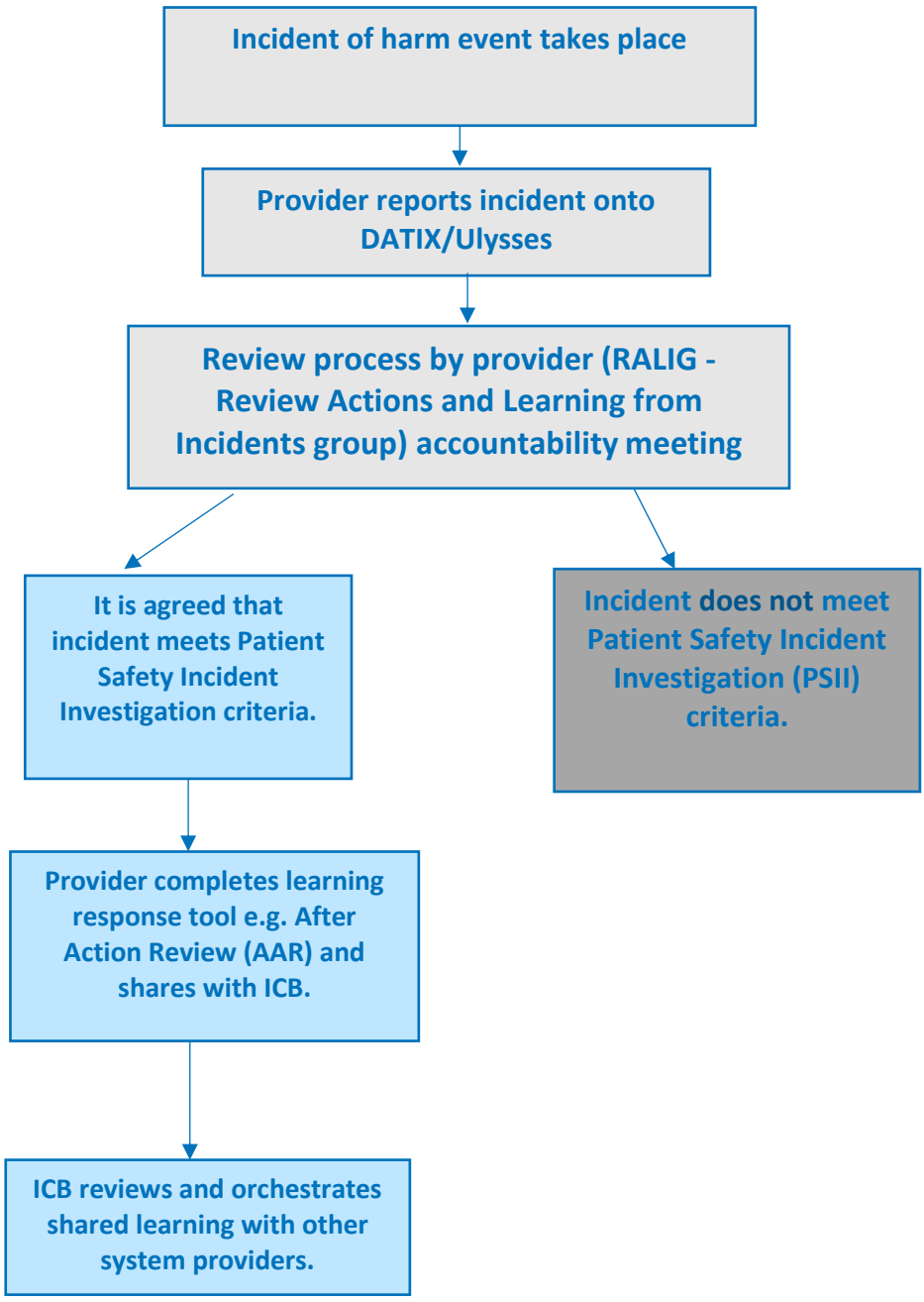
SEVERITY RATING	EXAMPLE OF (NOT EXHAUSTIVE)
NEAR MISS (NO HARM CAUSED, BUT POTENTIAL TO CAUSE HARM)	Amoxicillin prescribed, individual has a Penicillin allergy, prescribing error identified prior to administration and new prescription issued for alternative. Strength of medication dispensed does not 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

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 PERMANANT ACTUAL HARM CAUSED**
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 PERMANANT HARM.** **Please see Patient Safety Incident Investigation (PSII) /Never Event Review Process Flow Chart below.**
DEATH RELATED TO EVENT	**ANY PATIENT MEDICATION SAFETY INCIDENT THAT HAS/HAD THE POTENTIAL TO CAUSE DEATH** **Please see Patient Safety Incident Investigation (PSII) /Never Event Review Process Flow Chart below.**

All incidents listed above should be reported to the STW ICS Medicines Management team using the link provided, Incident reports are used to learn from and to prevent reoccurrence as well as monitoring trends and themes.

As per the NHS Shropshire, Telford and Wrekin Patient Safety Incident Investigation (PSII) framework, the following process should be followed:

Patient Safety Incident Investigation (PSII) /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 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 ICS Medicines Safety Group, quarterly meetings. It is important to stress that 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 or the potential for harm (any severity, including near miss and no harm incidents). 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.

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 the incident happened (was this in hospital and the care home have picked up the incident for example).
- What immediate action was taken by the staff member (remember that a person not involved in the incident needs to understand what happened next).
- What the status of the individual is 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?)

PLEASE ENSURE WHEN REPORTING AN INCIDENT VIA THE ULYSSES INCIDENT REPORTING SYSTEM, A SECURE EMAIL ADDRESS IS USED, PERSONAL EMAIL ACCOUNTS SHOULD NOT BE USED.

A step by step user guide is also available to support with logging an incident via the Ulysess incident reporting link and can be found at https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/Reporting-events-using-Insight-for-care-setting-staff-STW-Jan-2025.pdf

Reporting medication related incidents

Incident identified by reporter and risk assessed as per below indicators

NONE /NO HARM /NEAR MISS
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:
https://ulysses.midlandsandlancashirecsu.nhs.uk/Incident.aspx?link=D0155A368A63EBE15F
Please refer to the Ulysses guide:
https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/Reporting-events-using-Insight-for-care-setting-staff-STW-Jan-2025.pdf

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/s, 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 team newsletter and medicines management education and training sessions.