**Medication Incidents and Fair Blame**

**Outcome:** If a medication administration error occurs or the correct procedures are not followed which could result in an error occurring, it should be reported to the Senior Leadership team in the school and a medication administration incident form completed and acted upon to prevent the error recurring.

**Quality Standard:**

Those administering medication should expect:

* Not to be asked to administer medication until trained and deemed competent
* To receive training in accordance with the national standards as part of their induction.
* That their manager identifies, through achievement and development process, if refresher or update medication training is required.
* Parents and pharmacists comply with the medication policy by presenting medication in suitably labelled and packaged containers.
* To be supported by colleagues, pupils and managers when they are administering medication by creating an environment which enables employees:
  + to undertake this task free of any expectation that they will undertake any other duties,
  + be free of interruptions.

**General Principles:**

* A fair and consistent working environment that does not seek to apportion blame.
* Colleagues are encouraged to report any situation where things have or could have gone wrong.
* The full facts must be reported within 24 hours of the error occurring or being discovered and the root cause of the medicine related incident must be determined.

**Procedures:**

Employees will ensure:

* That medication is presented in clearly labelled appropriate container with a pharmacist’s label.
* That a medication administration record (MAR) sheet is completed.
* That the MAR sheet is completed accurately.
* That any incidents of non-compliance are recorded on the MAR sheet. Where this becomes habitual this should be reported to a manager.
* That they concentrate on the important task of administering medication to the exclusion of all other duties and distractions.
* That they report any instance of a medication error immediately to their manager and if required, seek medical advice, initially be the community pharmacist who has supplied the medication.
* That they assist the manager with the completion of a medication incident report form. A copy will then need to be sent to the Corporate Health and Safety Team by emailing: [employee.healthandsafety@derby.gov.uk](mailto:employee.healthandsafety@derby.gov.uk)
* That they discuss annually in an achievement and development session their medication training needs, such as if they require updating or refreshing.

School Leaders / Managers will ensure:

* That employees receive appropriate medication training and /or refresher training as identified.
* That employees feel confident about their role and responsibilities and feel that their line managers will reinforce the importance of this task.
* That medication policies, procedures and forms are monitored and checked for implementation and are audited. Reviewed at least annually or at the point where there is a change in medication.
* Schools maintain an awareness of the quantities of medication in stock and ensure that excess is not kept.
* That procedures, policies and training in a supportive workplace environment are intended to reduce the risk of medication error and the associated risks to pupils and employees.
* That errors must be reported (see appendix for Medication Incident Report Form). Failure to do so could result in serious consequences for the pupil and the individual employee.
* That employees who report errors immediately will be supported.
* That all colleagues have an important role to play in risk identification, assessment, and management. To support colleagues in this, the department tries to provide a fair and consistent working environment and does not seek to apportion blame. We hope that this will encourage a culture of openness and willingness to admit mistakes. Colleagues are therefore actively encouraged to report any situation where things have or could have gone wrong.
* When errors are reported or identified, the appropriate manager will undertake a fact-finding audit with the intention of ensuring remedial action.
* If it is found from the investigation that employees have not followed guidelines and safe practice or have acted illegally, maliciously, negligently or recklessly in line with their duty of care, an investigatory interview may be undertaken in line with the school or Derby City Council’s disciplinary procedures.
* Medicines-related incidents should be reported to the local safeguarding board as per the threshold guidance.
* Ofsted and other relevant persons may need to be notified in line with current regulations.
* The school should have a clear process for reporting medicines-related safeguarding incidents under local guidance and safeguarding processes.
* Reviewers of the medication incident will use the Derby City Council tool to identify the level of consequence and severity of the incident and subsequent actions that are required to be taken by the manager or provider.

**How to use the Consequence/Severity Tool**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | **Likelihood** | | | | |
|  | | **1** | **2** | **3** | **4** | **5** |
| **Actual Harm to Child/ young person** | | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost certain** |
| **Impact** | | This will probably never happen/recur | Do not expect it to happen/recur but it is possible it may do so unless practice is altered | Might happen or recur occasionally unless practice is altered | Will probably happen/recur OR History of incidents/repeated incorrect doses | Will undoubtedly happen/recur, possibly frequently AND History of repeated incidents/ systems not followed |
| **1** | **Negligible (No harm)** Near miss or harm prevented | **Example 1**  1 x 1 = 1 |  |  |  | **Example 2**  1 x 5 = 5 |
| **2** | **Minor (minimal harm)** Pupil required extra observation or minor treatment |  |  |  |  |  |
| **3** | **Moderate (short-term harm)** Pupil required further treatment or procedure |  |  | **Example 3**  3 x 3 = 9 |  |  |
| **4** | **Major (permanent or long-term harm)** Pupil required permanent or long-term treatment |  |  |  |  |  |
| **5** | **Catastrophic:** Pupil died as a direct consequence of the error/ incident |  |  | **Example 4**  5 x 3 = 15 |  |  |

MULTIPLY THE TWO NUMBERS TOGETHER TO GET A FINAL SCORE WHICH WILL INDICATE GUIDANCE ON ACTION TO BE TAKEN

**Risk Scoring / Outcome**

**1-3: Low risk:** Discussion one to one with line manager

**4-6: Moderate risk:** Observed medicine administration during supervision

Documented discussion one to one with line manager

Consider need for attendance on medication training course

Consider safeguarding referral

**8-12: High risk:** Observed medicine administration during supervision

Documented discussion one to one with line manager

Consider need for attendance on medication training course

Systems review by manager

Consider safeguarding referral

Managing Individual Capability

Consider immediate suspension from administration of medicines until competency restored.

**15-25: Extreme risk:** Observed medicine supervision during supervision

Documented discussion one to one with line manager

Attendance on medication training course

Systems review by manager

Managing Individual Capability

Consider immediate suspension from administration of medicines until competency restored.

Report to Ofsted and consider referral to safeguarding