Report to Governance and Quality Committee

Title of Report	**Medication Safety Report**
Action required	
Report presented by:	**Julie Sprack**

Decisions Required: **G&QC is asked to (approve, agree or note)** To note the potential of the report, and endorse recommendations to minimise the risk of patient harm through medication safety errors.
Timetable for decision: At committee
Links to other key reports/decisions: Risk Management Strategy National Reporting and Learning System
Links to other relevant frameworks: NPSA Standards for Better Health NHS Litigation Authority
Implications for service delivery, financial impact, governance and quality: Improvement in patient safety regarding medication Financial implication of drug errors, particularly omissions
Consideration of legal issues (including Equality Impact Assessment): Potential litigation from medication errors Legal requirements as per medication legislation

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G&QC Date	

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Report on Medication Safety Errors September 2008

Background

Medication errors are recorded as the 2nd highest number of Trust adverse incidences, with 771 reported during 2007. Although identified as a high risk to the Trust, it is acknowledged that only a proportion of all errors are reported therefore the Trust can assume that there are considerably more unreported. To reflect this risk, Medication Errors are also one of the Trust's 7 Clinical Priorities for this year, which support the "*No Needless Medication Errors*" theme; one of the Strategic Health Authorities' Patient Safety Federation Work Streams.

Methods

Route cause analysis has been undertaken to correctly identify the issues associated with the Trusts' medication errors. It was identified from early analysis that some of the Trust's data was wrongly categorized. It was therefore felt necessary to undertake a comprehensive analysis to ensure principle risks were identified before action planning. By this method, a large group of adverse incidents assigned to 'Other' was able to be reassigned appropriately. Using a multi-professional team approach, with representatives from Risk, Pharmacy, Learning and Development and the Lead Nurse for Clinical Standards and Patient Safety, detailed analysis was undertaken on the three top errors identified, which account for half of all of the reported medicines errors; 'omission of medications', 'wrong or unclear prescriptions' and 'documentation'. Each group was examined in depth and themes of errors were identified, the themes were then combined to illustrate the top risks to the Trust, illustrated in Chart 1 by the following colour codes:

Colour Code	Responsibility
	Pharmacy
	Nursing/midwife/ODP
	Medical prescriber
No colour	Other factors

Chart 1: Top Risks to the Trust (332 = half of total PHT medication errors in 2007)

Themes		
Wrong Dose Administration	36	
No Valid Prescription	32	
Recording Error	31	
Policy or process	26	
Error in dosage in prescription	25	
No drug available	25	
No reason for omission recorded	24	
Error in pump setting	22	
Miscellaneous	19	
Pharmacy Errors	15	
Transfer Issues	15	

CD recording	14
No Drug Chart	9
Illegible Charts	8
IV Access	8
Communication	6
Workload	5
Incorrect Preparation	3
Wrong drug	3
Prescription errors	2
Equipment	2
Wrong method	1
Not ordered	1

Recommendations

In order to facilitate changes in practice by action planning, the themes of errors could be allied to 3 professional groups with lines of responsibility; pharmacy, medicines administrators or medicines prescribers. Some could be assigned to two groups, ie pharmacy could pick up many prescribing errors if they were available to review charts daily. A literature search was also undertaken to examine current evidence and best practice, to support the recommendations; the references are within.

On behalf of the multi-professional review group, the following recommendations are suggested:-

- Each group would have a professional lead who would review all incidents relating to their profession and provide an annual report with an action plan and outcomes to the Medication Safety Committee to provide assurance.

Medicine Prescribers

- Annual update process to ensure mandatory training requirements are fulfilled
- To examine current induction and training to ensure robust systems exist
- Lead on a process of reflection and learning following errors- enabled by agreed retraining indicators

Registered health care professionals undertaking administration of medicine

- Lead will liaise with learning and development to ensure that the provision of learning addresses key aspects of medication safety highlighted from route cause analysis.
- Develop increased awareness of policy via risky business, e-learning programmes, one to one and group tutorials.
- Ensure competencies are signed off and enforced via annual clinical reviews
- Agree a standard of reflection and learning following errors, with escalation to formal measures if indicated.
- Work with existing change management programmes to incorporate proven interventions.
- Review existing methods of administration with pharmacy support, to facilitate move to more individualized patient medication administration. As a move to more individualized patient medication supplies may reduce the errors from nursing although

the potential to shift errors to pharmacy is acknowledged (Joanne Briggs Institute, 2006)

Pharmacy

- To liaise with other nominated leads to provide overview and internal learning mechanism from medication errors
- To have pharmacists available on ward rounds particularly post-take, to ensure reviews of medication take place soon after admission (NICE, 2007, NPC 2008) and effective reconciliation of medication takes place (Amerik, et.al. 2007). This would allow for interaction between pharmacists and consultants which was found to significantly reduce the risks to the elderly of polypharmacy (Rollason and Vogt, 2003, NPC, 2008)
- The use of pharmacists to double check prescriptions and for advice to prescribers (Joanne Briggs Institute, 2006). Overall the literature showed that interventions of a specialist pharmacist can contribute to the reduction of medication errors.

References:

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Rollason,V. and Vogt,N. 2003. Reduction of polypharmacy in the elderly
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