|  |  |
| --- | --- |
| **Date of Error :** |  |
| Personal ID number or IAS number of Service User:  |  |
| Service / Establishment: |  |
| **Medication details:**(Name of drug, quantity, administration time, route).**What is the drug for?** (e.g. water tablet, antibiotics for infection |  |
| **P****erson making this report & position:** |  |
| **Person responsible for the error & position:** |  |
| **Date person responsible for error was trained:****When were they last observed as competent?** |  |
| **Name of witness & name of second checker at time of error (only with controlled drugs):** |  |
| **Nature of error:**(please tick appropriate boxes and provide further information)Controlled drugs [ ] Missed Dose [ ] Wrong Dose [ ] Given at wrong time [ ] Given to wrong person [ ] Meds signed for but not given [ ] Missed Signature [ ] 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 (Delete as applicable) |
| **Police**  |  |
| **Action / Advice recommended by GP / CHOC –** give details: |  |
| **Outcome for Service User** (e.g. any observable side effects or distress?) |  |
| Medical intervention required / Controlled drug?(E.g. attend hospital, see GP etc). | **Delete as necessary by drawing a line through** Yes – go to (a) below**No – go to (b) below** |
| **Registered Services only –** For registered services, if the error has resulted in the need for medical intervention or an incident involving the police, 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?**  |  |
| **(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) |  |
| **Date, time and name of Single Point of Access (SPA) informed:** (If appropriate) |  |
| **Date and time Service User****informed:**(If appropriate) |  |
| **Medication Error Report Checklist and Action Plan forwarded to the Service Manager**(Must be within 7 days of date of error) | By whom: Date:  |

**Medication Error Date:**

Establishment:

Person responsible for the error:

1. **What happened to cause this breach / medication error?**
2. **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