



# Prescribing Points

A NEWSLETTER FOR ALL HEALTH CARE PROFESSIONALS IN OXFORDSHIRE, WRITTEN BY THE MEDICINES MANAGEMENT TEAM, OXFORDSHIRE PCT, JUBILEE HOUSE, OXFORD BUSINESS PARK SOUTH, OXFORD, OX4 2LH.

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In this issue:	
Page 1	Safety in Doses – Improving the Use of Medicines in the NHS
Page 3	Care Homes' Use of Medicines Study: prevalence, causes and potential harm of medication errors in care homes for older people
Page 4	PCT Error Reporting Process
Page 4	Being Open – Communicating with patients, their families and carers following a patient safety incident

## Safety in Doses - Improving the Use of Medicines in the NHS

Every day, about 2.5 million medicines are prescribed in the community and in hospitals in England. Most prescriptions are delivered correctly and do exactly what they are meant to do. However things can and do go wrong. *Safety in Doses – Improving the use of medicines in the NHS*, a report published by the National Patient Safety Agency, provides a national profile of these errors based on nationally reported safety incidents and outlines how clinicians and NHS organisations can minimise risks and improve the safe use of medicines.

The main findings from the report were:

- There has been a significant year-on-year increase in the reporting of medication incidents from 64,678 in 2006 to 86,085 reported in 2007.
- Incidents involving medicines were the third largest group (nine per cent) of all incidents reported to the RLS, after patient accidents (35 per cent) and treatment/procedure (nine per cent), from a total of 811,746 incidents of all type in 2007.
- The majority of medication incidents (96 per cent) had actual clinical outcomes of no harm or low harm.
- Acute care (all specialities) remains the highest reporter of all incidents (73 per cent) and medication incidents (76 per cent).
- Primary care is the next highest reporter of medication incidents (14 per cent) (although reporting levels of medication incidents in primary care continue to be low relative to the volume of healthcare provided)
- The NPSA received 100 medication incident reports of death and severe harm in 2007.
- The most serious incidents were caused by errors in medicine administration (41 per cent) and, to a lesser extent, prescribing (32 per cent).
- Three incident types – unclear/wrong dose or frequency, wrong medicine and omitted/delayed medicines – account for 71 per cent of fatal and serious harms from medication incidents.
- **Types of medicines most frequently associated with severe harm include cardiovascular, anti-infective, opioid, anticoagulant and anti-platelet medicines.**
- Following guidance on the safe use of potassium chloride injection and oral methotrexate there were no incident reports of death or severe harm involving these medicines in 2007.

## What can be learnt from medication incident reports?

- Healthcare organisations will use this report to review the number and quality of medication incident reports received. This will allow NHS organisations to identify whether current arrangements are allowing local learning to take place as well as take the necessary action to minimise the risk of harm to patients.
- They will also use the information and incident examples in the report relating to deaths and severe harm to assess risk and where necessary improve the safety of local medication management systems.
- Research shows that high reporting is a likely sign that an organisation takes safety and learning seriously. Organisations that have a poor reporting culture and system where few medication incidents are reported may be at greater risk of harming a patient as there is less opportunity to learn and improve their medication systems. Reporting levels of medication incidents in primary care continue to be low relative to the volume of healthcare provided.

## Reporting of incidents in primary care

Primary care is the setting in which most patients have contact with NHS healthcare services. Levels of activity have risen substantially over the past 10 years. However, incident reporting rates in primary care continue to be low in comparison with the acute sector. Although the vast majority of care is carried out in the community, the number of incident reports from primary care represents only 10% of the total medication-related reports received by NRLS.

- Most reported incidents in general practice are related to the administration of medicines. Work is being taken forward by the NPSA to increase patient safety incident reporting in general practice. This includes exploring the concept of themed reviews that will concentrate on a rolling programme of specific clinical themes. There is also work under way to test a method of identifying patient safety events in Significant Event Audits (SEA). SEA in general practice is being promoted and supported by a number of national bodies through the use of the SEA toolkit ([www.npsa.nhs.uk/nrls/improvingpatientsafety/primarycare/significant-event-audit/](http://www.npsa.nhs.uk/nrls/improvingpatientsafety/primarycare/significant-event-audit/))
- Most reported incidents in community pharmacy, unsurprisingly, relate to the dispensing or preparation of medicines. Community pharmacies are encouraged to continue reporting patient safety incidents, including prescribing errors. Confidentiality remains a concern for some contractors, and the NPSA continues to assure community pharmacists, GPs and dentists that reports are confidential.
- Very few patient safety reports are received from general dental practice, and, of those that are received, 73% relate to the administration of medicines. A relatively high proportion of reports received from dental practice relate to allergic reactions to medicines that could not have been foreseen. These should be reported to the MHRA via the yellow card scheme.
- The most common interface where incidents are reported is between secondary and primary care when patients are discharged from hospital or following outpatient appointments. Particular problems appear to be related to faxed prescriptions and discharge summaries.
- It is important that incident reports are completed as fully as possible. For example, only a third of reports had the medicine name data field completed. Failure to complete this makes identifying the medicines most frequently associated with safety incidents difficult.

The full report of 'Safety in Doses – Improving the use of medicines in the NHS' is available at <http://www.nrls.npsa.nhs.uk/resources/?entryid45=61625>

## Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people

In October 2009 the results from the [Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people](#) <sup>[1]</sup> (CHUMS) were published. The objective of the study was to determine the prevalence and potential harm of prescribing, monitoring, dispensing and administration errors in UK care homes, and to identify their causes.

The main findings of the study were as follows:

- residents (mean age 85 years) were taking an average of 8 medicines each;
- on any one day 7 out of 10 patients experienced at least one medication error;
- whilst the mean score for potential harm was relatively low, the results did indicate opportunity for more serious harm.

Contributing factors to the findings included:

- Doctors who were not accessible, did not know the residents and lacked information in homes when prescribing
- Home staff's high workload, lack of medicines training and drug round interruptions
- Lack of team work among home, practice and pharmacy
- Inefficient ordering systems
- Inaccurate medicines records and prevalence of verbal communication
- Difficult to fill medication administration systems

In the discussion section, the authors of [Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people](#) <sup>[1]</sup> make several suggestions that could contribute to improved patient safety in care homes.

These include:

- Constant review of the use and accuracy of medication administration records. (The authors noted that lack of protocols and adequate staff training is an issue)
- Prescribing medicines for different times to ease busy morning drug rounds which can often be interrupted
- Monitoring of omitted doses and ordering systems, particularly of "as required" medicines, to reduce administration errors from omissions when a drug is not available
- ensuring appropriate monitoring of patients on riskier medicines and that all patient's medication is reviewed by a pharmacist
- Consideration of one person having overall responsibility for medicines use in one or more care homes

An alert from the Department of Health has suggested that Primary Care Trusts with primary medical care contractors, providers of pharmaceutical services and social care partners should:

- review the safety of local prescribing, dispensing, administration, and monitoring arrangements in the provision of medication to older people in care homes;
- establish a plan for effective joint working in the future

Within Oxfordshire we have set up a working group which includes representatives from the PCT, medical contractors, local pharmacists, care home managers and representatives from Oxfordshire County Council. The aim of the group is to investigate the safe use of medicines by residents in care homes across the county and any improvements that can be made. This may include a series of 'Top Tips' for prescribing for care home residents; effective monitoring of the medicines prescribed; for dispensing medicines for care home residents

and administration of medicines to these patients. These and any other findings will be circulated in due course.

Any medication errors, including prescribing; dispensing; monitoring or administration errors involving care home residents should be dealt with through the Oxfordshire PCT medication error reporting process. Care homes that are registered with The Care Quality Commission (CQC) should report any medication errors that result in a discussion with a doctor or nurse as a 'notifiable event' to the CQC.

### Oxfordshire PCT Medication Error Reporting Process

If a healthcare professional has been made aware of a medication error, they should first ensure there are no immediate patient safety issues. The error should then be discussed with the pharmacy or practice in question and the error should be reported 'in house' through their own reporting system and, if possible, to the NPSA.

If there was no harm to the patient and the necessary action has been taken by the pharmacy or practice then there is no need to report the error the PCT.

If either the patient has been harmed, or there is an unsatisfactory response / ongoing concerns with the source of the error, then the error should be reported to the PCT via DATIX or the Medicines Management Governance lead.

Please note, *all* errors involving controlled drugs should be reported to the PCT Accountable Officer, Sula Wiltshire on 01865 336723.

Report patient safety incidents to the NPSA at <https://www.eforms.npsa.nhs.uk/staffeform/> or report via DATIX (NHS Oxfordshire incident reporting system) available on the Oxfordshire PCT intranet.

### Being Open – Communicating with patients, their families and carers following a patient safety incident

*Being Open* is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which a patient was harmed.

It supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened.

This is a revised version of the 2005 *Being Open* policy. Since the release of this the NHS in England and Wales has undergone significant changes that have altered the context, infrastructure and language of patient safety and quality improvement. A review of the policy in 2008 showed more needed to be done to strengthen the implementation of *Being Open*.

A patient safety alert has also been issued which sets out actions for the NHS.

#### Why is openness important?

Communicating effectively with patients, their families and carers is a vital part of the process of dealing with patient safety incidents in healthcare. Research has shown that patients are more likely to forgive medical errors if they are discussed in a timely and thoughtful manner and that being open can decrease the trauma felt by patients following a patient safety incident.

Openness also has benefits for healthcare professionals as it can: help to reduce stress through the use of a formalised, honest, communication method; alleviate the fear of 'being found out'; and improve job satisfaction by:

- Ensuring that communication with patients, their families and carers has been handled in the most appropriate way
- Helping the healthcare professional to develop a good professional reputation for handling a difficult situation properly

- Improving the healthcare professional's understanding of incidents from the perspective of the patient, their family and carers

The benefits of *Being Open* are widely recognised and supported by policy makers, professional bodies and litigation and indemnity bodies.

The NHS constitution for England embeds the principles of *Being Open* as a pledge to patients in relation to complaints and redress. It states:

*"The NHS also commits when mistakes happen to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively"*

Fear of legal action may be preventing some healthcare professionals from being open with patients, but the Medical Defence Union (MDU), Medical Protection Society (MPS), National Health Service Litigation Authority (NHSLA), Royal Pharmaceutical Society of Great Britain (RPSGB) and Welsh Risk Pool have all issued recent guidance to reassure healthcare professionals that they are not admitting liability if they apologise when something has gone wrong with their treatment of a patient. Healthcare professionals may wish to refer to their professional body's guidance on dealing with patient safety incidents.

The principles of *Being Open* are becoming recognised worldwide and there is an increasing bank of best practice examples from which the NHS can learn. These include examples from the Australian Open Disclosure project, Singapore and the United States.

The full document is available at <http://www.nrls.npsa.nhs.uk/resources/?entryid45=65077>