**M4 Medication Error Report**

**Appendix 6**

**PART A – Error report checklist**

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| **Date of Error:** |  |
| **Personal ID number or IAS number of Service User:** |  |
| Service / Establishment:R |  |
| **Medication details:**  (Name of Medication / cream, quantity, administration time, route).  **What is the medication/**cream/gel **for?**  (e.g. Pain, Eczema, Moisturiser, Broken skin. Psoriasis |  |
| **Person making this report & position:** |  |
| **Person responsible for the error & position:** |  |
| **Date person responsible for error was trained:**    **When were they last observed as competent?** | Date:      Date: |
| **Person responsible is this the first error:**  (Where a 3rd error has occurred part b must be completed and forwarded to the service manager) | Yes / No      (Please tick appropriate box)  1st 2nd 3rd |
| Has supervision been arranged or taken place: | Yes / No / N/A    Date: |
| **Nature of error:**  (please tick appropriate boxes and provide further information)    Missed Dose  Wrong Dose  Given at wrong time  Given to wrong person  Missed Signature (Go straight to page 3)  Stock Discrepancy  Other (please provide more details) |  |
| **Has it been reported to the GP / CHOC?**  **Reported to GP / CHOC** (Name of GP, who reported it to the GP, time, and date). | Yes / No / N/A (Delete as applicable) |
| **Action / Advice recommended by GP /**  **CHOC –** give details: |  |
| **Outcome for Service User** (e.g. any  observable side effects or distress?) |  |
| **Registered Services only –** For registered services, if the error has resulted in the need for medical intervention, inform the Care Quality Commission (CQC) by completing a notification form. Report to the Service Manager and others as appropriate. | Record the date the notification was sent below and attach a copy to this report. |
| **Has the threshold tool been considered?**    **Is this notifiable to Safeguarding?**    **Has the alert been made?** | Yes / No / N/A      Yes / No / N/A    Yes / No / N/A Date: |
| **(b) Date and time of Manager was informed (within working hours):** |  |
| **Date, time “on call number / email “ was informed (Out of hours if serious):**    (N.B. it should be reported to the Service Manager within 7 days of the error) |  |
| **Date, time, and names of SU / Carer / NOK / parent informed:** (If appropriate) |  |
| **Medication Error Report Checklist and Action Plan forwarded to the Service Manager**  (Must be within 7 days of date of error) | Yes / N/A      By whom: Date: |

**PART B – Incident Report and Action Plan**

**Medication Error Date:**

Establishment:

Person responsible for the error:

1. **What happened to cause this breach / medication error?**

1. **Has this person been involved in any medication errors / breaches of medication policy within the past 12 months: Yes / No**

(If yes, please indicate what actions were taken):

1. **Any Lessons Learned and recommendation / action plan / as a result of this error, with associated timescales and any review dates:**

(Detail what you have / will put in place e.g. prompt sheet training, 1:1 coaching on policy and procedure, what are the effects of the error, supervision etc).

**A.**

**B.**

**C.**

**Signed:**  **Date:**

**Print Name:**

# A COPY OF PART A IS TO BE PLACED ON THE SERVICE USER FILE

# A COPY OF PARTS A & B ARE TO BE PLACED ON THE EMPLOYEE FILE