Manager's Guide: Reducing Medicines Errors

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Overview

The problem:

Medicines errors occur more than they should in my care organisation.

What I want to achieve:

- ✓ Reduce the number of times medicines are given incorrectly
- ✓ Reduce the number of gaps on the MAR sheets
- ✓ Reduce the number of times medicines have been missed

You're thinking…..:

- I have told the staff to be more careful but still mistakes occur
- The same sort of mistakes happen all the time
- How many more times do I have to say the same thing?!

What is behind the problem?

Care staff never set out to harm people however more often than not, a number of factors combine that make it more likely for mistakes to be made.

It is important to understand these factors, when they are likely to occur and the ways to overcome them in order to make a safer system.

FACTOR 1: Human Behaviour

Human behaviours can be separated into different categories, to which certain errors can be attributed. One human behaviour model categorises behaviours as:

- Knowledge-based behaviours
- Rule-based behaviours
- Skill-based behaviours

This model links the type of error with how much experience someone may have with a task and therefore how automatic it may feel when they carry it out.

KNOWLEDGE BASED WORKING ERRORS **: Occur when the rules learnt and usually used for similar scenarios no longer appear helpful for that particular scenario.**

e.g. the medicine should be kept in the fridge (and it is when the person lives in their supported living accommodation) but as the person is now away on a residential camping holiday, there is no fridge so the medicine is not refrigerated.

ERROR OUTCOME: Medicine is stored at the wrong temperature and may not be effective.

RULE-BASED WORKING ERRORS **: Occur when situations are different to what you assume.**

e.g. you assume you don't have a medicine for a person because it is not in the place you would expect. In your organisation, the rule might be that if the medicine is not on the top shelf of the cupboard, we don't have any. The rule could be wrong if someone has rearranged the shelves or put the medicine away in the wrong place.

ERROR OUTCOME: Person misses their medication which could have consequences.

SKILL-BASED WORKING ERRORS**: Are often slips and lapses.**

Slips occur when someone is working on "autopilot" rather than making conscious decisions and they do the wrong thing despite having the best intention to do the right thing.

e.g. A new medicine has been added to the MAR sheet. For the first 2 days on the MAR sheet, no one has signed for the medicine being administered and therefore on day 3 that day's staff member also does not sign, not wanting to be the first person to sign the record, in case they get it wrong.

ERROR OUTCOME: The person may or may not have had the medicine and it cannot be ascertained from the MAR sheet. The person may receive a double dose or no dose at all.

Lapses occur where someone forgets to do something or forgets that they have done something and repeats it.

e.g. A person wakes early and requests their medicine early. The staff member gives the medicine at that time, forgets to sign the MAR sheet and then, at breakfast, another member of staff gives the medicine again.

ERROR OUTCOME: The person receives double dose which can have serious consequences.

ACTION POINTS:

In order to prevent these types of mistakes being made, care organisations can work to:

1) **Understand behaviours**

By understanding the types of behaviours that can lead to errors being made, managers and senior staff can look for these behaviours in their staff and address them before errors occur. Similarly, all staff can be made aware of these potential risk areas, meaning they can self-monitor as well as alert other members of staff should they be showing similar signs.

2) **Ensure staff know correct procedures**

It is vital that staff know the correct procedures they are to follow in order to identify when they've made a mistake. If they are not certain of what the correct or best practice is, they will have no benchmark by which they measure their own actions.

3) **Encourage staff to recognise when they're working on 'autopilot'**

It is important for staff to know when they are acting out of habit rather than making active choices and decisions. However regularly actions are undertaken, staff still need to make active decisions each time, based on the particular circumstances they are dealing with. It is all too easy to work on 'autopilot' but staff should be made aware of this possibility and be alert.

FACTOR 2: Complacency in the Workplace

When staff work together regularly, it is almost inevitable that individuals fall into a pattern and become more reliant on others. This can be dangerous in working environments where precision and accuracy are imperative.

When administering medicines, staff need to assess each situation individually every time and undertake all actions relating to the administration rather than relying on other team members or creating their own short- cuts. Staff should be alert and aware at all times.

To reduce medicines errors in your care organisation, managers should work to strike a balance between creating an enjoyable working environment for staff with a supportive team structure, and ensuring staff take responsibility for their own actions.

ACTION POINTS:

Managers should encourage staff to:

1) **Always work as a team but not rely on others**
2) **Take responsibility for every part of their own role**
3) **Take pride in their role**
4) **Understand the importance and consequences of their role**

FACTOR 3: Inadequate Auditing of Errors and Incidents

What to Audit

A common shortcoming when attempting to audit errors and incidents in care organisations is failing to isolate exactly **what** should be audited.

The purpose of an audit is to provide meaningful information to the managers and staff so, before beginning an auditing process, the following questions should be asked:

- ✓ Will this audit provide meaningful outcomes?
- ✓ Does this audit provide any useful information or am I just form filling?

Approach to Auditing Errors

Having a "fair blame" culture is essential if you want to get to the bottom of how an error has occurred or what has contributed to it. Staff should feel able to discuss errors made by themselves or others with a view to preventing the error being made again.

Auditing errors, incidents and near misses provides an opportunity to look for trends. Do the errors occur at the same times of day? By the same people? With the same medicines?

Lessons Learnt Exercise

If you are experiencing too many errors, a "lessons learnt" exercise represents a method of gathering data and then evaluating it to determine which errors are the most important to address first.

The exercise is broken down into 3 stages:

1) Identification

Firstly, staff should take time to identify:

- the error made, including what the circumstances were and what each person involved experienced
- the impact and recurrence of the error
    - how critical it is to address the issue
    - how frequently it may recur
    - the impact the error had
    - the likelihood of the same situation occurring again

2) Analysis

Once the key elements of the error have been identified, these should be analysed by:

- ranking and prioritising the results from the identification process
- preparing a list of all lessons learnt from the errors

3) Action Planning

Finally, it is important to conclude what changes and actions should be put in place to avoid the error occurring again. Staff should:

- document the actions required to implement the lessons learnt including:
    - how the actions will be implemented
    - when
    - by whom

REMEMBER:

Opus are able to undertake this 'Lessons Learnt' exercise on behalf of your care organisation.

By following the above "Lessons Learnt" process, staff will have an in-depth and complete analysis of the error and the circumstances surrounding them. This information will provide helpful insight into the workings of your care organisation and furthermore can be used to inform and train other staff members of the risks identified to prevent similar errors taking place.

ACTION POINTS:

1) **Undertake an initial analysis before beginning any audit process to ensure it will provide you with outcomes and information that can be used going forward.**
2) **Adopt a 'fair blame' culture to encourage staff to come forward with any errors or concerns.**
3) **Use the "Lessons Learnt" approach to auditing to ensure repeat errors are properly analysed and reviewed to provide key learning points for staff and can inform any necessary procedural changes or reviews.**

"You're more likely to make mistakes if you're under pressure and in a rush, trying to do three things at once," Sandra Gidley MP, Chair of Royal Pharmaceutical Society English Pharmacy Board

FACTOR 4: Confusing Internal Medicines Handling Processes

One of the most important aspects of medicines handling is to make sure you have a clear medicines handling structure in place.

Without an up-to-date, easy-to-read policy and procedures, staff can't be expected to correctly follow the expected ways of working, making the appropriate checks and recording exactly what they have done.

COMMON ISSUES

- ✓ Staff are unaware of the correct procedure to follow.
- ✓ Staff are not sure where to find the information they need to determine what the correct procedure is.
- ✓ Procedures are difficult to understand and follow.
- ✓ When mistakes are made, often new processes and tasks are added to a procedure which makes the procedure even more complicated, time consuming and confusing.
- ✓ In attempts to avoid mistakes, additional paperwork is created for staff leading to duplication. In practice, this actually means staff have more to do so are more likely to make a further mistake.

SOLUTIONS

1) Clear Policy & Procedures

Staff need to be able to easily find the information they need in relation to the tasks they carry out. A medicines policy and associated procedures should be clear, concise and easily accessible for staff.

2) Staff Training

Without adequate training, staff cannot be expected to understand the nuances associated with medicines, their administration and the responsibility they have to the people they support and to your organisation.

Training is imperative to encourage confidence in staff and competence in medicines handling and administration. A trained workforce is a competent workforce.

3) Competency Assessment

Once training has been completed, it is vital that staff are competency assessed in the workplace. Without this taking place, you can't be assured that the training is being put into practice and the right procedures are being carried out day by day in the workplace.

4) Further Monitoring & External Audits

Once all of the structure is in place, you can add further levels of intervention such as:

- gap monitoring to reduce the gaps on the MAR charts;
- external audits to evidence compliance to the regulator; and
- regular update /briefing meetings for staff.

Additionally, having an external audit of your procedures will give an indication as to HOW clear the systems actually are for staff. This is a very helpful perspective that will allow you to amend and tweak your procedures, as appropriate.

ACTION POINTS:

1) **Ensure your organisation has clear procedures that are easy to follow and understand.**
2) **Create a training programme for your staff and ensure all staff are appropriately trained in medicines handling and in the organisation's procedures.**
3) **Competency assess staff following training to ensure learning is being put into practice.**
4) **Undertake additional monitoring and have an external audit to give an outside perspective of your procedures.**

Conclusions: What You Can Do To Avoid Medicines Errors

PREVENTION IS BETTER THAN CURE!

The key actions to avoid medicines errors in your organisation are as follows:

1) **Create a culture where high priority and focus is put on medicines. The Manager must take the lead. Lead by example!**
2) **Ensure staff aren't interrupted when they are administering medicines.**
3) **Avoid complacency.**
4) **Put a structure in place.**

5 Ways Opus Can Help!

Opus can provide you with:

1. A **policy with easy-to-follow visual flow-chart procedures** to ensure staff can effectively handle any situation
2. **Accredited training** to update staff on the do's and don'ts of medicines handling to ensure staff have the most up-to-date knowledge
3. A **competency assessment programme** to ensure staff continue to work within current good practice guidelines (using online tools or providing paper versions)
4. **Regular audits** to ensure compliance with CQC/Ofsted/CIW/Care Inspectorate Scotland
5. **Refresher training** to keep staff refreshed and feeling confident to take on medicines-related tasks

Download your FREE resources from our website www.opuspharmserve.com/downloads today

Free resources include: Competency assessment tool, audit tool, PRN protocol. We also have a range of other paperwork and forms in the 'download" area of our website.

References

CPPE Risk Management-A CPPE Guide February 2018