

Multi-disciplinary Medication Incidents Management Policy

DRAFT FOR CONSULTATION

Policy information

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Summary of document:

Hywel Dda University Health Board encourages a sensitive response to medicines errors through a comprehensive assessment taking full account of the context and circumstances surrounding the incident. This policy is to ensure a consistency of approach in the practice of managing medicines errors throughout the organisation and the various professionals involved in prescribing, administering, supplying and monitoring medications.

Scope:

This policy applies to all healthcare staff (including bank and agency) and pre-registration healthcare professional students involved in any medication

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processes. including nursing, medical, pharmacy and professions allied to health and HCSW.

To be read in conjunction with:

[894 'Putting things Right' Management and Resolution of Concerns Policy \(Incident, Complaints and Claims\)](#) (opens in a new tab)

[268 Medicines Policy](#) (opens in a new tab)

[203 All Wales Capability Policy](#) (opens in a new tab)

[201 All Wales Disciplinary Policy & Procedure](#) (opens in a new tab)

[488 All Wales Upholding Professional Standards in Wales- \(Medical and Dental Staff\) Policy](#) (opens in a new tab)

[176 Non-medical Prescribing Policy](#) (opens in a new tab)

Relevant Professional and Departmental Procedures

[982 Incident, Near Miss and Hazard Reporting Procedure](#) (opens in a new tab)

Patient information:

Include links to [Patient Information Library](#)

Owning group:

Medicines Management Sub-Committee

Associate Medical Director with responsibility for Medicines

Date signed off by owning group

Executive Director job title:

Director of Nursing, Quality and Patient Experience

Reviews and updates:

1 - new

Keywords

Medication medicine error incidents

Glossary of terms

PSA	Patient Safety Agency
ASI	Assurance, Safety and Improvement
MERG	Medicines Event Review Group

Keypoints:

Please summarise key points of the document

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Introduction

Patients Safety Incidents (PSI) are Medication Errors or Adverse Drug Reactions (ADRs). Medication errors continue to cause harm to our patients and indirectly to our staff and organisations (Berwick 2016). Medication errors are any PSI where there has been an error in the process of prescribing, preparing, dispensing, and administering, monitoring, or providing advice on medicines (NHS Resolution 2022). Medication errors can occur at any point in the medication process involving all health professionals (doctor, nurse, midwife, pharmacist, or professions allied to medicine and HCSW that have had the delegated task). An adverse drug reaction (ADR) may arise following the use of a medicinal product within or outside the terms of the marketing authorisation, such as off-label therapeutic use, overdose, misuse, abuse or medication errors, or from occupational exposure (NICE March 2022).

It is important that in organisations healthcare professions approach the management of errors and staff involved in a medication error or ADRs incident consistently and with a Just Culture as a central feature (National Health Service Employers 2021). As healthcare professionals there is a duty of candour which is being open and honest when things go wrong. The WG The Health and Social Care (Quality and Engagement) (Wales) Act which came into force in the Spring 2023 supports this approach.

Policy Statement

Hywel Dda University Health Board (HDUHB) encourages a sensitive response to medicines errors, taking full account of the context and circumstances surrounding the incident. The primary principal is to ensure harm is reduced to patients, relatives, and staff and that any lessons are learnt and shared.

The [HDUHB Putting things Right' Management and Resolution of Concerns Policy \(Incident, Complaints and Claims\)](#) (Opens in a new tab) provides more detailed advice on the management of errors and incidents involving medicinal products. This guidance is to ensure a consistency of approach in the practice of managing medicines errors throughout the organisation and aims to:

- Facilitate organisational learning through the findings of thorough and careful investigation at both divisional and corporate level.
- Provide a framework for practitioners to improve practice.
- Assure proportionate response to adverse healthcare events.
- Ensure appropriate actions are taken by managers and are applied consistently across all healthcare professionals throughout HDUHB.

There are multiple causes of errors such as disruptions in workflow, process failures and system factors. Understanding the causes of errors is vital to

prevent the error from happening again, and to share learning. Including staff involved in the error in the investigation is critical to understand how it happened, and to prevent the error from re-occurring.

Scope

This policy applies to all healthcare professionals (including bank, locum, and agency staff) and preregistration healthcare professional students involved in any medication processes including nursing, medical, dental, pharmacy, HCSW and allied health professionals.

Aim

The aim of this policy is for a multidisciplinary standardised approach to managing medication errors. Encourage timely reporting of all medicine errors, omission, and near misses.

Objectives

The objectives of the MDT Medication Incidents Management Policy are to:

- Detail the actions required to ensure the immediate and long-term safety of the patient.
- Detail the processes in HDUHB for monitoring medication errors and incidents and ensuring that lessons are learnt and shared to minimise such occurrences in the future.
- Support staff to learn from any medication errors.

Definitions of medication errors, incidents and ‘near misses’

Medication errors can be defined as PSI involving medicines in which there has been an error in the process of prescribing, dispensing, preparing, administering, monitoring, or providing medicine advice, regardless of whether any harm occurred (NNS Resolution (2022)).

Errors may result in an incident or an adverse event or where averted, they can be classified as a ‘near miss’.

The below list provides examples of scenarios in which medication errors can occur; however, it is not definitive, and therefore clinicians, managers and

clinical governance managers must exercise professional judgement when investigating the incident. 'Near miss' incidents must also be investigated.

Prescribing Errors

- Patient prescribed the wrong medication / dose / route / rate.
- Medication prescribed to the wrong patient.
- Transcription errors
- Medication omitted on admission to or discharge from hospital (reconciliation error)
- Prescribing without considering the patient's clinical condition
- Prescribing without taking into account patients' clinical parameters e.g. weight
- Failure to take account of known allergies.
- Prescription not signed.
- Illegible prescriptions.
- Deviation from HDUHB [268 Medicines Policy](#) (Opens in a new tab) and 176 [Non-Medical Prescribing Policy](#) (Opens in a new tab) and all Wales prescription writing standards.

Preparation and Administration Errors

These can occur in 3 areas; the preparation of a medicine in a clinical area that deviates from the prescription, manufacturer's guidance, national or locally agreed policy procedure or guidance, or standards for aseptic preparation. Secondly, the administration of a dose of medication that deviates from the prescription, as written medication chart, patient group direction or from policy and procedures. Thirdly, the preparation of a medicine within the controlled environment of a pharmacy manufacturing unit that deviates from the prescription, manufacturer's guidance, national or locally agreed policy procedure or guidance, or standards for aseptic preparation.

- Administration without valid authorisation
- Patient administered the wrong medication/dose/route
- Patient administered an out-of-date medicine
- Medication administered to the wrong patient
- Medication omitted without a clinical rationale
- Medication incorrectly prepared (e.g. use of wrong diluent/strength diluent, use of wrong preparation technique, contamination of prepared product)
- Use of incorrect administration device
- Incorrect infusion rate (always utilise the infusion device drug library where applicable)
- Inappropriate use of PRN medicines
- Medication administered late / early* (for Critical Time Medicines)

**(HDUHB recognises this is a complex issue and the full context of late/early administration should be considered, however where it would have a*

significantly detrimental effect on patient care, this would constitute an error)

- Deviation from HDUHB [268 Medicines Policy](#) (Opens in a new tab) and 176 [Non-Medical Prescribing Policy](#) (Opens in a new tab)

Prescribing and Administration

Simple good practice guidance and all training should focus on the 10 rights of medication: -

Right patient	Name and wristband, ideally 2 identifiers (within areas that they are being used)
Right medication	Name and brand names avoided, unless required check expiry date and prescription and review regularly
Right dose	Check prescription. Appropriateness of dose, check the calculation
Right route	Check the route noted, check patient can take the medication via that route
Right time	Frequency on chart, check the time it is being given if that differs, confirm when the last does was given
Right patient	Side effects awareness
Right documentation	Signed MAR chart
Right to refuse	Consent needs documenting
Right assessment	Observations need to be logged with certain medication
Right evaluation	Ensure the medication is working

Dispensing Errors

Any unintended deviation from a written prescription or medication order, including pharmacists written endorsements, occurring during the process of selecting and assembling medication for stock or patient specific use, generating and affixing dispensing labels and issue of dispensed medication to patients/clinical areas.

- Patient dispensed the wrong medication/dose/route
- Medication dispensed to the wrong patient
- Patient dispensed an out-of-date medicine
- Medication is labelled incorrectly
- Deviation from HDUHB [268 Medicines Policy](#) (Opens in a new tab) and 176 [Non-Medical Prescribing Policy](#) (Opens in a new tab)

Monitoring and Other Errors

A failure to review the effectiveness of a prescribed medicine and impact on physiological parameters. It includes medication reviews in clinics and primary care

- Inappropriate monitoring/follow up
- Failure to monitor therapeutic levels

Medicine Information and Advice

The provision of advice to support the safe use of a medicine to a patient, carer or healthcare professional. This includes verbal and/or written information on indications, mechanism of action, cautions, contraindications, dosage information, dose alterations, side-effects, administration, formulations, storage, monitoring, sourcing, licensing, teratogenicity, stability, compatibility, management of poisoning/overdose etc.

Other Errors

Including

- Failure to provide the patient with correct information regarding their medication e.g. when to take, what it is for, side effects and drug interactions
- Failure to undertake appropriate review
- Failure to monitor patient / carer who is undertaking self-medication.
- Deviation from HDUHB [268 Medicines Policy](#) (Opens in a new tab) and 176 [Non-Medical Prescribing Policy](#) (Opens in a new tab)
-

Actions to be taken following the discovery of a Medication Error/Incident

Please see flow charts to support the process for Pharmacy incidences, Administration/near misses and Prescribing incidences.

If the patient has not taken the medication (near miss) please go to point B

A. Immediate Action

- Assess the patient's condition and take necessary actions to keep the patient stable.
- The error must be reported immediately to the Ward or Department Manager/person in charge and the clinicians in charge of the patients care and inform the patient/carer/next of kin of the error.

- Seek advice from pharmacist / prescriber regarding the possible outcomes of the medication error.
- Develop and record a monitoring care plan for the patient based on the properties of the medicines involved and the condition of the patient in the patient's medical notes.

B.

- In the instance of a dispensing error, inform the pharmacy and make arrangements for re-dispensing.
- Incident report form (Datix) to be completed by individual highlighting the error. Ensure the incident is documented in the patients' record if they have taken the drug.
- Obtain first-hand accounts from the staff involved. [Appendix 1](#).
- Following an assessment based on the Datix risk rating, the line manager may feel it is appropriate to withdraw the member of staff from undertaking medication prescribing, dispensing or administration until a critical incident reflective exercise (which should be completed within 7 days of the incident) has been undertaken. In these cases, the line manager must consult with the Hospital Head of Nursing or Medical Lead/Head of Service/ Head of Department. (Appendix 2,3,4,5)
- The line manager will ensure the incident report is completed and escalated as appropriate. It is essential this is carried out expediently to allow for a timely investigation in the event of a more serious event. In the event of an incident occurring out of hours the Manager on call should be informed. Follow the detailed guidance on the reporting of Level 4 and 5 (Major or Catastrophic Harm) incidents (including Serious Incidents and Never Events)

Assessment of medication errors and incidents

Where the line manager making or investigating the Datix report notes actions or omissions of other healthcare professionals that may have contributed to the medication error/incident the relevant manager (e.g. Consultant, Site Lead Pharmacist, Head of Department) should be informed and the staff member included in the investigation to enable multi-disciplinary learning and action.

Medium Term Actions

- Where appropriate a systematic review of the root causes for the error must take place with the staff involved.
- There may be occasions where staff wish to withdraw themselves from prescribing, dispensing or administration due to concerns regarding their own practice or a loss of confidence. This should be discussed and agreed with their line manager/ Head of Service as it may have implications for staffing levels / allocation. This decision should be respected and addressed within the reflective exercise (which should be completed within 7 days of the incident). Any formal decision will be in consultation Hospital Head of Nursing or Medical Lead/Head of Service/ Head of Department and QAST Team (or duty manager if out of hours) before any decision is reached.
- The line manager or delegated deputy, in conjunction with the Hospital / Directorate Head of Nursing or Medical Lead/Head of Service/ Head of Department, will undertake a critical incident reflective exercise (within 7 days of the incident) with the member of staff.
- A copy of the agreed actions identified within the reflective exercise is kept on the member of staff's personal record and the agreed actions reviewed at an agreed date. This review is separate from the individual's PADR.

Long Term Actions

- A Copy of the Root Cause Analysis Checklists (where completed) must be sent to the Hospital Head of Nursing or Medical Lead/Head of Service/ Head of Department and QAST Team and a copy attached to the Datix incident. The results will be analysed and reviewed to identify any themes and trends. The monthly Site (or Primary Care) Scrutiny Meeting and departmental meetings will discuss the medication incident and the outcome of the discussions is included in the Scrutiny Report sent to each Medication Events Review Group (MERG). These results will be reported to the MERG on a bi-monthly basis.
- The QAST Team and the Medicines Management Operational Group (via MERG) must have clear processes in place to review information on medication errors from Datix and the actions taken to address the incident and to identify any themes and trends. Concerns regarding medication

errors/incidents or the management of medication errors/incidents must be highlighted and escalated as appropriate.

Informing the Patient

[894 'Putting things Right' Management and Resolution of Concerns Policy \(Incident, Complaints and Claims\)](#) (opens in a new tab) must be followed.

Addressing Concerns of Competency

- While each profession will need to interpret this pathway according to their Professional Code of Practice, action must be proportionate to the (potential) severity of the medication error/incident and equitable and consistent between individual staff and professions. NPSA decision tree may be used as support for this process (Appendix 6) (see section: [Assessment of medication errors and incidents](#)).

If the critical incident reflective exercise highlights an issue with competency relating to medication prescribing, dispensing or administration, the individual should undertake a period of re-assessment planned in collaboration with their line manager. Specific timescales must be set and regularly reviewed and monitored throughout.

Qualified healthcare professionals

- The line manager of a qualified healthcare professional employed by the HDUHB who has been involved in a medication error/incident will be informed. The line manager will assess and support the individual and identify any further training needs. Where required they will inform any other relevant parties (for example, professional body, university, deanery). Where a Newly Qualified Nurse is involved, their mentor will be informed. Specific eBMJ training modules on prescribing are available, CDEP, Medication Safety Study Days are provided by the Health Board on a monthly basis. ESR modules on medication administration charts and VTE Risk Assessment are also available. Local Universities also deliver training that is useful to all staff.

7.6.3 Temporary, short-term contract staff

(These include bank or agency nurses and, for other healthcare professions, locum, or agency staff).

- If a healthcare professional on a short-term temporary contract (i.e. bank, agency or locum staff) makes a medication error they may be limited to where they can work until such time that training has been completed and assessed. Where the healthcare professional also holds a substantive HBDUHB contract then their line manager will be informed, and they may be limited to working in their substantive ward/department for the period of time of training and monitoring. The locum agency will be informed (for nursing by the Head of Nursing Workforce Utilisation, for medical-by-Medical Staffing/Site Lead Clinician and for other healthcare professionals by the Head of the relevant Department) and evidence of the completion of any additional training (if required by the HDUHB) will be requested. If any subsequent errors are made, consideration will be given as to whether placement within the HDUHB remains appropriate.

Healthcare professional trainees and undergraduates

- The mentor, tutor, or supervisor of an undergraduate, preregistration and trainee healthcare professional who are involved in any medication error/incident while working under direct or indirect supervision will be informed. Medical Education will also be informed of any Datix reports involving a medical trainee. The mentor, tutor or supervisor will assess, advise and support the individual and identify any further training needs. Where required they will inform any other relevant parties (for example, the university or Deanery)
- After the period of education, training and re-assessment the member of staff's competence is still in doubt they should be managed in accordance with the HDUHB [203 All Wales Capability Policy](#) (opens in a new tab)
- Where an individual member of staff has made subsequent errors, the process will be undertaken by their line manager and comprehensive assessment made of the practitioner's competence level, the timescale and context. Subsequent errors will be assessed independently by the line manager but may inform decisions around competence levels, taking into consideration the timescale and content.

Support for Staff

- Support for staff throughout the medication error process is available from (this not a Definitive list):
 - Line Manager
 - Head of Nursing

- Head of Clinical Service
 - Clinical Lead
 - Practice Development Staff
 - QAST Team
 - Trade Union (if member)
 - Professional Indemnity Insurer (e.g. MDU, The Pharmaceutical Defence Association, RCN) (if member)
 - Professional Association (if member)
 - Occupational Health
 - Professional Bodies
 - Human Resources staff
- Line Managers can gain advice and support in managing staff that have made a medication error from:
 - Head of Nursing
 - Assistant Directors of Nursing
 - Director of Nursing
 - Clinical Director
 - Clinical Lead
 - Consultant
 - Practice Development Staff
 - Site Lead Pharmacists or Lead Pharmacist Primary Care
 - Senior Nurse Medicines Management
 - Head of Service (e.g. Physiotherapy, Occupational Health, Speech Therapy)
 - Occupational Health
 - QAST Team
 - Human Resources staff

Legal Liability

The organisation will generally assume vicarious liability for the acts of its staff. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training and assessment of competence identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and Directorate/Head of Clinical Service to undertake the activity.
- Fully comply with the terms of any relevant organisational policies, guidelines and/or procedures at all times.
- Only depart from any relevant organisational guidelines providing always that such departure is confined to the specific needs of the individual circumstances and undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable – such decision to be fully recorded in the patient's notes.

Staff are recommended to have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the organisation does not automatically assume vicarious liability and where support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies.

Responsibilities

Chief Executive and Board (as commissioner/provider)

Provision of resources to ensure the management of medication errors is the responsibility of the Chief Executive and Board. It is their responsibility to ensure that guidance is consistent with the legal requirements, NHS and WG local Health Board guidance.

The leadership of the organisation should be able to monitor adherence to this policy.

Where there is non-compliance, the Board is responsible for ensuring that there are appropriate actions in place to mitigate any risks identified.

Executive Director of Nursing, Quality & Patient Experience

Is responsible for the implementation and review of this policy in consultation with other Healthcare Professional Leads.

Clinical Director of Pharmacy & Medicines Management

Is responsible for the implementation and review of this policy in consultation with other Healthcare Professional Leads.

Medical Director

Is responsible for the implementation and review of this policy in consultation with other Healthcare Professional Leads

Senior Management Leads

The Senior Nurse Managers, Senior Pharmacists, Consultants and Professional Heads of Department are responsible for the dissemination of this Policy, ensuring the implementation of this policy in their area of responsibility, ensuring

that their staff are appropriately trained in line with the requirements of this policy, monitoring the implementation, managing medicines errors and incidents in line with this policy, auditing adherence to the Policy.

Individual staff (registered Healthcare professionals)

It is the responsibility of all staff (including students) that are involved in and/or managing medicines to ensure that they are aware of this policy, follow the procedures included (particularly the immediate actions to be taken when a medicine error involving a patient is identified) and referring to other Health Board policies for further information. Staff must report any incidents where this policy is not adhered to.

The Medicines Event Review Group (MERG)

Monitors all medicine related incidents across the Health Board; detect trends and clusters of activity. MERG scrutinises and prepares a summary report of those incidents for presentation to the Medicines Management Operational Group and the QSEC. MERG ensures that lessons are learnt from such incidents and that this information is then disseminated to all those who may benefit from it.

Medicine Management Operational Group (MMOG)

It is the responsibility of the MMOG to lead the review this guidance with the professions involved in medicines management for presentation for final approval at Clinical Written Control Document Group. The group also have oversight and accountability of all medicines management related issues including errors and incidents.

References

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National Health Service Employees (2021) Implementing a Just and Learning Culture. <https://www.nhsemployers.org/.../implementing-just-and-learning-culture>. Accessed 14.7.22

National Health Service Resolution (2022) <https://resolution.nhs.uk/2022/03/31/learning-from-medication-errors>. Accessed 14.7.22

Nursing and Midwifery Council (2018) The Code, Professional Standards of practice and behaviour for nurses and Midwives
<https://www.nmc.org.uk/standards/code/>

General Medical Council (2019) Good Medical Practice <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice>

General Pharmaceutical Council (2017) Standards for pharmacy professionals
<https://www.pharmacyregulation.org/spp>

RPSGB Competency framework for all prescribers (Sept 2022)
<https://www.rpharms.com/resources/frameworks/prescribing-competency-framework/competency-framework>

Royal College of Physicians Supporting junior doctors in safe prescribing (2017)
<https://www.rcplondon.ac.uk/projects/outputs/supporting-junior-doctors-safe-prescribing>

NICE Guideline [NG5] Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (March 2015)
<https://www.nice.org.uk/guidance/ng5/chapter/1-Recommendations#systems-for-identifying-reporting-and-learning-from-medicinesrelated-patient-safety-incidents>

References for the Ten Rights of Medicines Administration

Nurselabs: <https://nurseslabs.com/10-rs-rights-of-drug-administration>

Edwards S, Axe S. The ten 'R's of safe multidisciplinary drug administration
Nurse Prescribing 2015 Vol 13 No 8
<https://bucks.repository.guildhe.ac.uk/id/eprint/9407/1/Edwards,%20Sharon%20Axe,%20Sue%20%2010%20%E2%80%98R%E2%80%99s%20of%20safe%20multidisciplinary%20drug%20administration.pdf>

The Health and Social Care (Quality and Engagement) (Wales) Act:
<https://gov.wales/health-and-social-care-quality-and-engagement-wales-act-summary-html>

Acknowledgements

This policy is based on: CHANGE

- C&VUHB Procedure for the Management of Staff involved in Medication Errors (July 2006)
- Lincolnshire Community Health Services NHS Trust: Management of Medication Errors Policy (May2016)
- Mersey Care NHS Trust Guidelines for the management of Medicines Errors within Mersey Care NHS Trust (MM09) (May 2015)
- Powys Teaching Health Board Medicines Policy (2021).

Appendix 1: First-hand account template.

Your name:	
Your occupation or job title and the length of time in post:	
Usual place of work/base:	
Qualifications with dates/ relevant other training/brief summary of experience within the NHS/UHB:	
Subject of first-hand account e.g. details of person affected or incident date and reference number	
<p>Factual account of the event</p> <p><i>You may like to begin your statement along the following lines: I, [insert full name], am employed by Hywel Dda University Health Board as a [insert your role].</i></p> <p>This first-hand account is based on [<i>personal recollection / review of records, or combination</i>].</p> <p>On [<i>day and date</i>] I was on duty from [<i>insert time</i>]</p> <p>At the time of the incident, I was</p>	
Signature:	Date:

Appendix 2: Management of Pharmacy near misses (including dispensing, accuracy checking, clinical advice and checking)

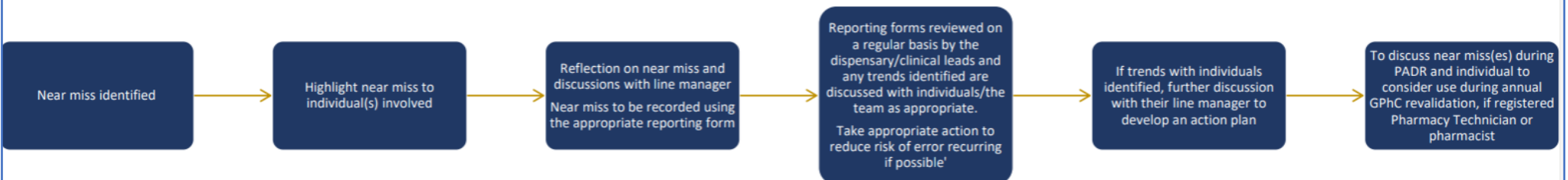
Appendix 2



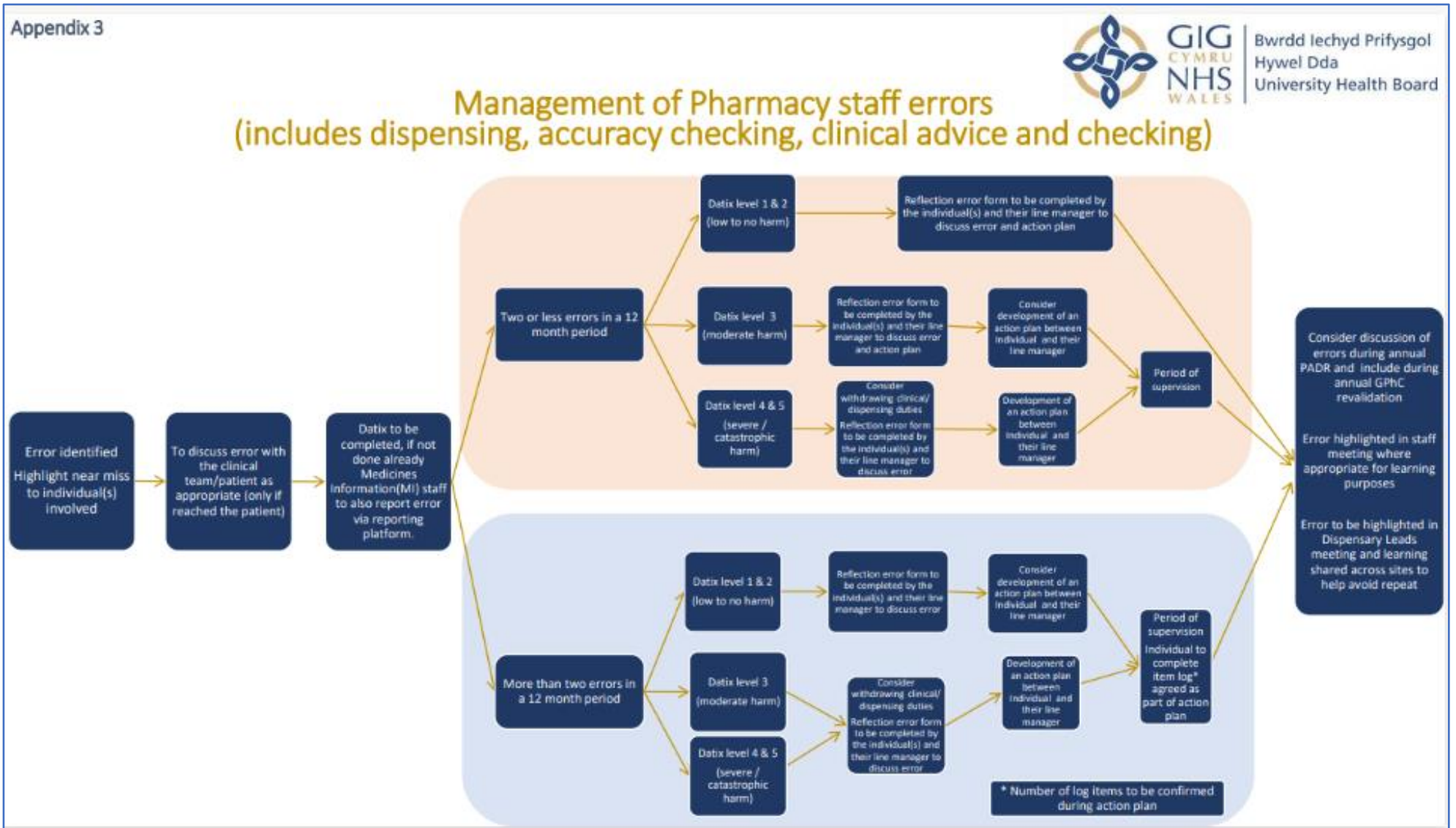
GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Management of Pharmacy near misses (includes dispensing, accuracy checking, clinical advice and checking)



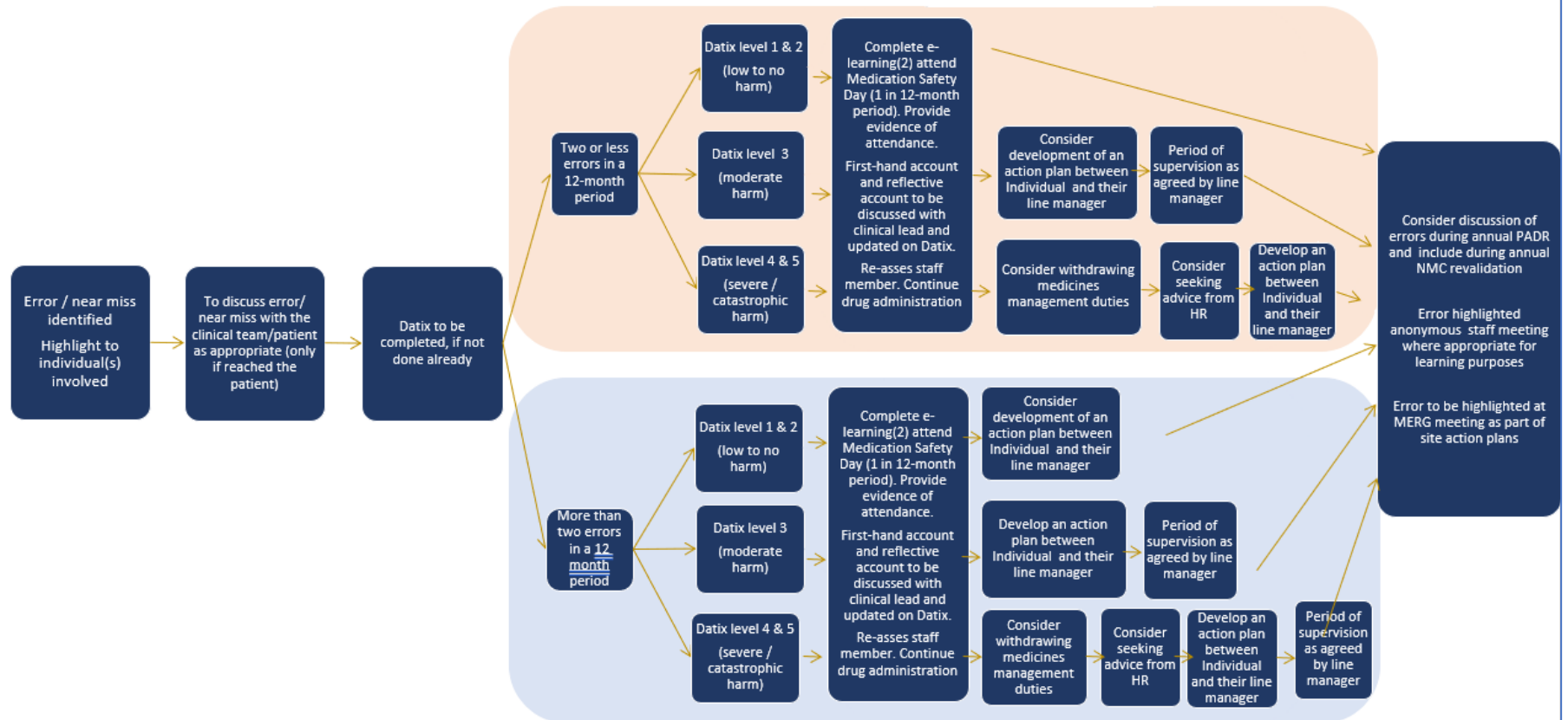
Appendix 3: Management of Pharmacy staff errors (including dispensing, accuracy checking, clinical advice and checking)



Appendix 4: Management of drug administration errors and near misses

Appendix 4

Management of drug administration errors / near misses



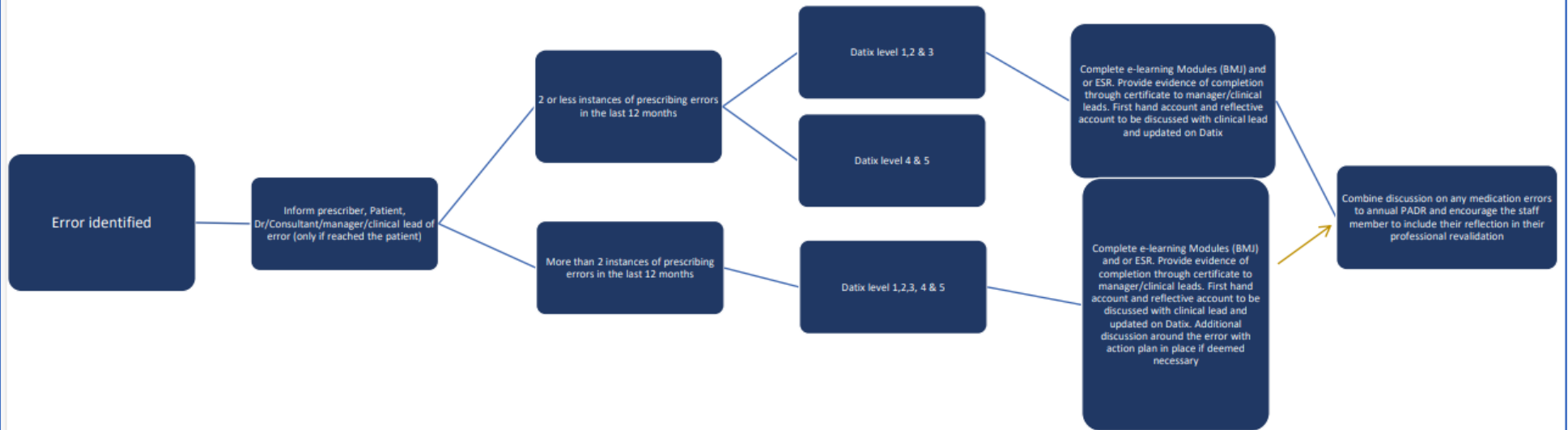
Appendix 5: Management of drug prescribing errors

Appendix 5



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University Health Board

Management of drug prescribing errors



Appendix 6: National Incident Reporting (NRI) Reporting Flowchart

