

Patient safety quarterly report: Quarter 1 (January – March) 2017

Introduction

This is the NPA Medication Safety Officer's patient safety report for Quarter 1 of 2017. The quality of incident reports being submitted via the NPA's reporting system has remained consistently high and the numbers of reports have increased by 45% since the last quarter.

NOTICEBOARD

New NPA inhaler identification checker resource

As highlighted in [last quarter's report](#), a recurring theme of patient safety incident reports received by the NPA involved incorrect inhalers being dispensed against generic prescriptions. To address this, the NPA has produced a new [inhaler identification checker](#), in order to help dispensing staff identify the different inhalers available and ensure the appropriate inhaler is selected. This resource can be printed and kept in the pharmacy to help reduce the occurrence of such errors.

Updated MHRA valproate resources

The Medicines & Healthcare products Regulatory Agency (MHRA) has issued a [Patient Safety Alert](#) and updated its resources regarding the use of valproate in females of childbearing age. The valproate toolkit can be used by healthcare professionals, including pharmacists, to help them communicate the risks of valproate in pregnancy to patients. The toolkit materials can be accessed from the MHRA section of the [GOV.UK website](#).

Quality payments – NPA resources to help you complete the written patient safety report

The NPA has produced general guidance, monthly and annual template report forms, and guidance on how to complete the annual report template, all of which can be used to help you meet this patient safety quality criterion. These resources are available on the [NPA website](#).

Completing the NPA Patient Safety Incident report form

We occasionally receive calls querying various aspects of the NPA online Patient Safety Incident Report form – the [2016 guidance document](#) for completing the form can be downloaded and used as a convenient guide. **Please note, if you want the form emailed back to yourself, you need to enter your email address at the end of stage 2 (page 2 of the form) where indicated.**

Frequent errors – common themes

Errors involving monitored dosage systems

Errors involving monitored dosage systems (MDS) have continued to be one of the most common types of errors, making up 10% of all reported incidents this quarter. Examples of MDS errors reported this quarter include:

- Trays completely missing one of the prescribed drugs – in one circumstance this was identified when the patient experienced withdrawal effects
- Trays including medication at the wrong doses
- Once weekly medication, such as alendronic acid, being placed in the compartment for the wrong day of the week

The NPA's [MDS resources](#) can help to minimise the occurrence of such errors, particularly the guidance document and the template standard operating procedure (SOP).

Errors involving delivery of medication

Amounting to 9% of errors, a significant number of reports have been submitted involving in the delivery of medication. These include:

- Wrong bag labels attached to a patient's medication and consequently delivered to the wrong patient
- Medication being delivered to the wrong patient due to a driver error

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- Additional medication for a different patient being included in the patient's bag

Errors involving fridge lines

Errors involving fridge lines, particularly insulin, have consistently appeared on the NPA patient safety incident report form, examples of which include:

- Confusion between different insulin products, such as Humalog® Kwikpen™ / Humulin® M3 Kwikpen™ and NovoMix® / NovoRapid®
- Failure to indicate additional fridge lines on bag labels, subsequently, patients not receiving insulin amongst other prescribed fridge items
- Mismatching patients and medicines – with patients receiving fridge lines intended for other patients

Errors involving Electronic Prescription Service (EPS) prescriptions

Errors involving EPS contributed to 4% of incidents, examples of which include:

- Failure to clarify doses and writing out abbreviations appropriately on the dispensing label – for example, 'QDS' not being written out as 'four times a day', causing confusion for patients
- Selecting the wrong patient with an EPS release 1 prescription - this could have potentially been avoided by scanning the barcode
- EPS release 2 prescriptions not being checked for patient medication changes and subsequently patient not receiving updated medication strengths and doses

Other interesting errors

Distractions in the pharmacy are frequently associated with the occurrence of dispensing errors. Two examples that were brought to light this quarter are:

- The incorrect dispensing of ramipril against a prescription for atovaquone and proguanil – the result of which meant the patient was not receiving adequate malaria chemoprophylaxis while travelling
- Mismatching two patients and their medication, resulting in a child being dispensed methadone instead of a reconstituted antibiotic

Key statistics and frequently appearing drugs

Medication error categories

Figure 1 illustrates the main medication error categories that were reported during Quarter 1 and the frequency of each in comparison to each other.

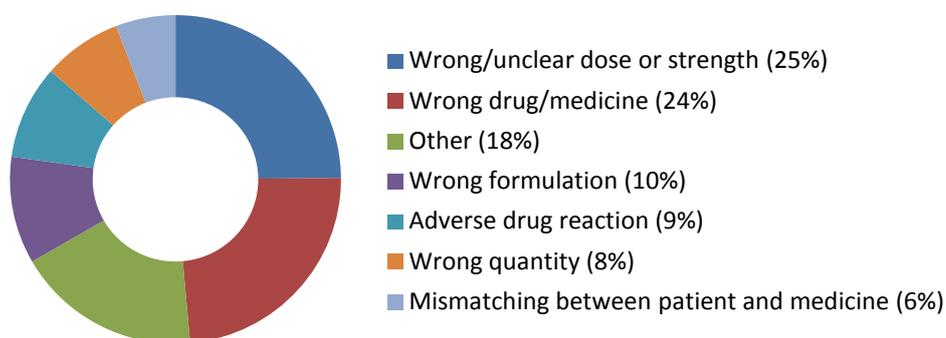


Figure 1. Medication errors reported during Quarter 1 by category

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- The two most common medication error categories continued to be dispensing a **wrong/unclear dose or strength** (25% of reported errors), and dispensing the **wrong drug/medicine** (24% of reports)
- Levothyroxine, similarly to Quarter 4 of 2016, was the most common drug given out as the '**wrong strength**', along with fluoxetine, ramipril and citalopram
- The most common '**wrong drug/medicine**' errors included:
 - Allopurinol/atenolol
 - Amitriptyline/amlodipine
 - Amitriptyline/atenolol
 - Levothyroxine/losartan
 - Pregabalin/gabapentin
 - Quetiapine/topiramate
- Ramipril was dispensed as the '**wrong formulation**' most frequently – other medications dispensed in the wrong formulation include salbutamol, carbamazepine, montelukast and metformin

Contributing factors

Figure 2 illustrates the most commonly reported contributing factors to patient safety incidents during Quarter 1.

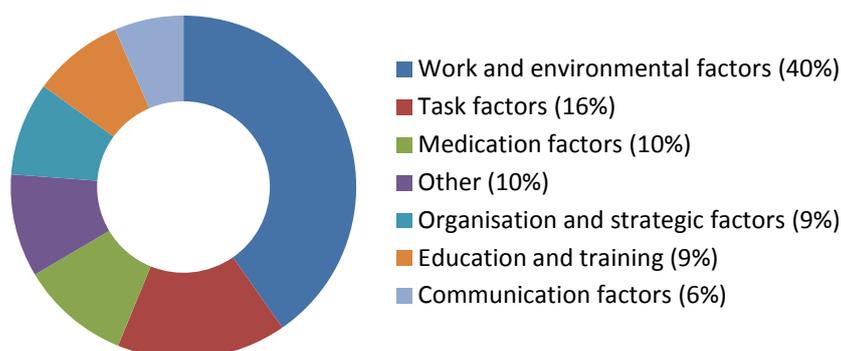


Figure 2. Contributing factors to errors reported in Quarter 1.

- Work and environmental factors contributed to over 40% of errors
- This is followed by task factors (16% of incidents), which includes not following SOPs, policies and guidelines

Degree of harm

Figure 3 illustrates the degree of harm caused to patients by incidents reported during Quarter 1.

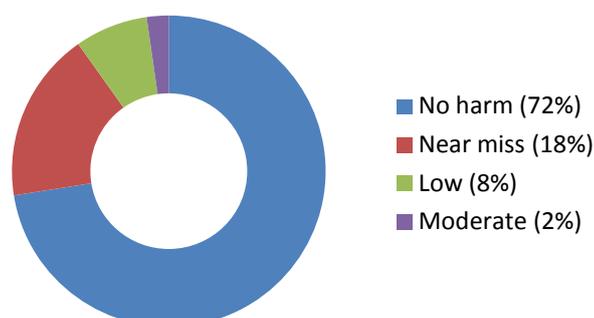


Figure 3. Errors for Quarters 1 categorised by degree of harm

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- 72% of errors reported caused no harm to the patient
- Approximately 8% of incidents caused a low degree of harm to patients

Top tips for minimising risk /general action points

Safety culture within the pharmacy

- ✓ Address any safety issues identified in the pharmacy – carry out a root cause analysis to help identify the cause(s) and take steps to prevent any reoccurrence
- ✓ Conduct safety huddles and staff meetings – these are a good way to ensure all staff members are kept up-to date with recent patient safety incidents
- ✓ Implement an open culture where there is a focus on learning, rather than blame
- ✓ Make it easy to report incidents by bookmarking the NPA Patient Safety Incident Report form
- ✓ Improve data quality and make reporting matter – incidents that are categorised as ‘Other’ in any of the fields restrict the level of useful analysis of the information
- ✗ Do not confine reporting to dispensing errors and near misses only – remember the NPA Patient Safety Incident Report form can be used to cover all errors from prescribing errors/incidents to adverse effects felt by the patient following use of the medication

Dispensing environment

- ✓ The physical surroundings be kept as free of dust and as de-cluttered as possible – ensure a cleaning rota is in place
- ✓ Ensure a separate basket is used for each patient (including members of the same family) to prevent checking against an incorrect prescription or bagging incorrectly
- ✓ Fast moving lines may be placed in a more accessible areas for the convenience of dispensers
- ✗ Do not dispense or check more than one prescription at one time and do not conduct the final check while distracted

Pharmacy practice

- ✓ Ensure owing slips are destroyed once the owing has been redeemed to avoid confusion and prevent the risk of the patient being dispensed more than the amount prescribed
- ✓ All staff members, including delivery drivers, should have read and signed the relevant SOPs, which should be reviewed regularly – consider additional risk minimisation measures such as patients checking and signing for deliveries upon receipt
- ✗ Do not rely on EPS systems to label items correctly – this does not override your clinical check and labels should be checked against the prescription