AJ AND FRIENDS C.I.C.
AJ and Friends 6 Carlton Lane Centenary Building Hoylake Wirral Merseyside CH47 3DB

Review Sheet

Last Reviewed 29 Apr 2025 | Last Amended 29 Apr 2025 | This policy will be reviewed as needs require or at the following interval: Annual

Business Impact:	LOW — Minimal action required. Circulate information amongst relevant parties.
Reason for this Review:	Scheduled review
Changes Made:	Yes
Summary:	This policy details how medication errors will be managed within the service. It has been reviewed with some minor word changes. References and further reading links have been checked and updated to ensure they remain current.
Relevant Legislation:	• The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • Medical Act 1983 • Medicines Act 1968 • The Human Medicines Regulations 2012 • Misuse of Drugs Act 1971 (Amendment Order 2024) • The Misuse of Drugs (Safe Custody) Regulations 1973
Underpinning Knowledge:	• Author: Royal Pharmaceutical Society of Great Britain, (2024), Professional guidance on the safe and secure handling of medicines [Online] Available from: https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines/professional-guidance-on-the-safe-and-secure-handling-of-medicines [Accessed: 29/04/2025] • Author: Care Quality Commission, (2022), Reporting medicine related incidents [Online] Available from: https://www.cqc.org.uk/guidance-providers/adult-social-care/reporting-medicine-related-incidents [Accessed: 29/04/2025] • Author: NHS, (2020), Improving medication error incident reporting and learning [Online] Available from: https://www.england.nhs.uk/2014/03/improving-medication-error-incident-reporting-and-learning/ [Accessed: 29/04/2025] • Author: Care Quality Commission, (2023), Medicines: information for adult social care services [Online] Available from: https://www.cqc.org.uk/guidance-providers/adult-social-care/medicines-information-adult-social-care-services [Accessed: 29/04/2025] • Author: National Institute for Health and Care Excellence, (2017), Managing medicines for adults receiving social care in the

AJ AND FRIENDS C.I.C.
AJ and Friends 6 Carlton Lane Centenary Building Hoylake Wirral Merseyside CH47 3DB

	community - NICE Guideline [NG67] [Online] Available from: https://www.nice.org.uk/guidance/ng67 [Accessed: 29/04/2025] • Author: Care Quality Commission, (2022), Medicines in health and adult social care: Learning from risks and sharing good practice for better outcomes [Online] Available from: https://www.cqc.org.uk/news/stories/medicines-health-adult-social-care-learning-risks-sharing-good-practice-better-outcomes [Accessed: 29/04/2025]
Suggested Action:	• Encourage sharing the policy through the use of the QCS App • Ensure relevant staff are aware of the content of the whole policy • Ensure the policy is discussed in planned supervision sessions with relevant staff
Equality Impact Assessment:	QCS have undertaken an equality analysis during the review of this policy. This statement is a written record that demonstrates that we have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

AJ AND FRIENDS C.I.C.
AJ and Friends 6 Carlton Lane Centenary Building Hoylake Wirral Merseyside CH47 3DB

1. Purpose

1.1 To define medication errors and detail the action required following the discovery of a medication error to ensure V.I.P safety whilst supporting staff.

1.2 This policy should be read with the Overarching Medicines Management Policy and Procedure at AJ AND FRIENDS C.I.C. and any other local contractual policies that may supersede this policy.

1.3

Key Question	Quality Statements
SAFE	QSS8: Medicines optimisation
WELL-LED	QSW5: Governance, management and sustainability
WELL-LED	QSW7: Learning, improvement and innovation

1.4 Relevant Legislation

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Medical Act 1983
- Medicines Act 1968
- The Human Medicines Regulations 2012
- Misuse of Drugs Act 1971 (Amendment Order 2024)
- The Misuse of Drugs (Safe Custody) Regulations 1973

2. Scope

2.1 Roles Affected:

- Registered Manager
- Other management
- Care staff

2.2 People Affected:

- V.I.Ps

2.3 Stakeholders Affected:

- Commissioners
- External health professionals
- Local Authority
- NHS

3. Objectives

3.1 To ensure that there is an open, transparent, just and fair learning culture within AJ AND FRIENDS C.I.C.. This enables staff to report and record errors, omissions and near misses in a timely manner and for investigations and identification of the root cause of issues to take place.

3.2 All staff responsible for any aspect of medication management recognise their role in safeguarding the wellbeing of V.I.Ps at all times.

4. Policy

4.1 Medication Errors

These are incidents where an error in the medication process has occurred. This is regardless of whether any harm to the V.I.P has occurred. They could be:

- Prescribing errors
- Dispensing errors
- Medicines administration errors
- Monitoring errors

Providing incorrect advice on medicines administration errors by staff can include:

- Medication given to the wrong V.I.P
- Incorrect medication given to the V.I.P, (the administration of medication which has not been prescribed)
- Incorrect dose given, too much or too little medication given
- Medication given via the wrong route
- Medication not given
- Medication given more than once
- Medication given at the wrong time
- Medication not documented
- Medication given after being discontinued
- Wrong dose interval
- Not following 'warning' advice when administering, e.g. take with or after food
- Giving a drug to which the V.I.P has a known allergy
- Giving a drug past its expiry date or which has been stored incorrectly

Medication errors are not the same as adverse drug reactions.

4.2 Near Miss

A near miss is an event that has the potential to injure the V.I.P but does not.

Near misses are important, as many incidents share common root causes. Looking into near misses can help prevent more serious incidents. Therefore, it is important to formally investigate and report them.

4.3 AJ AND FRIENDS C.I.C. promotes a culture where staff feel able to raise any concerns with the Registered Manager in order to provide an effective and safe service.

4.4 The priority of the Registered Manager is to ensure the safety and wellbeing of V.I.Ps, and in the event of a medication error or incident, staff will seek immediate advice from the

relevant and most appropriate health professionals according to the severity of the incident.

4.5 Beverley Williams will record accurate details of all medication errors and near misses, including medicines-related safeguarding incidents.

These will be recorded as soon as possible after the incident.

Records will be availble for any investigation and reporting.

4.6 AJ AND FRIENDS C.I.C. actively encourages a sensitive response to medication errors through investigation, taking full account of how the incident occured and the circumstances surrounding the incident.

4.7 Where applicable, incidents are reported to Wirral Council and the Care Quality Commission in a timely manner and AJ AND FRIENDS C.I.C. gives due consideration to, and is compliant with, the duty of candour.

4.8 AJ AND FRIENDS C.I.C. uses root cause analysis to ensure that lessons are learned and applied to reducing the risk of reoccurrence. Staff are fully involved in this process and the outcomes are shared with relevant staff at AJ AND FRIENDS C.I.C..

4.9 AJ AND FRIENDS C.I.C. will ensure that near miss events involving medication are also investigated to evidence lessons learned and give the opportunity for discussion in meetings and staff supervisions.

5. Procedure

5.1 Reporting

Reporting errors is only the first step in the process of reducing errors and ensuring quality improvement at AJ AND FRIENDS C.I.C..

The Registered Manager will encourage staff to report all medication errors, incidents or near misses as soon as possible. This should be in the context of a no blame culture as often a range of circumstances has occurred in the lead up to the incident, and blaming an individual will not address the underlying risk factors or system flaws.

5.2 Reducing the Risk of Medication Errors, Near Misses and Discrepancies

A proactive approach must be taken when identifying where the risks are in relation to medication management. To achieve this, the following principles apply:

- Any member of staff that is responsible for medication is competent, trained and accountable for their actions as per their code of professional conduct
- Staff feel supported and able to raise concerns directly and in a timely manner. Refer to the Raising Concerns, Freedom to Speak Up and Whistleblowing Policy and Procedure at AJ AND FRIENDS C.I.C.
- Systems and processes for all aspects of medication management are followed as per the suite of medication policies and procedures at AJ AND FRIENDS C.I.C. including:
    - Reducing distractions and interruptions of staff undertaking the administration of medication
    - Ensuring that MARs are accurately maintained to reflect changes to V.I.Ps' medicine

- Environmental factors, such as poor lighting, temperature, cluttered workspace and noise are reduced

- Issues arising from partnership working are managed in a proactive and timely manner
- Staff are aware of, and adhere to, notifications from national safety alerts and notices (refer to the Distribution of Safety Alert Broadcasts, Rapid Response Reporting and Safety Notices Policy and Procedure at AJ AND FRIENDS C.I.C.)
- Best practice is followed at all times and staff maintain their knowledge and keep updated with changes (this list is not exhaustive)

5.3 Action to be Taken by a Member of Staff Involved in a Medication Error or Near Miss

The following actions should be taken:

- As soon as the error or near miss is identified, assess the V.I.P's condition to establish if the V.I.P has suffered any harm
- If harm has occurred and the V.I.P is unwell, call 999
- If the V.I.P does not appear immediately unwell, report the incident to the doctor responsible for the V.I.P's care. During out of hours contact 111. Advice should be clearly documented in the V.I.P's records
- Discuss and agree who will inform the V.I.P that a medication error has occurred
- Document the nature of the incident in the V.I.P's records
- Report the incident immediately to AJ AND FRIENDS C.I.C. and record it
- If the incident involves a dispensing error, inform the relevant pharmacy immediately

5.4 Action to be Taken by the Senior Member of Staff/Registered Manager

The following actions should be taken:

- Check the medical status of the V.I.P if relevant, and check if any harm has occurred
- Ensure that all appropriate support has been offered to the member of staff involved in the incident
- Confirm that the V.I.P's GP has been informed and that the incident has been reported
- Ensure that the incident is recorded on the V.I.P's notes and an incident log made. A Medication Incident Report Form can be found in the Forms section of this policy

Once the V.I.P is stable, the person in charge/senior manager/Registered Manager must:

- Ensure that a CQC notification is made if there was harm to the V.I.P
- Ensure that Wirral Council is informed in line with local safeguarding procedures and in line with any contractual requirements (staff must refer to the Safeguarding Adults Policy and Procedure at AJ AND FRIENDS C.I.C. and Wirral Council safeguarding policies and procedures)
- Consider if duty of candour applies and refer to the Duty of Candour Policy and Procedure at AJ AND FRIENDS C.I.C. to determine this
- An investigation must be carried out using a Root Cause Analysis (RCA) to review what caused the incident
- At the appropriate time, allow the member(s) of staff involved in the incident to reflect on the circumstances and identify their own learning
- Identify if there are any training or performance issues with the member(s) of staff, and depending on the level of risk, take any necessary actions which may involve

immediately suspending a member of staff from prescribing, dispensing, preparing or administering medication

- Reflect on ensuring that there remains an open, honest and transparent culture to raising concerns, and consider reinforcing key supportive policies to staff such as the Raising Concerns, Freedom to Speak Up and Whistleblowing Policy and Procedure at AJ AND FRIENDS C.I.C.
- Ensure a medication competency assessment is carried out on the staff member involved in the incident to identify if there are any gaps in practice. Dependent on the severity of the medication error, a number of competencies may have to be completed and the Registered Manager should also consider whether additional training is required. These should both be supportive measures for staff and are in no way a 'blame' mechanism

5.5 Safeguarding V.I.P**s**

A safeguarding issue in relation to managing medicines could include the deliberate withholding of a medicine(s) without a valid reason, the incorrect use of a medicine(s) for reasons other than the benefit of a V.I.P, deliberate attempt to harm through the use of a medicine(s), or accidental harm caused by incorrect administration or a medication error. (NICE 2014)

Different areas may have different locally agreed criteria for reporting medication errors or near misses. The Registered Manager should make themselves aware of what their local criteria and process for reporting medicines-related safeguarding incidents are.

The Registered Manager should have a clear process for reporting medicines-related safeguarding incidents, including which medicine incidents will be reported, and ensure that accurate details of any medicine-related safeguarding incidents are recorded as soon as possible so that information is available for any investigation and reporting.

Local safeguarding processes should include the investigation of each report of a medicines-related safeguarding incident and should monitor reports for trends.

There is no requirement to notify the Care Quality Commission about medicines errors, but the Care Quality Commission must be informed if a medicines error has caused:

- A death
- An injury
- Abuse, or an allegation of abuse
- An incident reported to, or investigated by, the police

Where relevant, you should make it clear that a medicine error was a known or possible cause or effect of these incidents or events being notified. (CQC 2022)

5.6 Action After the Incident has Occurred - Staff

After a medication error or near miss has occurred and all of the necessary immediate actions have been taken, it is important that there will be an opportunity for the staff to discuss the incident with Beverley Williams as soon as possible after the incident. The purpose of the discussion is to:

- Enable the member of staff to reflect on the circumstances
- Allow the member of staff to discuss how they feel, and discuss any concerns that they may have
- Identify if there are any training or performance issues with the member of staff
- Determine if the medication incident is a repeat incident (check if the member of staff has made a similar medication error previously and in what timeframe)

- Dependent on the severity of the error/near miss, ensure that all appropriate support has been offered to the member of staff

To promote a fair and open culture and encourage the reporting of incidents, the Discipline Policy and Procedure will not be used for the investigation of adverse incidents unless there is clear evidence of wrongdoing, a complete disregard for the safety of others, intent to harm, repeated events, theft or fraud. This may include:

- Gross professional or gross personal misconduct
- Repeated breaches of acceptable behaviour or protocol
- An incident that results in a police investigation

5.7 Being Open with the V.I.P Following a Medication Incident

It is important to be open and honest when things go wrong. Therefore, it is of great importance that the V.I.P is informed if a medication error has occurred.

- The V.I.P must be informed at an appropriate time and an apology offered
- If the error is of a serious nature, following the formal investigation and at the appropriate time, the V.I.P must be offered an opportunity to discuss the outcome of the investigation and to discuss its findings. This provides an opportunity to reassure the V.I.P that AJ AND FRIENDS C.I.C. is keen to always learn any lessons from medication errors and to prevent similar occurrences in the future
- Consent will be obtained from the V.I.P before discussing any medication errors with their family. If the V.I.P is unable to consent due to the lack of mental capacity, the person responsible for their best interests will be informed
- Care will be taken not to cause unnecessary alarm and information will be provided in a way that is easy to understand and enables the V.I.P to ask questions
- If at any time the V.I.P or their representative is unsatisfied with the management of the medication incident, staff must signpost them to the complaints process as detailed within the Complaints, Suggestions and Compliments Policy and Procedure at AJ AND FRIENDS C.I.C.

5.8 Root Cause Analysis (RCA)

Incidents will be investigated for the purposes of learning and change. Staff remain accountable to V.I.Ps, AJ AND FRIENDS C.I.C. and their professional bodies (where relevant) for their actions and a staff member who makes repeated medication errors would ordinarily be given the opportunity to undertake further training and be assessed for competence for whichever part of the medicines pathway they are involved in. The Registered Manager is responsible for ensuring that an RCA is carried out for all medication errors and near miss events:

- The RCA process starts by holding a meeting and stating the problem. The staff (it can be one person but they must have the skills, knowledge to challenge, and seniority to question individuals) nominated to investigate the incident will gather documentation MARs, Care Plans, V.I.P notes, incident reports, etc.) and interview staff involved in the error to find out the sequence of events. This is called the 'Fact Find Investigation' and will result in a timeline of events
- The RCA team will review the documentation and sequence of events and continue asking themselves “why did this happen?” until they arrive at each root cause
- The team must assume that any problem is preventable and caused by a weak or vulnerable process rather than individual incompetence. Even in the case of a person making a mistake, the team must ask “why do our systems allow these types of mistakes to happen so easily?” or “what factors set this person up to make this error?”

- Try to focus on the process rather than on an individual to encourage an open culture where staff are willing to report errors

The investigation should ask and get answers to the following questions:

- What happened?
- What normally happens?
- What do policies/procedures say about how it should be done?
- Why did it happen?
- How was AJ AND FRIENDS C.I.C. managing the risk before the event?

A Medication Error Root Cause Analysis Form can be found in the Forms section of this policy.

5.9 Actions from Root Cause Analysis

When the investigation has finished, the investigators will review the following to understand what went wrong and how to prevent the error occurring again. These 'lessons learnt' will be used as evidence of providing a safe service:

- How can we decrease the chance of the event occurring again?
- How can we decrease the degree of harm if the event were to occur again?
- What is best practice (when considering changing local procedures or rules)?
- How can devices, software, work processes or workspace be redesigned?
- How can we reduce reliance on memory and vigilance by improving processes in the workplace?
- Is the proposed action achievable within the limitations of the resources at AJ AND FRIENDS C.I.C.?
    - For example, if the error occurred because of something out of the control of AJ AND FRIENDS C.I.C., concentrate on the factors that are in the control of AJ AND FRIENDS C.I.C.

Once this has been conducted, the information will be shared in a way that maintains confidentiality but ensures that staff understand why an error occurred and how to prevent it arising again. The Registered Manager should ensure that learnings from medication incidents are shared through a variety of forums including staff meetings, group and individual supervisions.

5.10 Training and Competency

AJ AND FRIENDS C.I.C. will ensure that all staff who administer medicines complete relevant training and will only administer medication when they are competent.

Where staff make a medication error, staff competencies will be re-assessed. AJ AND FRIENDS C.I.C. will also review the training needs of any staff who make repeated medication errors.

6. Definitions

6.1 Root Cause Analysis (RCA)

- A process (sometimes described as a tool) to help identify what, how, and why an event occurred so that steps can be taken to prevent future occurrences

6.2 Timeline

- A useful tool when undertaking an investigation as it gives the time and date order of when things happened
- When the fact find is conducted it is important to ask staff for details of dates and times to collate a timeline of events

6.3 Adverse Drug Reactions

- An unwanted or harmful reaction that occurs after administration of a drug or drugs
- Must be reported through the Yellow Card Scheme

7. Key Facts - Professionals

Professionals providing this service should be aware of the following:

- AJ AND FRIENDS C.I.C. will notify the CQC of medication incidents where harm has been caused and follow local safeguarding procedures for reporting medication incidents. These records will be retained and be accessible
- A medication competency assessment should be carried out on any staff involved in an error and the Registered Manager should also consider additional training
- It is the responsibility of AJ AND FRIENDS C.I.C. to ensure that adequate systems for managing, administering and monitoring medication are in place and a review of medication systems by an outside professional, for example a pharmacist, may help to identify any deficiencies
- Each incident will be reviewed to understand what went wrong and to ensure that it does not happen again
- All staff involved in the administration of medication have a responsibility to report errors, omissions, and near misses

8. Key Facts - People Affected by The Service

People affected by this service should be aware of the following:

- You will be made aware of how to raise a complaint, and if you need support to make a complaint, this will be arranged
- You will be informed if there is a medication error that affects you

Further Reading

NHS - Training for Non-registered Medicines Workforce:

https://www.hee.nhs.uk/our-work/medicines-optimisation/training-non-registered-medicines-workforce

AJ AND FRIENDS C.I.C.
AJ and Friends 6 Carlton Lane Centenary Building Hoylake Wirral Merseyside CH47 3DB

Outstanding Practice

To be "outstanding" in this policy area you could provide evidence that:

- There is evidence that competencies and training are re-assessed after medication incidents
- The wide understanding of the policy is enabled by proactive use of the QCS App
- All errors and near misses are discussed at team meetings and followed up with robust written action plans to prevent a further recurrence. The learning is shared with staff responsible for medication errors
- There is a record of each error and the action taken
- There is a process in place for receiving and acting upon medication and safety alerts
- All errors and near misses with respect to medication are recorded and reported in a timely manner and according to legislation

Forms

The following forms are included as part of this policy:

Title of form	When would the form be used?	Created by
Medication Incident Report Form - CM38	To report medication incidents.	QCS
Examples of Medication Errors - CM38	A reference tool if an error occurs.	QCS
Medication Error Levels of Harm - CM38	When a near miss or incident occurs.	QCS
Medication Error Route Cause Analysis (RCA) - CM38	To undertake a medication Route Cause Analysis (RCA).	QCS

AJ AND FRIENDS C.I.C.
AJ and Friends 6 Carlton Lane Centenary Building Hoylake Wirral Merseyside CH47 3DB

Medication Incident Report Form - CM38

Details of V.I.P Affected by the Medication Incident	
Name of V.I.P:	
Address of V.I.P:	
Date of Birth:	

Details of Medication Incident	
Date of Incident:	**Time of Incident:**
Names of Staff Involved:	
Name of Person Completing Report:	
Describe the incident	
Why do you think it happened?	
Did it involve a GP, district nurse or pharmacist? If so, how?	
What actions (if any) were taken to minimise the impact on the V.I.P?	
If harm occurred, describe any injuries:	
What actions have you taken to prevent the incident arising again?	
What do you think caused the incident, that if corrected, would stop the incident arising again?	
Date GP/Pharmacist/111 Informed?	
What was the Advice from GP/Pharmacist/111?	

What Medication was Involved in the Incident?		
	What was Correct?	**What was Incorrect?**
Name of Medication:		
Dose:		
Route:		
Type of Medication (e.g. Tablet, Liquid, etc.):		
Name of Person Completing the Form:		
Date of Form Completion:		

CQC Notified?	**Yes**	**No**	**Not Applicable**

AJ AND FRIENDS C.I.C.
AJ and Friends 6 Carlton Lane Centenary Building Hoylake Wirral Merseyside CH47 3DB

NMC Notified? **(use only for Registered Nurses)**	**Yes**	**No**	**Not Applicable**
Date of CQC Notification:			
Date of NMC Notification:			
Safeguarding Referral Required:	**Yes**	**No**	**Not Applicable**

AJ AND FRIENDS C.I.C.
AJ and Friends 6 Carlton Lane Centenary Building Hoylake Wirral Merseyside CH47 3DB

Examples of Medication Errors - CM38

Prescribing

- Duplicate medicine
- A drug prescribed by both the brand and generic names, e.g. Losec and Omeprazole
- Two medicines that have the same action, e.g. Omeprazole and Lansoprazole
- Wrong dosage, strength or formulation
- Issuing of a discontinued medicine
- Medication requested from a surgery, but no prescription supplied without reason
- A V.I.P is prescribed a medicine that they are allergic to
- A V.I.P is prescribed a medicine that is contraindicated
- A V.I.P is prescribed a medicine that is unnecessary for them
- A V.I.P is prescribed a medicine that has an unwanted interaction with another medication that they are taking

Monitoring

- Monitoring not requested/requested but not done/results not available
- Results not acted upon
- Examples of drugs requiring monitoring include:
    - Warfarin, Digoxin, Diuretics, Amiodarone, Thyroxine, Lithium, Insulin, Clozapine and some anti-rheumatic drugs

Dispensing

- Supply of duplicate medication
- Dose/strength/formulation error
- Wrong drug, no supply, deteriorated drug
- Labelling error

Administration

- Omission for any reason, including no stock
- The error involved someone being given another person’s medication which is not prescribed for them
- Extra doses, wrong doses, allergy
- Wrong medicine, formulation error, deteriorated drug, timing error, wrong route

Ordering and Record Keeping

- Prescriptions not ordered on time despite it being part of the Care Plan
- Medication Administration Record (MAR) not signed
- MAR signed inappropriately, e.g. signed by another care worker

AJ AND FRIENDS C.I.C.
AJ and Friends 6 Carlton Lane Centenary Building Hoylake Wirral Merseyside CH47 3DB

Medication Error Levels of Harm - CM38

Level of Harm	Definition	Example
No Harm	Any medication incident that did not result in harm, or injury or that had the potential to cause harm but was prevented resulting in no harm (near miss).	Penicillin was prescribed for a V.I.P with a Penicillin allergy. This was noticed by the Care Worker when he/she was checking the MAR.
Low Harm	Any medication incident that required extra observation or minor treatment.	TheV.I.P was given a water tablet at the wrong time that resulted in passing urine frequently late at night.
Moderate Harm	Moderate harm incidents are any medication incidents that resulted in a moderate increase in treatment and which caused significant but not permanent harm.	The V.I.P is given an extra sleeping tablet by mistake, they suffer drowsiness and their respiratory rate needs monitoring.
Severe Harm	Severe harm incidents are any incidents that appear to have resulted in permanent harm including, but not limited to, death.	The V.I.P is given too much liquid morphine by mistake, they have a respiratory arrest and suffer brain damage because of receiving the medication.
Death	Any unexpected or unintended event that caused the death of one or more persons.	The V.I.P is given too much liquid morphine by mistake, they have a respiratory arrest followed by a cardiac arrest and die because of receiving the medication.

AJ AND FRIENDS C.I.C.
AJ and Friends 6 Carlton Lane Centenary Building Hoylake Wirral Merseyside CH47 3DB

Medication Error Route Cause Analysis (RCA) - CM38

Medication Error Route Cause Analysis (RCA)				
What happened?				
Date error reported:		Date error occurred:		
Reported by: (Name/Position/Title)				
Confirm accident form completed: By whom/date and time				
Investigation - summary of findings • Review MARs and take copies • Check booking in process • Check stock count • Interview staff • Check staff training • Check staff competency assessment • Check staff record for any previous errors • Check MARs in good order				
Outcome (Detail any harm experienced by the V.I.P)				
Name of person (s) who appear to have made the error				
Immediate actions taken (Consider suspension from medication administration pending investigation/further action)				
Duty of Candour				
Name of **V.I.P:**			D.O.B:	
Has the **V.I.P** been informed?	Yes / No	Date informed:		
	Details of interaction **or** reasons for not contacting the **V.I.P:**			
Confirm GP/other healthcare practitioner notified	Yes / No	Date informed:		
	Name:			
	Details of advice given:			

AJ AND FRIENDS C.I.C.
AJ and Friends 6 Carlton Lane Centenary Building Hoylake Wirral Merseyside CH47 3DB

Next of kin informed (Mandatory if the V.I.P does not have the mental capacity to understand that an error has occurred)	Yes / No	Date informed:
	Details of interaction:	
Safeguarding informed (Mandatory for all medication errors)	Yes / No	Date informed:
CQC notification completed (Mandatory IF Section 42 safeguarding enquiry opened)	Yes / No	Date informed:
Why did it happen?		
What has been learnt?		
What action has been taken to reduce the risk of the error happening again?		
Action		Confirm completed (date and sign)
Date report completed:	Signature:	
Name:	Position:	