MP04
Management of Medication Incidents

Contents

Appendices

1.0 Policy Statement (Purpose / Objectives of the policy)

A medication incident is any preventable event that may cause, or lead to, inappropriate medication use or patient harm while the medication is in the control of the healthcare professional. This can occur in the process of prescribing, dispensing, preparing, administering, monitoring or reconciliation of medicines, or through the provision of medicines supply, storage and advice.

This policy covers the actions to be followed in the management of medication incidents. The policy aims to:

- Strengthen Trust values of providing safe and effective care through a fair accountability culture in response to incidents involving medications.
- Facilitate organisational, and individual (where appropriate), learning through a system approach to understand contributory factors in medication incidents, and produce improvement to prevent recurrence.
- Ensure appropriate actions are taken by managers when a medication incident occurs and these actions are applied consistently throughout the Trust.

Additionally, healthcare professionals are regulated and bound by the requirements of their relevant professional body. All healthcare professionals have an obligation to consider patient safety and ensure that patients do not suffer any avoidable harm as a result of the healthcare they receive. This includes reflection following involvement in a medication incident such that change and improvement will prevent future events.

This policy must be read in conjunction with:

- Medicines Policy (MP01): Prescribing, Storage and Administration of Drugs,
- Medicines Policy (MP03): Medicines Reconciliation,
- Patient Safety Incident Response Policy (GOP02),
- Risk Management and Patient Safety Reporting Policy (OP10),
- Being Open (Duty of Candour) (OP60),
- Disciplinary Policy (HR03),
- Capability Policy (HR19)

and any relevant professional standards and guidelines.

Please note that the Disciplinary Policy (HR03) will only apply to drug or medication errors where it is evident that appropriate support and, or training has already been put in place to address errors, or where there is a clear non-adherence of Trust policies and procedures.

The Management of Medication Incidents Policy, and associated actions, covers all

medication incidents, irrespective of the level of harm caused to the patient. Medication incidents which have resulted in moderate or severe harm, or death, maybe subject to further scrutiny under the Patient Safety Incident Response Framework (PSIRF) to understand the processes and work systems which have led to the incident happening.

In line with NHS England's Being Fair tool, all medication incidents will be reviewed with the primary aim of identifying systemic factors and opportunities for improvement, rather than attributing blame to individuals. Staff involved in medication incidents will be treated with kindness, respect, and compassion, recognising the emotional impact such events may have.

Any learning responses will be proportionate, considering the wider context, including workload, staffing levels, training, and environmental factors. Where concerns arise regarding conduct or fitness to practise, the Being Fair decision-making framework will be applied to ensure a proportionate decision-making process that consistently balances accountability with fairness.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict of Interest Policy is to be considered the primary and overriding Policy.

1.1 Scope

The policy applies to all staff, including students, bank and agency, involved in any medication processes. If a student is involved in a medication incident their higher education institute must also be informed.

All staff involved in the prescribing, dispensing, preparing, administering, monitoring or reconciliation of medicines must be able to demonstrate competence and, understanding and compliance with relevant professional guidance and Trust policies and procedures.

Where specific protocols exist to delegate the administration of medications to unregistered staff (e.g. designated health care support workers who have been trained and deemed competent to administer medicines in the home, e.g. insulin, eye drops) the accountability for the administration and any incidents which occur remain with the registered professional who has delegated this responsibility, normally the team leader for the case load of patients (The Code, NMC, 2018).

2.0 Definitions

Administration: The application of a medicine to the body of an individual by an individual authorised to do so: includes topical, injection, inhalation, ingestion (not an exhaustive list).

Dispensing: The process of preparing and giving medicine to a named person on the basis of a prescription.

Medicinal Product: For the purpose of this policy a 'medicinal product' (or a 'Medicine') is defined as a substance or article, or an ingredient of either of these, (not being an instrument, apparatus, medical device or appliance) supplied for

administration to human beings for a medicinal purpose.

Non-Medical Prescriber: Any qualified prescriber other than a doctor or dentist.

Nurse in Charge: A nurse with operational responsibility for the ward or clinical area during a shift.

Preparation: The action or process of preparing a medicine for use before administration e.g. reconstitution of a powdered product to facilitate I.V. administration.

Prescribing: A direction for the supply and administration of a medicinal product in writing as above or by computer generated records which are identifiable to an individual practitioner and are date and time stamped.

Prescriber: Those classes of staff identified as having the authority to instigate the administration of medicinal products to patients, as described in this policy.

Reconciliation: the process of accurately compiling a list of a patient's current medicines.

3.0 Accountabilities

3.1 Corporate Responsibility

The Trust Chief Executive is responsible for ensuring that medicines management within the Trust conforms to best practice at all times. This responsibility is delegated to the Clinical Director of Pharmacy, who is the medicines management lead for the Trust. The Clinical Director of Pharmacy will ensure there are policies and systems in operation across the trust relating to medicine use, and facilitate the safe, rational and cost effective use of medicines, and minimise the risk of harm to patients from medicines.

Additionally, professional leads hold responsibility for ensuring compliance within their respective disciplines:

- Chief Medical Officer – accountable that all medical staff adhere to the policy.
- Chief Pharmacist/Clinical Director of Pharmacy is responsible for ensuring this policy is implemented by all pharmacy professionals and members of the pharmacy team.
- Chief Nursing Officer is responsible for ensuring that the policy is implemented and adhered to by all relevant nursing staff and allied healthcare professionals (AHP's).

3.2 Medication Safety Group

The Trust Medication Safety Group (MSG) will provide strategic oversight of medication-related incidents, identifying trends and making evidence-based recommendations to mitigate risks and enhance medication safety. The group will monitor the effectiveness of implemented measures and support continuous improvement through:

- Promotion and education of safe medication practices
- Fostering a culture of shared learning and transparency
- Development and implementation of audits and action plans to improve clinical

practice

3.3 Line Managers, Clinical Supervisors and Educational Supervisors

Staff with managerial, supervisory or educational responsibility for staff will:

- Ensure that the policy is implemented in their area of responsibility,
- Manage medication incidents in line with this policy,
- Ensure staff are appropriately trained in line with the requirements of this policy.

Directorate Clinical Directors will assume responsibility for medical staff who are not undertaking an education programme.

3.4 Trust Staff Members

All staff who are involved with any aspect of medicines handling must ensure they are familiar with the contents of this policy, and their obligations in the event of a medication incident.

4.0 Policy Detail

The healthcare professional involved in medicines processes must exercise professional accountability in the best interests of the patient and must always conform to Trust medicine policies and procedures.

4.1 Recognition of Medication Incidents

Identification of a medication incident can happen in a variety of ways:

- Self-reporting by the staff member
- Patient / representative reporting or raising a complaint
- Detected by a healthcare professional

Medication incidents must be reported on the Trust incident reporting system. Incidents will be assessed by the appropriate manager, and persons involved in the incident recorded in the relevant section of the incident form. The person assigned as the incident investigator will ensure that individuals involved and their line manager/clinical supervisor/ educational supervisor are informed of the incident.

Dispensing incidents detected before a medicine leaves pharmacy e.g. as part of the routine accuracy checking process, will be recorded using the pharmacy prescription tracking system, and will be managed as ‘unescaped errors’ following Pharmacy Department standard operating procedures. Dispensing errors which are detected after supply from pharmacy will be managed following this policy.

Examples of medication incidents can be found in appendix 1: Medication Incident Categories. N.B. This list is not exhaustive.

4.2 Immediate Actions

Upon identification of a medication incident the first concern must be that of the

welfare of the patient. Appendix 2: Immediate actions flow chart must be followed to ensure the patient is reviewed and monitored as required, remedial action to prevent recurrence is undertaken and a Trust incident report is completed to allow review and learning.

4.3 Informing the Patient/Parent/Carer of a Medication Incident

The Trust promotes a culture of openness and recognises that this is a prerequisite to improving patient safety and the quality of healthcare systems. This involves apologising and explaining what has happened to patients who have been affected as a result of their healthcare. Staff should refer to the Being Open (Duty of Candour) (OP60) Policy and adhere to the requirements of the policy.

4.4 Agency, Locum and Bank Staff

If an agency or locum staff member is involved in a medication incident, the Trust must also inform the agency for whom the healthcare professional was working.

Agency medical staff will have a designated Responsible Officer (RO) who should be informed in the event of an incident.

If a substantive member of staff normally employed by the Trust is involved in an incident whilst working extra shifts on bank, their substantive line manager must also be informed of the incident.

Where staff members employed on a 'bank only' contract, the Temporary Staffing Bank Lead must be notified of the medication incident.

4.5 Management of Staff Involved in Medication Incidents

The actions to be taken following a medication incident are outlined in appendices:

- Prescribing, transcribing and administration incidents (appendix 3)
- Dispensing incidents (appendix 4)
- Pharmacy Review and Clinical Checking incidents (appendix 5)

A member of staff who has been practising successfully does not suddenly become incompetent or unsafe following a single medication incident. However, it is vital to understand what went wrong and why it went wrong to prevent recurrence through the identification of causes and actions to address these. This will be supported by the PSIRF and associated tools, refer to the Trust PSIRF policy for full details.

The process for reviewing medication incidents is a supportive one which ensures reflection by the staff involved in the incident and subsequent identification of any system or organisational issues that contributed to the incident along with any specific actions for the individual staff members involved in the incident, see appendix 6: Example actions for individuals involved in medication incidents. The process is designed to ensure that actions are then taken to address the issues raised and prevent recurrence.

The line manager, clinical supervisor, or educational supervisor will discuss the incident with the member of staff, provide them with a reflection form to complete,

and agree on a management plan. The management plan should consider any additional support the member of staff may require, such as emotional support, supervision, further training, or competency assessment, and should include a clear timeframe for completing the actions.

Staff responsible for managing incidents must ensure that supportive remedial actions are carried out without unnecessary delay, as prolonged gaps in follow-up could adversely affect both the member of staff involved and the service provided. The timeframe for these actions must be discussed with the member of staff and formally agreed.

If repeated incidents occur — defined as three incidents within a six-month period by the same member of staff — despite all reasonable support and interventions, the manager must seek guidance from their own manager and Human Resources. The Trust Performance Capability Policy should then be consulted to determine the appropriate options to ensure patient safety is maintained.

4.6 Reflection

The member(s) of staff involved in the medication incident must write a written reflective account of the events preceding, during and after the event within 5 working days of being informed of the incident. It is important that the reflection is timely while the event is still readily recallable.

The reflection will help identify what went wrong and why and allow appropriate actions to be identified. An example of an incident reflection tool can be found in appendix 7: Mediation incident reflection form, Staff may wish to use others such as those provided by their respective regulatory and/or professional bodies.

Upon completion by the staff member, the line manager, clinical supervisor, or educational supervisor must convene a meeting with the staff member within five working days of receiving the written reflection. This discussion will review the reflection, ensure that appropriate actions are identified, and confirm that these actions are implemented as detailed within the management plan.

4.7 Performance Capability Policy

The Management of Medication Incidents Policy is not intended to address issues with the performance of a staff member. Where a member of staff has been identified as not performing to an acceptable level, the Performance Capability Policy (HR19) should be followed.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Doe the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

6.0 Equality Impact Assessment

An equality analysis has been carried out and it indicates that there is no likely adverse impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.

Tick	Options
☐	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.

7.0 Maintenance

The Medication Safety Officer is responsible for keeping the policy up to date. Any revisions to the policy will be reviewed by the Trust's Medication Safety Group and Medicines Management Group before being submitted through the Trust's policy approval procedure.

8.0 Communication and Training

This policy will be published on the Trust Intranet, and will therefore be available to all staff. Managers will ensure that all relevant staff are briefed on its contents and on what it means for them.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Review one Datix report per division per month to ensure policy has been followed.	Medication Safety Officer	Audit	Quarterly	MMG
A quarterly summary report of medication incidents will be reviewed by the MMG and subsequently the Trust Quality Governance Assurance Committee.	Chair of MMG/Director of Pharmacy	Report	Quarterly	MMG
Community Medicines Management will report quarterly to the Trust MMG and continue monthly reports to the community Risk Action Group	Clinical Lead Community Services	Report	Quarterly	MMG

Part A - Document Control

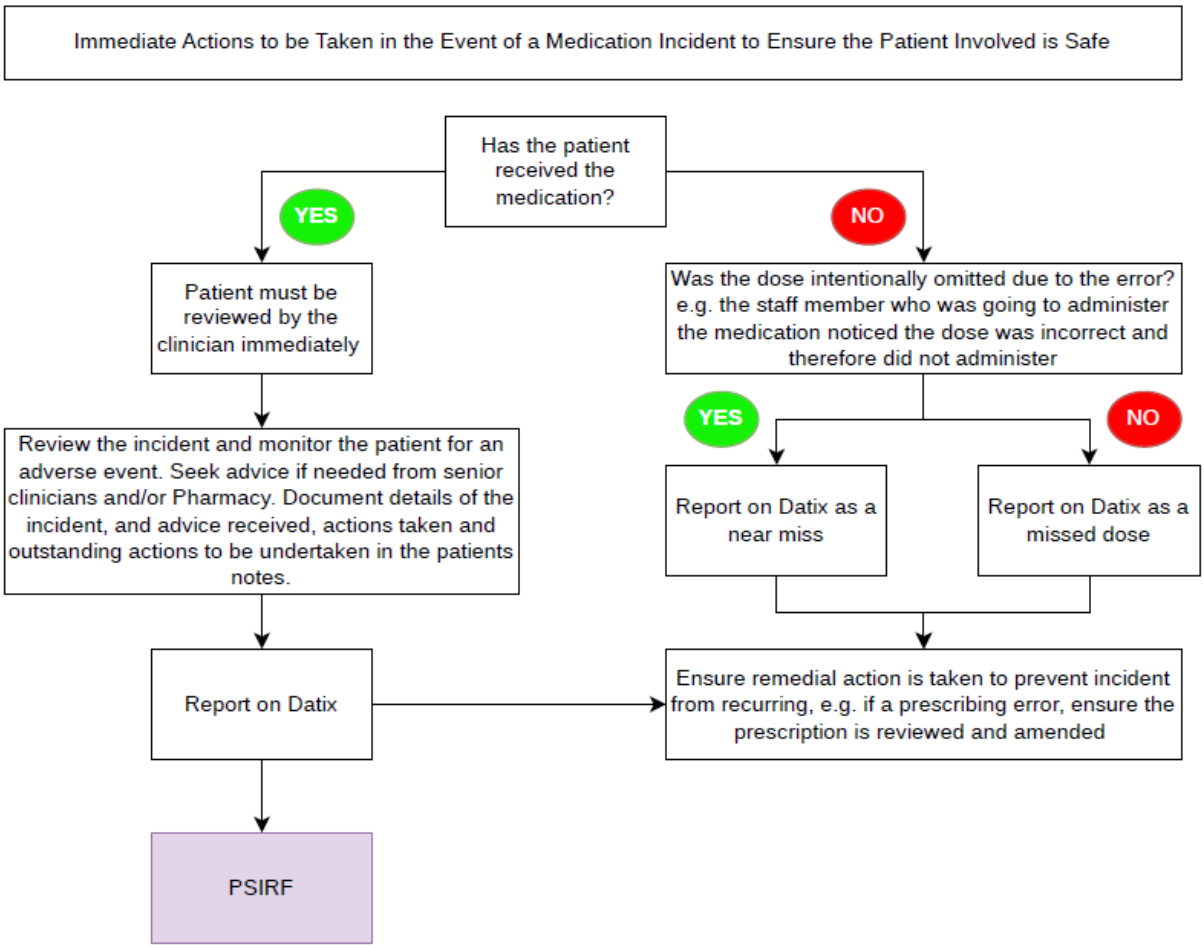
Policy number and Policy version: MP04 Version 8.0	**Policy Title:** **Management of Medication Incidents**	**Status:** Final		**Author:** **Medication Safety Officer** **Chief Officer Sponsor:** **Clinical Director of Pharmacy**
Version / Amendment History	Version	Date	Author	Reason
	1.0	November 2004	Director of Pharmacy	Standard review
	2.0	November 2005	Director of Pharmacy	Standard review
	3.0	November 2008	Director of Pharmacy	Standard review
	4.0	February 2012	Director of Pharmacy	Standard review
	5.0	July 2015	Director of Pharmacy	Standard review
	5.1	October 2015	Director of Pharmacy	Addition of Inpatient Prescribing, Dispensing or Administration Drug Error Investigation Tool
	6.0	March 2018	Digital Lead Pharmacist & Director of Pharmacy	Update to 2018 policy written before project implementation
	7.0	May 2019	Digital Lead Pharmacist & Director of Pharmacy	Review
	7.1	June 2022	Digital Lead Pharmacist & Director of Pharmacy	Extension applied to policy. Policy Management Officer updated version control number.
	7.2	Dec. 2022	Digital Lead Pharmacist & Director of Pharmacy	Extension applied to policy.
	7.3	Sept. 2023	Digital Lead Pharmacist & Director of Pharmacy	Extension applied to policy
	7.4	April 2024	Digital Lead Pharmacist & Director of Pharmacy	Extension applied to policy
	7.5	Nov. 2024	Digital Lead	Extension applied to policy

			Pharmacist & Director of Pharmacy	
	7.6	June 2025	Digital Lead Pharmacist & Director of Pharmacy	Extension applied to policy
	7.7	Oct. 2025	Digital Lead Pharmacist & Director of Pharmacy	Extension applied to policy
	8.0	January 2026	MSO	Full policy review and inclusion principles of PSIRF for incident management.

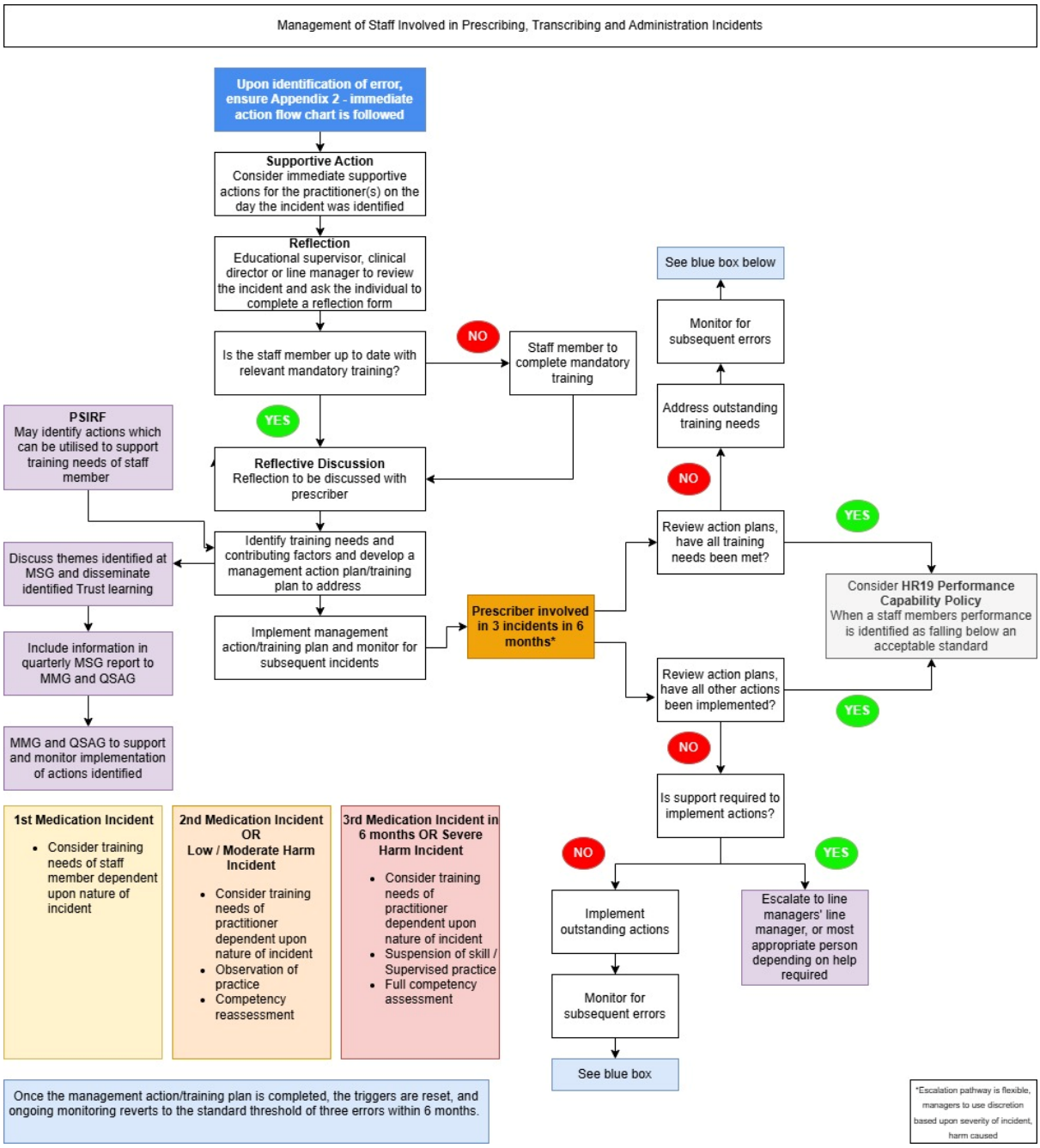
Intended Recipients: All Trust employees with responsibility for prescribing, storage, ordering and administration of medicines.	
Consultation Group / Role Titles and Date: Medication Safety Group (MSG) Medicines Management Group (MMG) December 2025 Learning Response Panel (LRP) December 2025 Group Policy Meeting – March 2026	
Name and date of Trust level group where reviewed	Group Policy Meeting – March 2026
Name and date of final approval committee	Group Policy Meeting – March 2026
Date of Policy issue	March 2026
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	March 2029 - every 3 years
Training and Dissemination: Via Trust Intranet bulletin Via Divisional, Management and Governance Forums	
To be read in conjunction with: Medicines Policy (MP01): Prescribing, Storage and Administration of Drugs Medicines Policy (MP03): Medicines Reconciliation Patient Safety Incident Response Policy (GOP02) Risk Management and Patient Safety Reporting Policy (OP10) Being Open (Duty of Candour) (OP60) Performance Capability Policy (HR19) Disciplinary Policy (HR03)	
Initial Equality Impact Assessment (all policies): Completed Yes / No Full Equality Impact assessment (as required): Completed Yes / No / NA If you require this document in an alternative format e.g., larger print please contact Policy Administrator 8904	
Monitoring arrangements and Committee	Medication Safety Group – via Datix reported incidents and routine audit
Document summary/key issues covered. The launch of the Patient Safety Incident Response (Policy) moves to investigate patient safety	

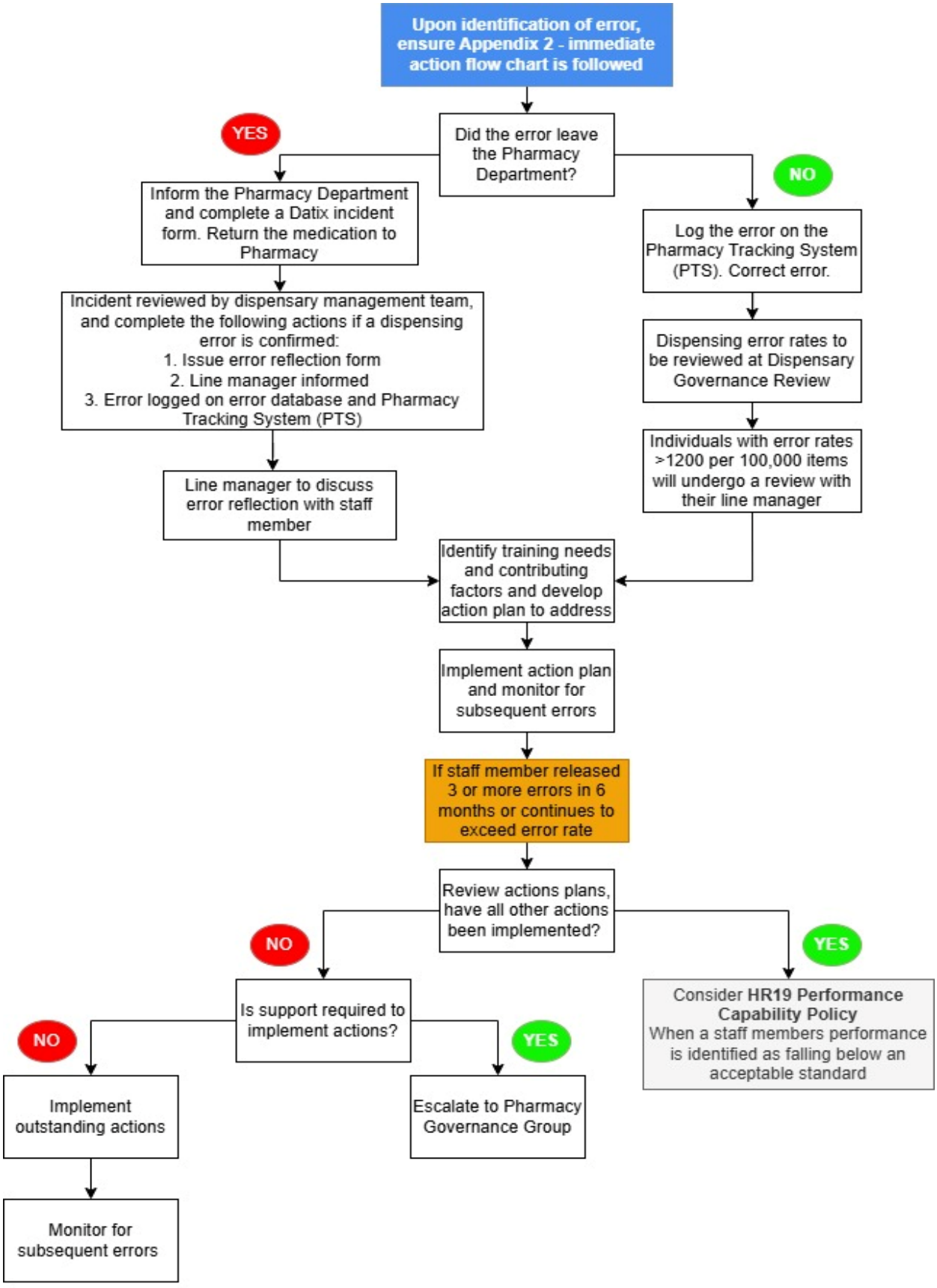
events using a holistic systems based approach, rather than seeking to apportion blame on individuals. Therefore, MP04: Management of Medication Incidents aims to provide a mechanism to support staff involved in an incidents to meet their professional obligation to reflect upon the event, and Trust oversight of medication incidents at Medication Safety Group.	
Key words for intranet searching purposes	MP04, Medicine, Medication, Drug, Incident, Error

<table>
<tr>
<td>Prescribing and Transcribing
• Incorrect patient
• Incorrect medication
• Incorrect dose
• Incorrect frequency
• Incorrect formulation
• Incorrect route
• Incorrect time
• Incorrect rate of administration
• Allergy documented to medication prescribed
• Contraindicated medication due to interaction or medical condition
• Calculation error
• Not prescribed/delay in prescribing
• Incorrect transcription
• Prescription not dated/expired
• Prescription not signed
• Patient details incomplete
• Incorrect quantity
• Incorrect duration</td>
<td>Administration
• Incorrect patient
• Incorrect medication
• Incorrect dose
• Incorrect route
• Incorrect time
• Incorrect rate of administration
• Incorrect preparation
• Missed dose
• Not prescribed
• Allergy documented to medication administered
• Calculation error
• Extravasation
• Expired product
• Contraindicated medication due to interaction or medical condition
• Inappropriate self-administration
• Incorrect/no documentation</td>
</tr>
<tr>
<td rowspan="2">Dispensing and Supply
• Label error – incorrect patient name
• Label error – incorrect medication
• Label error – incorrect strength
• Label error – incorrect form
• Label error- incorrect directions
• Label error – incorrect/missing warnings
• Label error – incorrect expiry
• Content error – incorrect medication
• Contents error – incorrect form
• Contents error – incorrect strength
• Contents error – expired product
• Contents error – incorrect quantity
• Missing/incorrect patient information leaflet
• Missing medication</td>
<td>Pharmacy Review and Clinical Checking
• Incorrect medication
• Incorrect dose
• Incorrect frequency
• Incorrect formulation
• Incorrect route
• Incorrect time
• Incorrect rate of administration
• Incorrect/missing endorsements
• Incorrect or unclear advice
• Failure to provide advice
• Incorrect/missing documentation
• Incorrect drug history</td>
</tr>
<tr>
<td>Patient Monitoring
• Failure to review blood level/observations
• Failure to review medication
• Failure to discontinue medication
• Incorrect or unclear advice
• Failure to provide advice</td>
</tr>
</table>


Immediate Actions to be Taken in the Event of a Medication Incident to Ensure the Patient Involved is Safe
Has the patient received the medication?
YES
NO
Patient must be reviewed by the clinician immediately
Was the dose intentionally omitted due to the error? e.g. the staff member who was going to administer the medication noticed the dose was incorrect and therefore did not administer
Review the incident and monitor the patient for an adverse event. Seek advice if needed from senior clinicians and/or Pharmacy. Document details of the incident, and advice received, actions taken and outstanding actions to be undertaken in the patients notes.
YES
NO
Report on Datix as a near miss
Report on Datix as a missed dose
Report on Datix
Ensure remedial action is taken to prevent incident from recurring, e.g. if a prescribing error, ensure the prescription is reviewed and amended
PSIRF

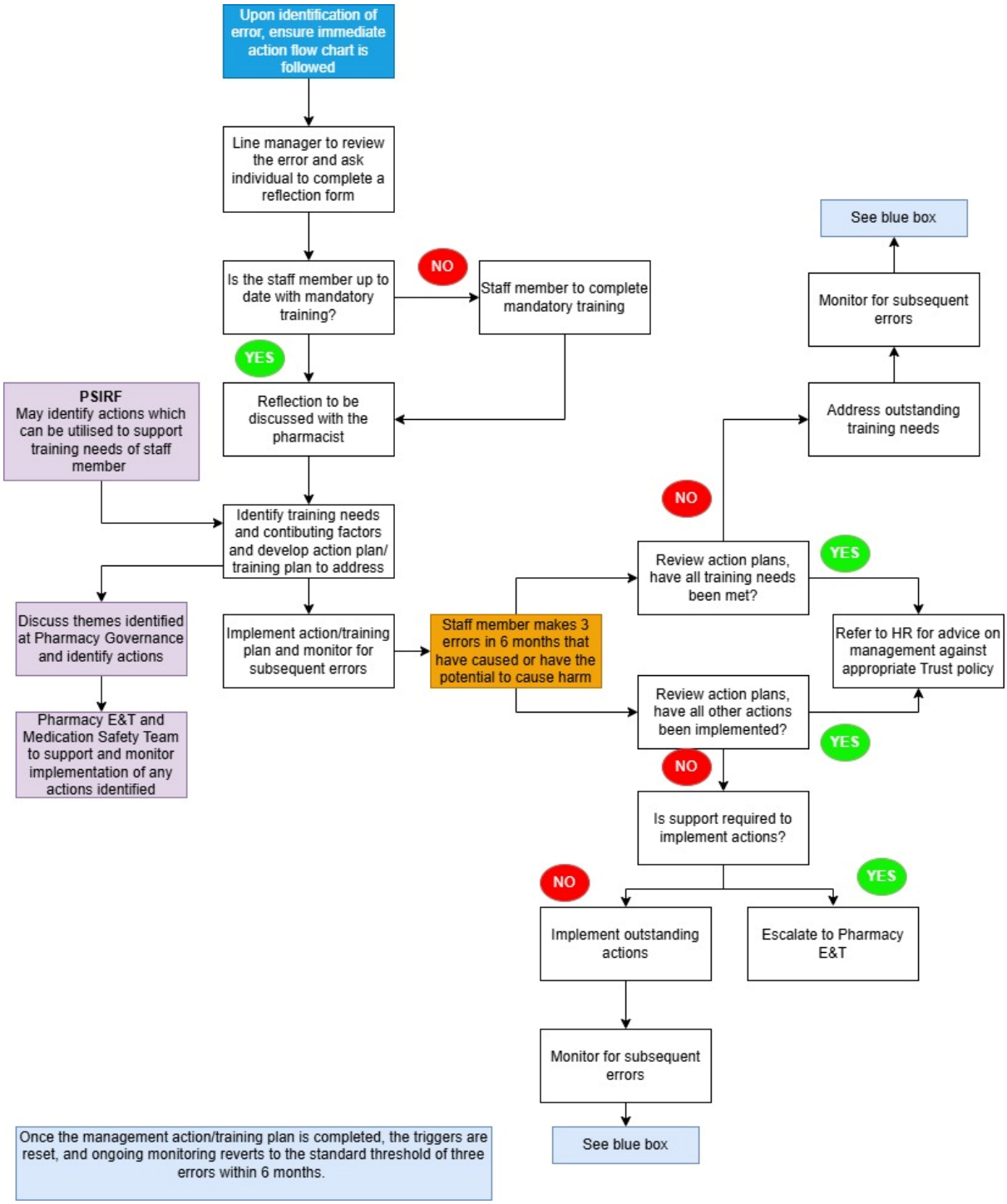
Appendix 3: Management of Staff Involved in Prescribing, Transcribing and Administration Incidents





Dispensing incidents are routinely monitored on a 6 month rolling basis. Management action/training plans will reflect this in the timescales.

Appendix 5: Pharmacy Review and Clinical Checking Incident Flow Chart



Appendix 6: Examples of actions to be taken for individuals involved in medication incidents

1. Reading of Trust policy and procedures

This will ensure the individual is aware of the correct process to be followed, if the policy/procedure is identified as being incorrect this must be escalated to Group governance.

2. Completion of relevant mandatory training

This will ensure the individual has the required knowledge and has demonstrated their understanding via successful completion of the multiple-choice questions.

3. Completion of identified Kite, My Academy and Professional site training modules

The choice of Kite, My Academy and professional e.g. Presquip site training modules required will need to be identified and agreed between staff member and line manager.

4. Supervised practice

Utilising 'Watch, Do Under Supervision, Do With Check'. This can provide assurance that the staff member who made the error is following correct procedures. The method and length of supervised practice will depend on the individual and nature of the error.

5. Competency assessments

This can provide assurance that the staff member who made the error is following correct procedures and is competent to undertake the task.

6. Suspension of duties

A pause in clinical duties is a constructive measure to safeguard both practitioner resilience and patient care quality. This will provide the staff member with the opportunity to reflect, recover and return to practice safely.

NB: This list is not exhaustive and is to demonstrate actions which may be taken to support the staff member.

Name:	**Position:**
Location:	**Datix Number (if reported):**
Line Manager/Clinical Supervisor:	**Date:**

What was the nature of the medication incident prompting a learning experience? Include a description of the actual event.
What should have happened?
What were the differences?
Were there any contributing factors? (e.g. individual, team, system/processes, environment, communication)
What went well, and why?

What could have gone better, and why?
How will you change or improve your practice as a result? How will you demonstrate the changes have been effective?
How is this relevant to your Professional Standards?
Manager Discussion
Actions Identified **1.** **2.** **3.** **Target Date For Completion**

Staff Signature		**Date**	
Manager Signature		**Date**	