NOTICEBOARD

New – NPA insulin identification checker resource

Patient safety incidents involving insulin were reported this quarter and 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 checker produced earlier this year, this resource can be printed and used as a patient safety improvement tool and to initiate a quality improvement discussion with the pharmacy team.

Reminder of useful resources

The NPA has produced a number of resources to enhance patient safety, including a suite of monitored dosage system resources and a dispensing best practice resource. To keep up to date with the new resources and quality improvement support check www.npa.co.uk/news-and-events regularly and subscribe to our Scottish NPA weekly email www.npa.co.uk/news-and-events/subscribe/

Introduction

This is the third NPA Report for Scotland on Patient Safety Incident Reports received by the NPA using the confidential online reporting system. The Patient Safety Incident Reporting service provides a thorough, systematic and quick way for any pharmacy staff to record safety incidents including near miss and dispensing errors. The reports can be printed, or sent by email to the responsible pharmacist or pharmacy superintendent to enable procedures to be identified which will improve the quality of patient care provided in your pharmacy. If any NPA member uses a different system of incident recording and would like to contribute their error reports to be confidentially included in the NPA Pharmacy services analysis of common incidents please contact j.oman@npa.co.uk.

Frequent Errors

Wrong/unclear dose or strength

Picking of the wrong dose accounted for 50% of all Scottish incident reports this quarter. Errors in this category included:

- Picking errors for fast moving generic lines
- Where a commonly prescribed strength is picked instead of the correct unusual strength
- Picking a 100mg strength instead of 10mg

All of these errors can result in significant harm to the patient; errors in this category included high-risk medicines such as warfarin, Controlled Drugs (CD), and modified-release preparations. As a quality improvement exercise, pharmacies may want to look at how different strengths of medicines are separated within the dispensary.

Suggestions:

- Operate a strict process of putting away stock, known by all staff including weekend staff, with a clear protocol for placement of differing strengths. For example, higher strengths always placed to the right, and/or the use of shelf-edge alert stickers.
- Use a rota or matrix for medicine stock date checking and shelf cleaning, to ensure all stock gets regular tidying and checking. Templates are available at www.npa.co.uk.

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- Have a process to highlight high-strength packs when stock is received. Examples to identify an item as requiring extra vigilance in dispensing are; use a highlighter pen through the strength on the pack when the stock is received or place a sticker or elastic band on the pack or secure it in a re-sealable clear plastic bag.
- Ensure you have a signature check box for the selection of medicines for prescriptions. For each dispensed item, can your team identify who selected the item from the shelves? Is this a different person to who labels the pack? Is there a process for the person to be identified, for example initialling the paper prescription or the medicine pack?
- Use high sided vertical dividers, (a dispensing carton on its side may be convenient) between shelf columns of differing strengths of certain high risk medicines, or ensure a shelf gap space between strengths or stipulate a maximum number of packs to be stacked
- Look particularly at the your stock storage for medicines that have 10mg and 100mg strengths and also different modified dosage forms to highlight these as potential safety concerns. Examples of medicines that have both 10mg and 100mg strengths include diamorphine ampoules and tablets, MST Continus, Morphgesic SR, MXL, Zomorph.

Hand written prescriptions

A significant number of incidents involved hand written prescriptions which have no electronic prescribing message to check against written instructions and are therefore a particular safety risk. When hand written prescriptions are dispensed, assumptions based on previous or common prescribing can often be made resulting in the wrong medicine or strength being supplied. Prescriber handwriting can also influence errors, for example the way certain letters or numbers are written can make them easily misread. It may be prudent to consider additional safety procedures in dispensing hand written prescriptions, such as two separate members of the pharmacy team individually reading the prescription, magnifying the handwriting or capturing a hand held device image of the prescription which can then be examined closely, and if there is any doubt as to what is intended, contact the prescriber.

Wrong drug/medicine errors

14% of error involved the wrong medicine being selected, examples of commonly mistaken medication include:

- Mefenamic acid 500mg/tranexamic acid 500mg
- Humalog Mix25/ Mix25 Kwikpen
- Co-amoxiclav suspension/Clarithromycin suspension

Contributing factors

Work and environment factors continue to be the most commonly reported contributing factor responsible for 60% of all Scottish reported incidents this quarter with 40% of all error reports stating that it was a “busy” time. Other work and environment factors included, not the usual staff working, and not enough staff available for the tasks normally done at that time of day.

When you review your own pharmacy incidents, consider the time of day as this can identify times when your team are consistently under pressure and risk compromising patient safety. Consider also when routine tasks are undertaken in the pharmacy. Quieter times of the day are usually when staff levels are at the lowest Staff at these times of day may be interrupted regularly to deal with “walk in” queries whilst trying to complete routine yet high risk activities such as preparation of daily prescriptions and

compliance aids. High risk tasks may be better carried out when more staff is available and a designated staff member and dispensary area is assigned solely to that task.
Pharmacy teams are reminded to follow standard operating procedures (SOP) at all times.

Degree of harm

70% submissions recorded no harm, 12% low risk of harm and 18% moderate harm.

Additional NPA patient safety resources

NPA MSO Report for England
Webinar on Dispensing incidents

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