Patient safety quarterly report: Quarter 1 (January – March) 2018

Introduction

This is the NPA Medication Safety Officer's (MSO) patient safety report for Quarter 1 of 2018. The number of incidents being reported has remained consistently high and the quality of incident reports submitted continues to improve.

We request that you submit complete reports and, where possible, avoid selecting '*other*' when answering questions.

! Please ensure the **no** patient identifiable information is included in the submitted reports; this is especially important with the approaching implementation of the General Data Protection Regulation (GDPR) on 25 May 2018.

NOTICEBOARD

Valproate and pregnancy prevention programme

The Medicines and Healthcare products Regulatory Agency (MHRA) has issued regulatory changes that mean that valproate medicines (Epilim®, Depakote® and other generic brands) must not be prescribed to women, or girls, of childbearing potential unless they are on the pregnancy prevention programme (PPP). This is due to possible risk of birth defects. New changes stipulate that pharmacists should:

- Ensure whole packs of valproate medicines are dispensed – all packs should have a warning label either on the carton or via a valproate sticker
- Discuss risks in pregnancy with female patients at the time of each dispensing episode of valproate medicines to ensure they have the Patient Guide and discussed with their healthcare professional their treatment choice and the need for contraception

The National Institute for Health and Care Excellence (NICE) is currently amending its guidelines and further information will be provided during the course of these changes.

MHRA alert – paraffin-based emollients: fire risk

- The MHRA recently released a reminder to healthcare professionals, including pharmacy teams, of the potential fire hazard risks associated when supplying paraffin-based emollients
- The advice includes — patients using clothing and dressings over paraffin-based emollients must not smoke due to the associated risk of clothing/dressings catching fire when in contact with open/naked flames
- Bedding and clothing that has been in contact with paraffin-based emollients should be changed regularly (preferably once a day) as the emollient can soak into the fabric, becoming a fire hazard

The National Patient Safety Alert (NPSA) published a suite of resources in 2007 on *"Fire hazard with paraffin-based skin products*" which includes information for healthcare staff, a poster and patient leaflet. To support implementation of this NPSA alert, a template SOP for dealing with paraffin-based products is available from the NPA.

Errors with methotrexate

In April 2018, the European Medicines Agency (EMA) announced a new review into the risk of dosing errors with methotrexate medicines. One of the most common errors involving methotrexate is patients incorrectly receiving a daily dose instead of a weekly dose. Even though this has been a recognised problem for several years, serious patient safety incidents are still occurring, some of which are fatal due to methotrexate overdose. Visual reminders on medicine packs such as cautionary wording have already been introduced to help pharmacy teams distinguish between the different strengths available.

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The NPA has produced a resource to support pharmacy teams when supplying oral methotrexate which contains a Standard Operating Procedure (SOP) to ensure the correct process is followed when methotrexate is supplied. The NPSA has also issued guidance to help improve compliance with oral methotrexate.

Recalls

The MHRA Defective Medicines Report Centre (DMRC) issues alerts to healthcare professionals in primary care, secondary care and wholesalers to inform them when a medicine is being recalled or if there are concerns about the quality in terms of safety or effectiveness. These alerts are graded in according to seriousness:

- Class 1: immediate recall – poses serious/life threatening risk to health
- Class 2: recall within 48 hours – may cause harm to patients but not life threatening
- Class 3: action within 5 days – unlikely to harm patients and defect is not related to patient safety
- Class 4: caution in use – poses no risk to patient

Pharmacy contractors are reminded to action alerts within the specific time frames and remember to share alerts with patients, patient representatives/carers, care homes and other relevant healthcare professionals, where required. Further information can be found on the MHRA website.

Quality payments scheme – NPA resources to help achieve patient safety quality criterion

The Pharmaceutical Services Negotiating Committee (PSNC) has announced the extension of the quality payment scheme for the first six months of 2018/19; the next review point will be on 29 June 2018. The patient safety report remains one of the eight quality criteria. If this criterion was claimed in 2017, the same results cannot be reported and therefore, the previous report will need to be reviewed and updated to demonstrate how the quality criterion has been met.

The NPA has produced general guidance, monthly and annual template report forms to help meet this patient safety quality criterion, available on the NPA website.

Frequent errors – common themes

Errors involving delivery drivers

Dispensing errors involving delivery drivers made up 5 per cent of incidents reported during Quarter 1 of 2018. The most common errors involving deliver drivers included:

- Medication delivered to the wrong patient due to similar looking and/or similar sounding names
  - One incident led to hospitalisation of a patient
- Medication delivered to the wrong address – due to incorrect address on the bag label and/or change of patient address but GP, lack of pharmacy awareness of this
- Standard Operating Procedures (SOPs) for delivery drivers not followed, or incorrectly followed

Another incident occurred whereby a temporary delivery driver posted medicines through the letterbox of a patient not at home. The delivery driver had not read the pharmacy SOPs and nor gained consent from the patient. Please see below for top tips when considering posting medicines through a letter box.

The NPA has produced a SOP on delivering pharmacy items, with a focus on patient safety. In addition, there is a separate SOP on the delivery of Schedules 2 and 3 Controlled Drugs (CDs).

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Errors involving methadone

Dispensing errors involving methadone were also commonly reported (4 per cent) during Quarter 1 2018. Examples of a number of cases reported include:

- Patients receiving standard methadone oral solution instead of sugar free
- Incorrect dose/quantity dispensed to the patient and supervised
- Confusion around the appropriate date, Home Office wording and supplies around the Bank Holidays

In one example, an empty bottle of methadone was found in another patient's bag, raising patient safety concerns.

In addition, there were many incidents reported as **wrong formulation** involved the following CDs in Quarter 1 2018, for example:

- Buprenorphine: tablet – oral lyophilisate
- Morphine: tablet – capsule
- Tramadol: capsule – modified release capsule

Errors involved in Repeat Management Service

There were several incidents (3 per cent) reported whereby pharmacy contractors are requesting prescriptions on behalf of patients but the surgery did not process the prescriptions, leaving the patient without medication for several days. In one particular incident, the pharmacy could not give an emergency supply of the medication as it was a Controlled Drug (CD) — buprenorphine patches (a Schedule 3 CD), leaving the patient in pain and discomfort.

Pharmacy contractors are reminded to ensure robust systems are in place to ensure the Repeat Management Service is running efficiently. The NPA has produced the '*Repeat prescription management service: guidance*', to support pharmacy teams implementing and managing a Repeat Management Service.

Other interesting errors – examples

Changes to Calpol (paracetamol) packaging

McNeil Products Ltd has recently changed their outer packaging for Calpol SixPlus® from a bright red colour to a dark red/purple colour. This is now very similar in colour to the Calpol® Infant suspension which already has an outer packaging with purple tones. This change has resulted in potentially serious patient safety incidents, whereby a patient accidentally bought the Calpol SixPlus® for a two year old child, which is double the strength of the correct product for this age range and could lead to overdosing the child. Given that the product has a licensing status of General Sales List (GSL); it is also easy for parents and/or carers to pick up the wrong product without any intervention and advice.

Primary and secondary care communication

During Quarter 1 of 2018, one patient safety incident reported involved an individual requesting tramadol from the surgery whilst in hospital. The tramadol prescription was processed by the surgery and pharmacy. On collection, the individual then also demanded his usual Repeat Dispensing prescriptions for gabapentin and amitriptyline. Two months supply was dispensed as requested by the individual, however, neither the GP nor the pharmacy was aware that the patient had been admitted into hospital, which had been in relation to an attempted life ending overdose.

Post-dated prescriptions

There were cases reported where post-dated prescriptions were dispensed and handed to patients before they were due. Pharmacy team members must ensure they are more stringent when prescriptions are received to ensure prescriptions meet the legal requirements. During the final

accuracy check, double checking the appropriate date is vital. If post-dated prescriptions are received, this should be clearly highlighted and segregated from other prescriptions, until it is due.

Key statistics and frequently appearing drugs

Medication error categories

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

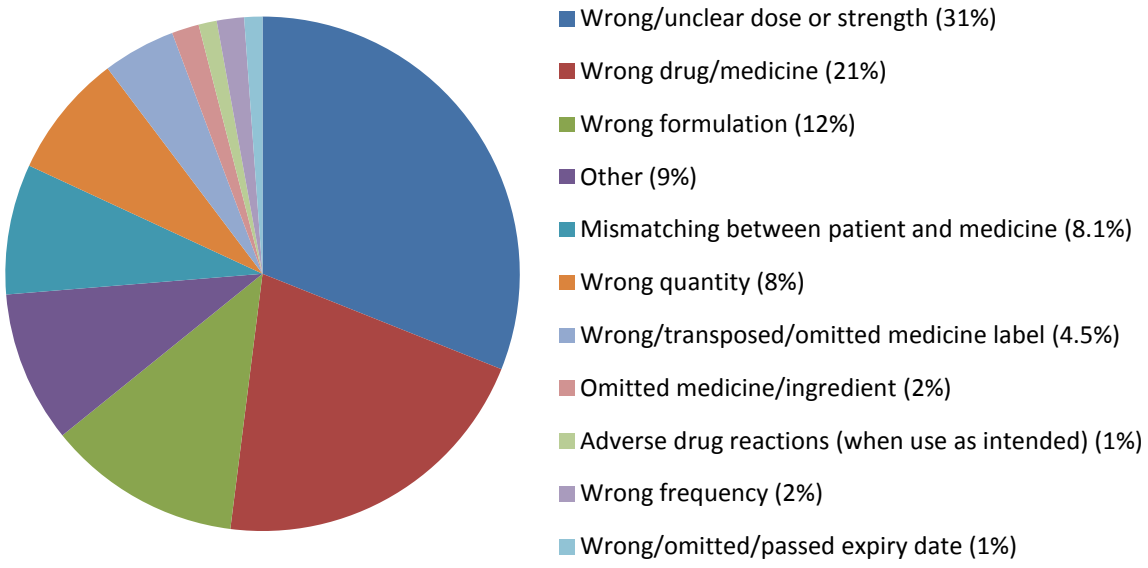

Figure 1: Medication errors reported during Quarter 1 by category

Key findings

- The two most common error categories reported continued to be dispensing a **wrong/unclear dose or strength** (31 per cent) and dispensing the **wrong drug/medicine** (21 per cent)
- The top look-alike sound-alike medicines reported in the **'wrong drug/medicine'** category are indicated in the table below:

Top mistaken medicines	
Amitriptyline	Amlodipine
Colchicine	Cyclizine
Pantoprazole	Paroxetine
Pregabalin	Gabapentin

- Other trends which were found in the wrong drug/medicine category were specifically with brand names:

Branded medicines	
Spiriva® Respimat® *(tioptropium)*	Spiolto® Respimat® *(tiotropium/olodaterol)*
Calcichew *(calcium carbonate)*	Calcichew D3 Forte *(calcicum carbonate/colecalciferol)*
Vensir *(venlafaxine)*	Viazem® *(diltiazem)*
Zestoretic *(lisinopril/hydrochlorothiazide)*	Zestril *(lisinopril)*

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- Mismatching between patient and medicine is continually rising (8.1 per cent in Quarter 1) compared to previous Quarters. Most errors included:
    - Patients receiving bags with their names on but containing medicines for a different patient
    - Two patients with similar names but placed into one bag
    - Well known/regular patients coming into the pharmacy to collect and not confirming their name and address during the handout process

Contributing factors

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

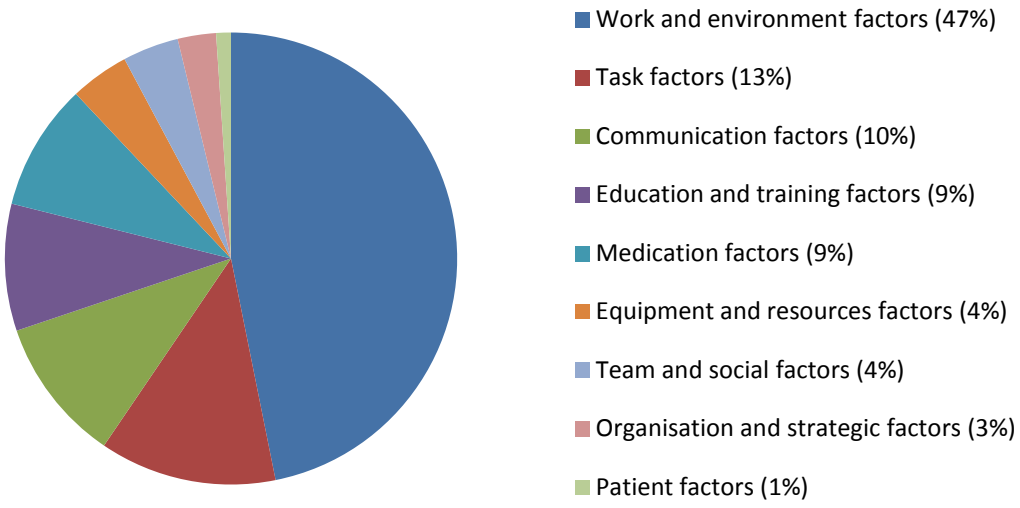

Figure 2. Contributing factors to errors reported in Quarter 1.

Key findings

- 'Work and environment factors' continues to be the main contributing factor, accounting for 47 per cent of errors
- This is followed by 'task and communication factors' – pharmacy teams are reminded to follow **all** SOPs and ensure communication with both healthcare professionals, and patients, is written and auditable

Degree of harm

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

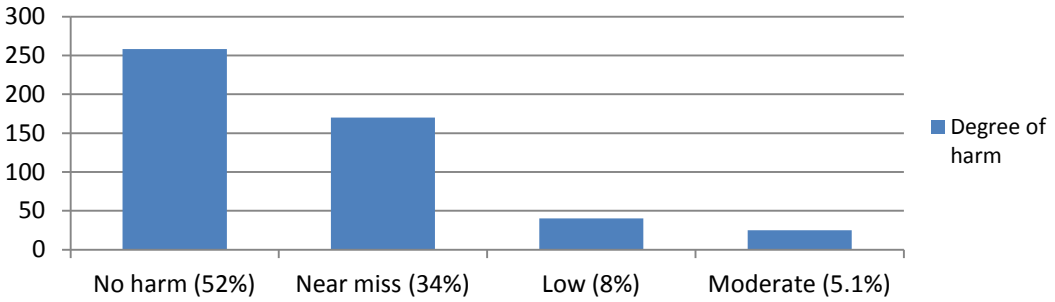

Figure 3. Errors for Quarter 1 categorised by degree of harm

Key findings

- Errors involving no harm to the patient continue to be in the majority of errors reported (52 per cent of errors reported)

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Top tips for minimising risk /general action points

Quality Payment – patient safety report

The purpose of the annual patient safety report is to improve patient safety, by encouraging pharmacy teams to share learning from incidents locally and nationally, identify what has been learnt from incidents and actions to minimise risks. Reflection is therefore a key element. The report should cover the previous 12 months, so it may be helpful to carry out a monthly analysis of incidents and issues which will provide a useful summary when compiling the annual report.

The core reporting principles are:

- **REPORT:** report all errors and near misses and involve the whole team
- **LEARN:** identify and investigate causes of errors and use them as learning opportunities
- **SHARE:** discuss with others and promote learning
- **ACT:** implement changes to practice
- **REVIEW:** review changes to practice

There is currently no requirement for the annual patient safety report to be sent to NHS England; however it will need to be kept as evidence of meeting the quality criteria.

Below are top tips to consider when completing the patient safety report:

- ✓ Collate information monthly and combine this annually
- ✓ Involve **all** pharmacy staff to maximise learning
- ✓ Ensure the annual report does not replace previous provisions for incident reporting
- ✓ Look at the MSO quarterly reports for ideas on improving patient safety
- ✓ Think about patient safety on a wider scale both within and outside of pharmacy
- ✓ Action **all** National Patient Safety Alerts, and record what you have done
- ✓ Reflection is important

Posting medicines – letter box

Medicines, including CDs, legally can be posted. However, there are a number of risks associated and the following should be considered:

- The medicine could be delivered to an incorrect address, breaching patient confidentiality
- Pets/young children/vulnerable patients could have access to medicines without supervision
- Less patient contact and opportunities to address any issues
- A clear audit trail would not exist as the patient signature cannot be obtained
- The responsible pharmacist is responsible for the patients journey until the medicine physically reaches the patient

Posting medicines through a letter box should be a last resort, however if it is deemed necessary, the following should be considered:

- ✓ An SOP should be in place for the delivery of medicines, including a process for posting the medicines through a letter box
- ✓ The indemnity insurer of the pharmacy should be contacted to ensure the process is covered if an incident occurred
- ✓ Patient consent/letter of authority should be sought that the patient authorises their medicines to be posted through the letter box and that there are no pets/young children/vulnerable patients present in the property

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