The Role of Managers & Senior Staff in Reducing Medicines Errors

OPUS
EXPERTS IN MEDICINES TRAINING

The role of Managers and Senior Staff is vital when working to reduce medicines errors within your organisation.

Managers not only have to identify or become aware of medicines errors, but then be confident in assessing them to determine why they happened, and then make a plan of action to not only resolve them, but to ensure they do not happen again.

By following the 3-point plan outlined below, Managers and Senior Staff can do their part to reduce medicines errors.

1. Awareness

Firstly, Managers and Senior staff need to ensure they are aware of existing or potential medicines errors within their organisation.

Senior staff must help to garner a culture of openness and transparency to encourage staff to report medicines errors, rather than feel embarrassed, ashamed or fearful.

Managers need to ensure they are engaged with their staff, and aware of any potential areas of risk or staff skill sets that might lead to medicines errors, to be able to keep a close eye.

2. Assessment

Secondly, it is vital that Managers and Senior Staff have a complete understanding of the 4 common risk factors identified in our previous emails, being:

1. Team
2. Procedures
3. Personal
4. Work Environment

and how they might be affecting staff and their ability to administer medicines safely in their own care setting or school.

When an error occurs, Managers and Senior Staff should review the 4 factors and identify which could be the cause of or a contributing factor towards the error.

It is important to recognise that more than one factor might be the cause of any given error.

3. Action

Once the attributing factors have been clearly identified, Managers must then take appropriate action to resolve the error, and prevent the same error occurring again- whether by the same member of staff, or any other.

The best way to manage the actions you've identified to help resolve your particular issues, is by creating an action plan.

We have put together a **case study which includes an action plan** to give you an example of what detail is required.

We are always happy to help our customers with any advice surrounding medicines errors and issues, including the creation of an action plan to ensure medicines are administered competently, and safely, in your care setting or school.

Contact us today to discuss any concerns you have with the administration of medicines where you work:

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CASE STUDY

Scenario

Care Worker A was a very experienced care worker. On a usual day, Care Worker A gave Person X their medicine at the care organisation.

Due to Covid-19, shift patterns had been altered, and staff were working different shifts to normal.

On the day in question, Care Worker B was tasked with administering Person X's medication.

Following all procedures correctly, Care Worker B administered Person X's medication, signed the MAR sheet, and continued with their other duties.

Care Worker A, as the usual carer who administered to Person X, later came by and administered Person X's medication. Care Worker A did not check the MAR sheet before doing so.

As a consequence, Person X received their medication twice.

Awareness:

Care Worker B when they later checked on Person X noticed that Person X was unusually drowsy and reported this to their Manager. It was then discovered that a double dose had been given.

Assessment:

By looking at the 4 factors, the following issues have been identified:

1. **TEAM:** There was a difference in the usual team structure which led to an error
2. **PROCEDURE:** Care Worker A did not follow the correct procedure and did not look at the MAR sheet before administering
3. **PERSONAL:** Covid-19 and the changes that come along with it may have caused confusion, anxiety or concern amongst the staff
4. **WORK ENVIRONMENT:** the variation of the usual rota had caused confusion and had not been well communicated to staff

In summary, Care Worker A was complacent in their role. They did not check the MAR sheet properly, or follow the correct procedure as they were used to administering medicine to Person X regularly. They also did not report the error to their Manager, instead it was discovered by another member of staff.

The Manager did not communicate effectively to the staff what potential impact the change in rota could have on staff, and the people they were to support that shift.

ACTION PLAN

In order to address the issues identified, and to reduce the chance of a similar mistake being made, the following actions should be taken by the Manager:

☐	1	Re-train staff to use correct procedures: Safe Handling of Medicines (Foundation) Course for Care Homes
☐	2	Competency assess staff the ensure training is being put into practice Care Homes Online Competency Assessment
☐	3	Sit down with Care Worker A to have a 1:1 coaching session to discuss the error and how it came about: • How did it occur? • Why did it occur? • What was difficult about what they were doing? • How could they do it differently next time? Assessors Workshop for Handling Medicines / Advanced Distance Learning Workbook
☐	4	Review the internal handover process: what information should be passed onto staff? How do we ensure everyone has understood the instructions when a variation of the normal process is implemented?
☐	5	Hold a team meeting to explain the error and highlight that it's happened. This error could easily happen to someone else.
☐	6	Assess the risk to Person X as an outcome of the medicines error. Consider the organisation's duty of candour to the person and any safeguarding issue.
☐	7	Work to promote a sense of openness and transparency within the organisation to encourage self-reporting and honesty from staff. • Open door policy? • More regular team meetings? • 1:1s with staff?