Patient safety quarterly report: Quarter 2 (April – June) 2017

Introduction

This is the NPA Medication Safety Officer's patient safety report for Quarter 2 of 2017. The number of reports submitted is consistently increasing. Additionally, the quality of incident reports being submitted via the NPA's reporting system is of a high standard.

NOTICEBOARD

New — NPA insulin identification checker resource

Patient safety incidents involving Insulin are reported recurrently. To support safe dispensing of insulin, the NPA Pharmacy team has produced a new insulin identification checker, to help identify and distinguish between the different types of insulin available and ensure the appropriate product is selected during the dispensing process. Similar to the inhaler identification checker resource produced last quarter; this can be printed and kept in the pharmacy to help reduce the occurrence of such errors.

Reminder of useful resources

The NPA has produced a number of resources to enhance patient safety, include a suite of monitored dosage system resources, the aforementioned inhaler identification checker resource and a dispensing best practice resource. Pharmacy teams are advised to utilise these resources that have been produced a result of the incidents reported, to ensure patient safety is addressed within the pharmacy at all stages of the preparation of medication.

Frequent errors – common themes

Errors involving hospital prescriptions

A number of reports have been identified involving hand written hospital prescriptions, the majority of which involve unclear hand written prescriptions that were dispensed incorrectly instead of clarifying with the prescriber.

Contributing factors include:

- Making assumptions based on previously prescribed medication
- Difficulty in getting hold of hospital prescribers
- Insufficient use of summary care records (SCR)
- Lack of communication between healthcare professionals – pharmacy teams are reminded of the contractual obligation to record all interventions

Errors occurring when handing out dispensed items

Patients with similar names have come to light as a common contributing factor in this type of patient safety incidents.

- A number of patients have received medication not intended for themselves due to insufficient checks being made when handing out dispensed items
- Patients with similar/same surnames inadvertently being given the wrong medication — consider alternative filing methods to filing bagged medication by surnames
- Failure to ask for additional information, such as date of birth, when ascertaining the patient's identity

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Errors involving expired medication

Two per cent of reports involved an expired product being dispensed. From appliances to medication, ensure that product expiry date takes into consideration the duration of treatment. The NPA Stock-Date Checking Matrix template can be used to ensure all short-dated stock is recorded to help manage stock and prevent such incidents.

Other interesting errors – examples

A number of incidents have occurred as a result of not following standard operating procedures (SOP) and best practice guidance when dispensing. One incident involved two prescriptions being labelled, dispensed and checked simultaneously using one dispensing basket, only to be discovered by a patient upon finding unfamiliar additional medication within their bag.

An incident involving a split pack containing various strips of different strengths of the same medication has been reported resulting in the patient receiving an inconsistent course of antibiotics comprised of different strengths. Ensure the correct product is stored in the correct corresponding packaging when using split packs. It is also essential to ensure batch numbers and expiry dates are clear and identifiable.

A picking error led to a patient safety incident where the patient had requested their medication to be popped out into bottles at time of dispensing. The error was identified by the patient due to the difference in appearance of the medication.

Key statistics and frequently appearing drugs

Medication error categories

Figure 1 illustrates the main medication error categories and incidence reported during Quarter 2.

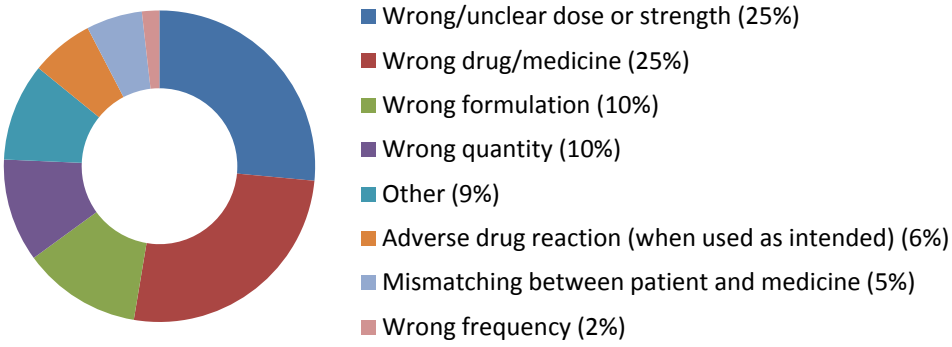

Figure 1: Medication errors reported during Quarter 2 by category

Key findings

- The two most common error categories reported continued to be dispensing a **wrong/unclear dose or strength** (25%), and dispensing the **wrong drug/medicine** (25%)
- Lansoprazole and perindopril were in the most commonly dispensed **'wrong strength'** category
- The most common **'wrong drug/medicine'** errors included:
    - Atorvastatin/Simvastatin
    - Bendroflumethiazide/bisoprolol
    - Levothyroxine/losartan
    - Pantoprazole/pravastatin

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  - Pregabalin/gabapentin
  - Risperidone/ropinirole
- Many of the incidents reported as '**wrong formulation'** involved modified release preparations being dispensed incorrectly in place of standard release formulations, and vice versa

Contributing factors

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

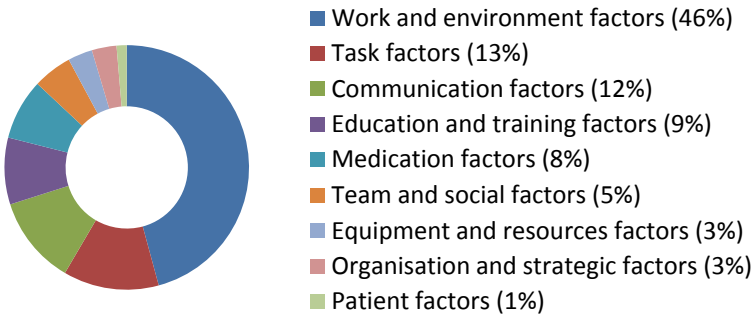

Figure 2. Contributing factors to errors reported in Quarter 2.

Key findings

- "Work and environmental factors" continues to be the main contributing factor, accounting for 46% of errors
- This is followed by task factors and communication factors – pharmacy teams are reminded to review their internal procedures and ensure all communication with both patients, and healthcare professionals, is written and auditable

Degree of harm

Figure 3 illustrates the degree of harm caused to patients by incidents reported during Quarter 2.

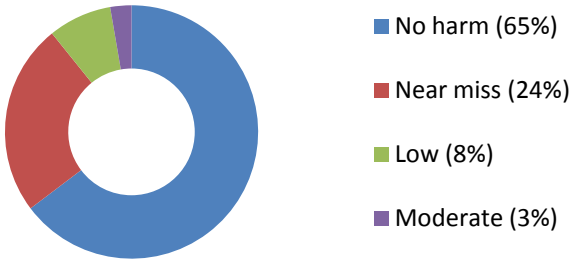

Figure 3. Errors for Quarters 2 categorised by degree of harm

Key findings

- Errors involving no harm to the patient continue to be the most reported (65% of errors reported)
- Approximately 8% of incidents caused a low degree of harm to patients

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Top tips for minimising risk /general action points

Calculations

Dose calculations have been found to be attributable to a number of incidents. It is important to ensure that if a dose is to be calculated:

- ✓ Always get a second person to check the calculation(s)
- ✓ Doses prescribed per weight should be confirmed with the patient/representative to ensure the correct dose has been prescribed
- ✗ Calculations involving weight should not be based on ideal weight within the BNF, this can be used as a guide only – the accurate weight of the patient should be obtained
- ✗ Calculations should not be done using mental arithmetics – always double check with a calculator

Learning from incidents

Pharmacy teams are encouraged to:

- ✓ Use root cause analysis to learn how and why incidents have occurred
- ✓ Identify common themes through the use of the NPA quarterly reports or via internal analysis/audits
- ✓ Identify practical areas for change that can lead to a reduction in the likelihood of incident reoccurrence
- ✗ Avoid building a punitive culture where a fear of reporting future incidents may develop
- ✗ Look at each error independently and not dismiss smaller errors or incidents with a lesser degree of harm as insignificant – addressing such incidents will help to prevent future errors that may have a greater level of harm

Adverse drug reactions

With seven per cent of incidents being reported as adverse drug reactions, further investigation has found a differing view as to what would be defined as an adverse drug reaction.

The EU Directive 2010/84/EU defined an adverse drug reaction as *'a response to a medicinal product that is noxious and unintended effects resulting not only from the authorised use of a medicinal product at normal doses, but also from medication errors and uses outside the terms of the marketing authorisation, including the misuse, off-label use and abuse of the medicinal product.'*

Pharmacy teams are therefore reminded to :

- ✓ Report all adverse drug reactions using the NPA Patient Safety Incident Report form
- ✓ Send a Yellow Card report to the MHRA for all suspected adverse drug reactions to products marked with an inverted black triangle symbol (▼); adverse drug reactions for black triangle products should be reported even if the effect is well recognised

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