Introduction
This is the NPA Medication Safety Officer (MSO) report for Quarter 4. There was a significant increase in the number of reports in Quarter 4, compared with Quarter 3 and the quality of incident reports was generally high.

NOTICEBOARD
Quality payments – update on written patient safety report
A template report form, to be used for the annual written patient safety report, is still being finalised – this will be published on the NPA website as soon as it is available. To complete this form, you will need to continue to record and investigate patient safety incidents, keep copies of reports and respond to patient safety alerts. When reporting incidents using the NPA Patient Safety Incident report form, remember either to print the form, or include your email address so that it can be emailed back to you.

New asthma review resources
The NPA recently published new asthma review resources, designed to help community pharmacies in England to meet the asthma review quality criterion. These refer to guidelines and resources that pharmacy teams are recommended to read in preparation. This preparation stage may also be a good opportunity to remind pharmacy teams of the different types and strengths of inhalers available, to help reduce the number of errors involving inhalers.

New monitored dosage system resources
In December 2016, the NPA published a suite of resources to support pharmacy teams that supply medicines in monitored dosage systems (MDS). The guidance and template standard operating procedure (SOP) will be very useful in helping to prevent MDS errors.

Frequent errors – common themes
The main themes that emerged in the errors reported this quarter are:

Delivery issues
These included:
- Deliveries containing extra items intended for a different patient, due to bags not being sealed properly or being clipped together
- Medicines posted to wrong address due to patient not informing pharmacy or GP of his change of address
- Medicines being delivered to the wrong house number due to delivery driver error
- Medicines being delivered to wrong address due to incorrect bag label

Errors involving CDs
These included:
- Prescriptions being dispensed and handed out before the signature date on the prescription (so not legally valid)
- Too many bottles of methadone being supplied in one instalment, and supervised methadone dose being given to the wrong patient
- Incorrect CD handed out due to wrong bag being taken out of CD cabinet
- Incorrect labelling and incorrect quantities being dispensed

Errors involving inhalers
Inhalers continued to feature in the error reports, as ‘wrong drug’ errors, ‘wrong strength’ errors and ‘wrong formulation’ errors. Compound inhalers, containing more than one active ingredient,
seemed to cause particular problems. In some cases, incidents included mix-ups between inhalers and nasal sprays.

Errors involving insulin
Insulin again featured in a number of reports, both as ‘wrong drug’ errors (for example, NovoMix/Novorapid) and ‘wrong formulation’ errors (for example cartridges/pre-filled pens).

Errors involving MDS
The same types of MDS errors as the previous quarter continued to occur, but there were also new ones, including:
- Unclear labels making dose incomprehensible
- Paracetamol tablets being dispensed instead of capsules; error spotted and corrected, but not all of the tablets removed, so tray contained extra paracetamol
- Tray containing duplicates of one medicine, from two different manufacturers
- Pharmacy informed of dose change, but tray already made up and handed out to patient without changing it to new dose

Labelling errors
As before, these included incorrect frequency, dose, name of drug, strength and patient name, as well as labels being stuck onto the wrong items. There were also errors of dose calculations or interpretation of prescriber’s instructions. Liquid medicines with a prescribed dose stated in milligrams, were labelled with an incorrect dose in millilitres (for example, a dose of 15mg of a product with a strength of 10mg/1ml being labelled with an instruction to take 15ml daily (instead of 1.5ml). Errors on MAR charts also occurred – for example a titration dose of memantine was misread and labelled as a reducing dose rather than an increasing dose.

Mismatching patients and medicines
We continued to see errors involving patients receiving medicines intended for someone else. These included:
- Patients receiving bags with their name on, but containing medicines for a different patient
- Two patients with similar names having their prescriptions dispensed together and bagged up in the same bag
- Patients answering when a different patient’s name was called out and collecting the wrong medication as a result

Other interesting errors
Some unusual errors, worth highlighting include:
- A specials company supplied an incorrect product, though the certificate of conformity was for the correct product – the product was imported, and the label and leaflet were not in English
- A patient with a prescription for sodium cromoglicate eye drops was advised to buy them over the counter as they were cheaper than the prescription charge – the patient was then sold sodium bicarbonate ear drops by mistake

Key statistics and frequently appearing drugs
As with previous quarters, the two main types of medication incidents reported were:
1. ‘Wrong drug/medicine’ supplied (28%)
2. ‘Wrong/unclear dose or strength’ labelled/supplied (26%)

Many of the ‘wrong drug’ errors reported in previous quarters continued to occur in Quarter 4. The most frequently reported was enalapril/escitalopram. Others included:
- Allopurinol/atenolol
- Amitriptyline/amlopidine
As in Quarter 3, amitriptyline, levothyroxine and ramipril continued to be among the most common drugs involved in ‘wrong strength’ errors in Quarter 4. Drugs which appeared more frequently as strength errors in Quarter 4 than previous quarters, included bendroflumethiazide, betahistine, calcium carbonate & colecalciferol, candesartan, clobazam suspension, co-codamol, dabigatran, Fostair, gabapentin, lisinopril, sertraline and simvastatin.

‘Wrong formulation’ errors included:
- aspirin dispersible/enteric coated tablets,
- omeprazole capsules/dispersible tablets,
- tablets/gastro resistant tablets,
- paracetamol capsules/tablets/soluble tablets,
- ramipril capsules/tablets,
- insulins and various inhalers

The most important factor for reported errors continued to be ‘Medicines with a similar looking or sounding name’ (62%). ‘Work and environment’ factor was again cited as the main contributing factor for the reported errors (42%). 83% of reported errors involved either a near miss (21%) or an error causing no harm to the patient (62%).

Top tips for minimising risk /general action points
In addition to the tips contained in previous MSO reports, the following tips should help minimise the risk of the errors reported in Quarter 4 re-occurring:

Dispensing and accuracy checking
- When dispensing from split packs, take all of the contents out and check they are correct and that no tablets have been put into the wrong box
- If the item being dispensed is an import, check carefully that the product is correct – the NPA Pharmacy Services team (01727 891 800) can help with the identification of foreign medicines
- Ensure that dispensed insulin is clearly marked as insulin, so that staff handing it out are aware of the need to confirm with the patient that is the correct product – you could use insulin stickers for this (fridge stickers are available from the NPA sales team 01727 800 401)
- If you are interrupted during the accuracy check, start the checking process from the beginning again
- Do not get involved in a conversation with the patient while dispensing or accuracy checking – ask them to kindly wait until the dispensing is finished

MDS
- When dispensing into MDS trays, cross-check the dose frequencies and count the number of tablets in each compartment to ensure they tally
- If an error is spotted while checking an MDS tray and the contents are changed as a result, ensure that the whole tray is checked again
### Clinical
- When calculating doses, write your calculations down on paper – **do not just do mental arithmetic**
- If advising the patient to purchase an item over the counter rather than pay the prescription charge, ensure that the correct product is selected for sale – the pharmacist should supervise this

### Handing out/delivery
- When handing out, always check the address of the patient, even if the patient is well known to you
- Before sending out items out for delivery, carry out a final check, ensure that bags are all properly sealed, and that bags for different patients are not attached to each other
- Ensure that the number of bags for each patient is clearly marked
- Consider carrying out role plays with the delivery driver to ensure they understand and follow the delivery SOP
- Consider carrying out an audit to see if there is a correlation between dispensing errors and deliveries
- When handing out methadone, deal with one patient at a time, and only remove the methadone from the CD cupboard for one person at a time – look at them just before handing out to check they are the correct patient

- Don’t assume that, because a patient answers when you call out a name, they are that person – always check their name and address carefully, ask them to repeat it back to you or write it down if necessary, and consider asking for their date of birth if still unsure

### Dispensary environment
- Ensure that stock is easily accessible to staff, and that they don’t have to reach up and guess which item they are selecting – ensure that steps or kick stools are available where necessary, and that staff use them

- Make sure that different strengths of the same item are not piled on top of each other on shelves/in drawers