Medicines Management

Quarter 2 Medication Incident Report 2014-15

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Executive Summary

- Majority of medicines related incidents result in no harm or minor harm
- Majority of incidents occurred due to dispensing errors in community pharmacy or at MEHT
- Several reported incidents were no fault incidents; usually resulting from a secondary provider, however these incidents were identified by Provide
- Fewer omitted and delayed doses were reported in Quarter 2
- Near miss incidents primarily occurred due to poor discharge from the acute and some dispensing errors both in community pharmacies and secondary care.
- 20% (5 out of 25) of all reported incidents resulted in a near miss
- 20% (5 out of 25) of all reported incidents resulted from an incident involving Insulin

Introduction

1.1 Medication Errors and Patient Safety Incidents

The MHRA recently published a Stage Three Directive: Improving medication error incident reporting and learning.

The National Reporting and Learning System defines a “patient safety incident” as “any unintended or unexpected incident, which could have or did lead to harm for one or more patients receiving NHS care.”

Medication errors are any patient safety incidents where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines. These incidents can be divided into two categories;

- Errors of commission e.g. wrong medicines or wrong dose

- Errors of omission e.g. omitted dose or failure to monitor such as international normalised ratio for anticoagulant therapy

All medication incidents are reviewed by the Head of Medicines Management when submitted and at the final approval stage.

Medication incidents are monitored via Quality and Safety and the medicines management committee. This report provides an overview of the incidents across Provide for Quarter 2 2014-15.

Where local actions are not able to resolve an issue, or trends are emerging that indicate wider actions are required, the Medicines Management Committee can agree further actions (such as a risk assessment, or developing / updating a standard operating procedure) for the appropriate team or escalate the issue as a risk via the risk register.

1.2 High risk medicines and processes

Certain subsets of medicines or particular processes are analysed separately in **Part B** to ensure they receive appropriate focus and monitoring. These are:

1.1.1 Controlled drugs (CDs)

Incidents involving CDs are identified and appropriate actions are taken to mitigate risk. CD incidents are also monitored by the organisations Accountable Officer for Controlled Drugs

(CDAO) on a monthly basis and reported quarterly. Incidents are reviewed immediately if the incident is significant.

1.1.2 Insulin incidents

Insulin is a high risk medicine and severe harm due to maladministration is a 'never event'. Due to the high number of insulin incidents an insulin action plan has been developed and is monitored via the Quality and Safety Committee.

1.1.3 Omitted and delayed doses

Medicine doses may be frequently omitted or delayed in hospital for a variety of reasons. Whilst only a small percentage of these occurrences may cause harm or have the potential to cause harm, it is important to recognise that harm can arise from the omission or delay of critical medicines. This can happen as a result of errors during the prescribing, dispensing, supply or administration of the medicines.

The National Patient Safety Alert on Reducing Harm from Omitted and Delayed Medicines (2010) highlighted the risks of omitted and delayed medicines in hospitals and stated that:

"Between September 2006 and June 2009, the NPSA received reports of 27 deaths, 68 severe harms and 21,383 other patient safety incidents relating to omitted or delayed medicines"

This can also be an issue in community settings and ongoing monitoring of the trend is required.

1.1.3.1 High Risk Medicines

Critical medicines where timeliness of administration is crucial include anti-infectives, anticoagulants, insulin, resuscitation medicines and medicines for Parkinson's disease.

This report will highlight current risks with these medicines.

1.1.4 Syringe driver incidents

To encourage understanding of current issues and monitor incidents including medication and equipment issues with syringe drivers (some of these issues will overlap with the CD issues above due to the nature of the medicines delivered using syringe drivers).

1.1.5 Near Miss Incidents

To encourage learning and reporting of near miss incidents to identify key learnings and improve patient safety.

1.2 Definition of levels of harm

- No harm incidents are near misses or incidents where there has been no affect on the **patient.**

- Low Harm incidents are any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care

- Moderate harm incidents are any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

- Severe harm incidents are any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care

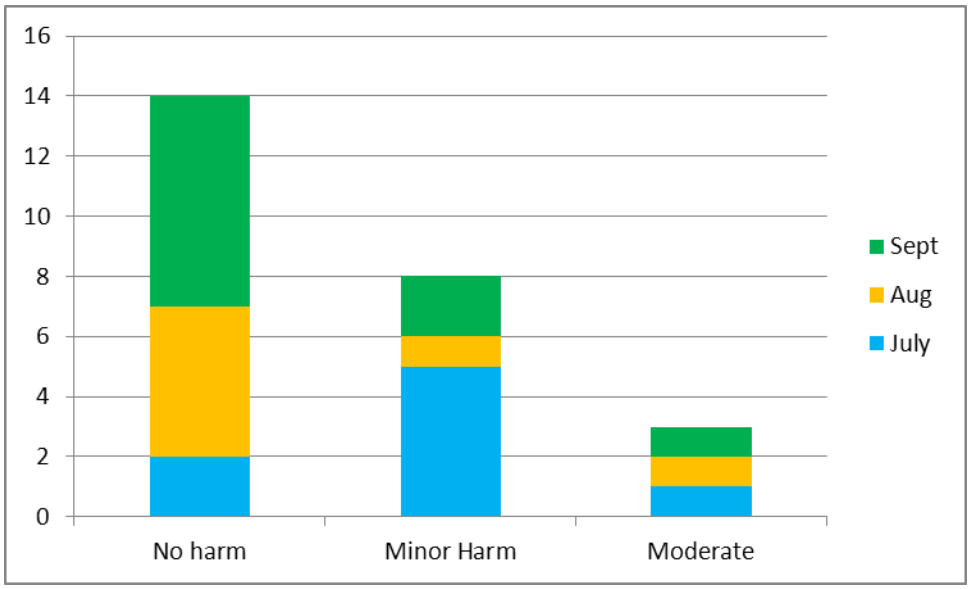
- Death: Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care

2. All medication related incidents

2.1 Number of reports by severity

The following graph shows the incidents by month of report and severity for Quarter 2 1st July 2014 to 30th September 2014

Fig 1: Breakdown of medication incident trends by severity Q2 (July 14 – Sept 14)



- A total of 25 incidents were reported for Q2

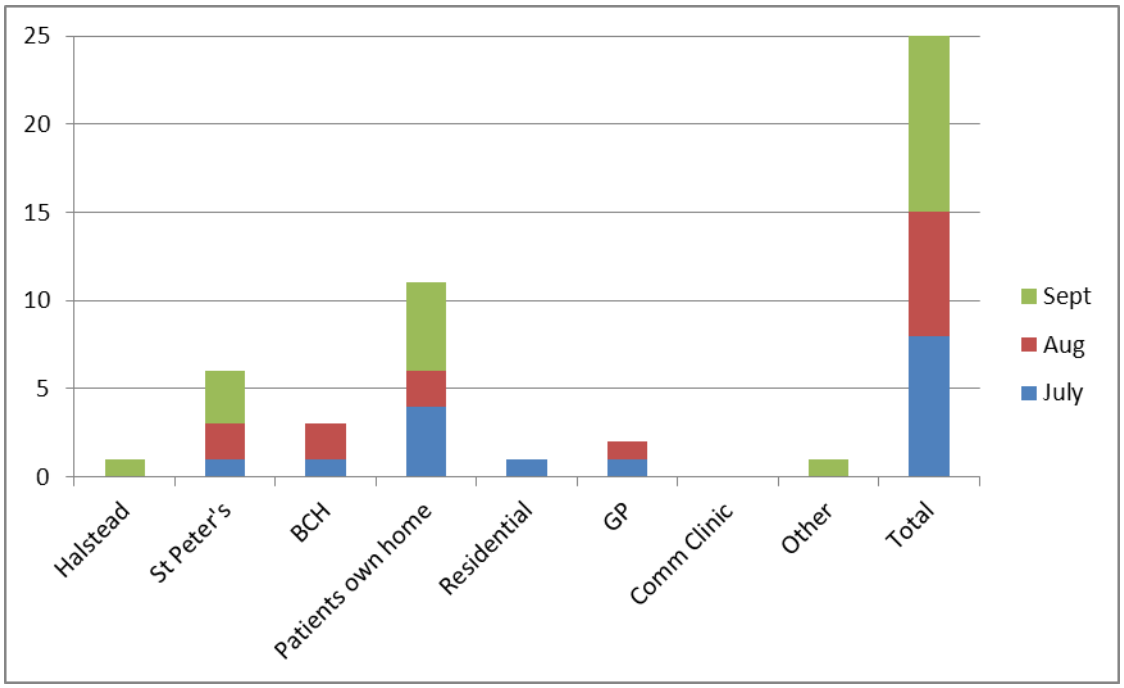
- This analysis demonstrates that the majority of medication incidents result in no harm or minor harm.

- Where moderate harm has occurred services are asked to investigate further and feedback to MMC and Quality and Safety with further information and an outline of what has been done to mitigate this risk.

- The low level of reporting suggests that not all incidences are being reported via datix; this can be evidenced via the Community Hospital Pharmacist intervention log.

The following graph shows the breakdown of all incidents by risk grading and locality.

Fig 2: Graph of all incidents by Locality and month Q2 (July 14 – Sept 14)



- Majority of minor harm incidents occur in the patient's home
- Integrated Care Teams have recorded the most incidents in this quarter, most of these are minor or no harm incidents
- Two out of three moderate incidents have occurred in GP surgeries

Moderate harm incidents

There were three moderate harm incidents in Q2 (July 14 – Sept 14)

These incidents have been subject to an increased focus on the actions to prevent recurrences where possible.

Moderate Harm incidents:

1. At St Peter's the moderate harm incident was the result of a poor discharge from Lister Ward, MEHT. The doctors discharge letter and the medication chart accompanying the patient stated that he patient was an non-insulin dependent diabetic and documented as patient taking gliclazide 80mg

   The patient is now on insulin, the discharge letter failed to mention this

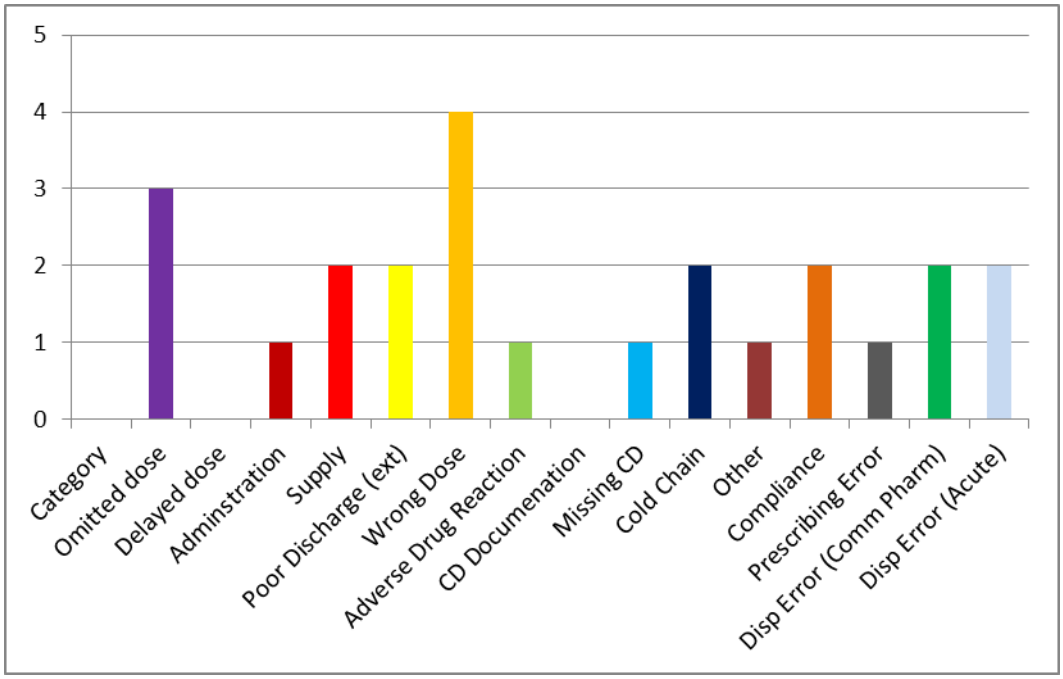
   During Medicines reconciliation it was noted that there were several discrepancies between the discharge letter and paperwork later faxed to the ward

   There were also several errors in prescribing on the discharge letter

2. The other two incidents related to a break in the cold chain due to severe weather conditions resulting in the loss of vaccines

The following graph shows the percentage of sub-categories for all incidents in Quarter 2 2014-15.

Fig 3: Sub-Categories for all incidents Quarter 2 (July 14 – Sept 14)



This highlights that:

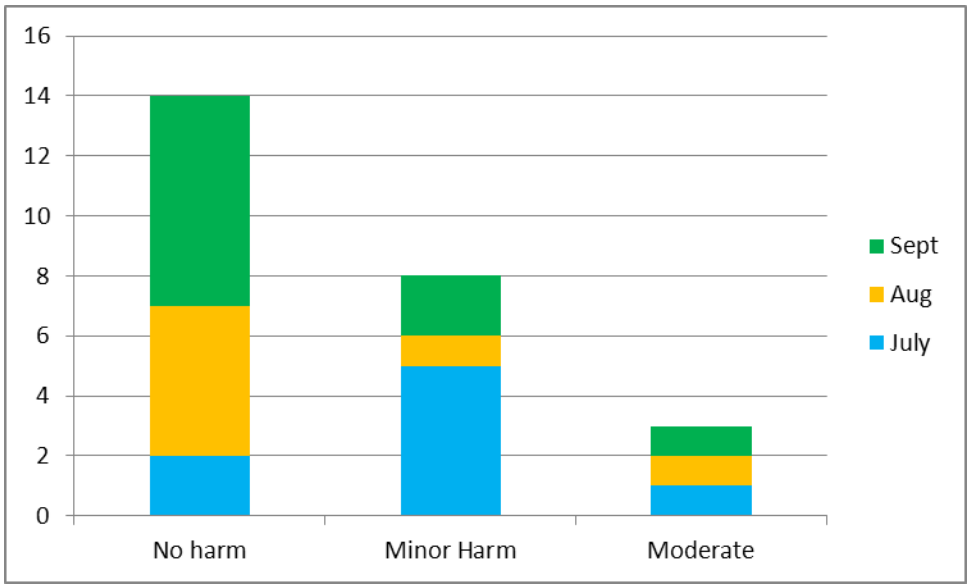
- A high level of reported incidents occur during the administration stage of the medicines pathway which includes wrong drug, wrong dose and wrong route (coincides with the findings of the NPSA Alert)
- A high level of administration errors resulted from a wrong dose
- There was one reported incident of an adverse drug reaction, where allergy was documented as none known; however daughter of patient stated that the patient had an allergy to Butrans
- No delayed medicines have been reported in Quarter 2
- A total of thirteen incidents were no fault incidents; but have been included as reported on datix; these included poor discharge, supply issues for medicines and unknown drug allergies
- Issues from a secondary provider, these included poor discharge, delayed in supply of medicines, inappropriate supply still occurs frequently. Incidents are reported to the Secondary porvider; however full investigation reports are rarley received back.These continue to be addressed via contract meetings with the provider (MEHT)

- 24 incidents are recorded here, as two identical data incidents were received for the incorrect dose of Methotrexate for a juvenile, which on investigation transpired to be a prescribing error at Broomfield

Incident risk

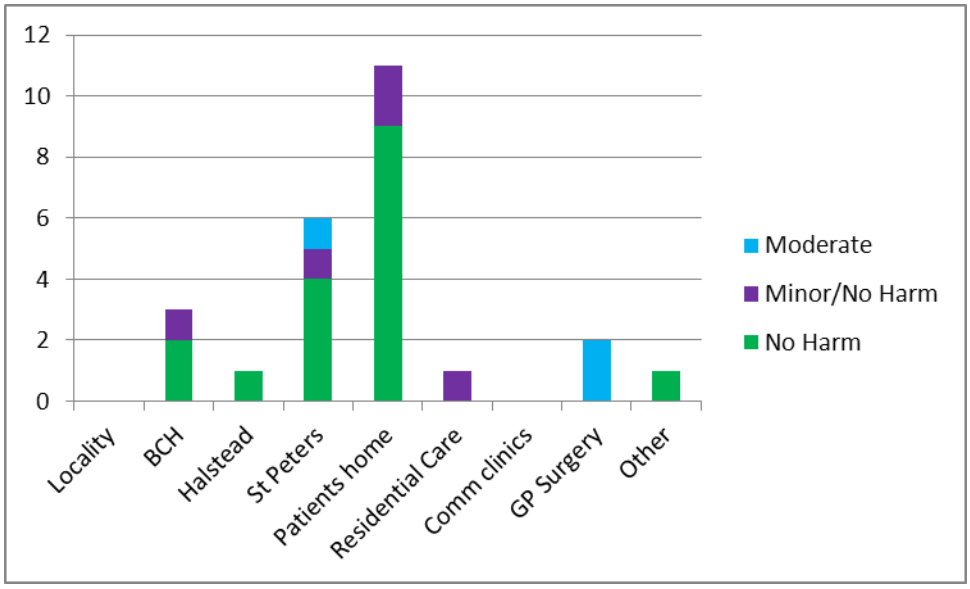
The following graph shows all incidents by risk classification for Quarter 2 (July 14 – Sept 14):

Fig 4: All incidents by risk Q2 (July 14 – Sept 14)



- The majority of incidents reported are no harm or minor harm
- Overall number of incidents reported is lower than what would be expected

Fig 5: Incidents by risk grading and locality Quarter 2 (July 14 - Sept 14)



This shows that:-

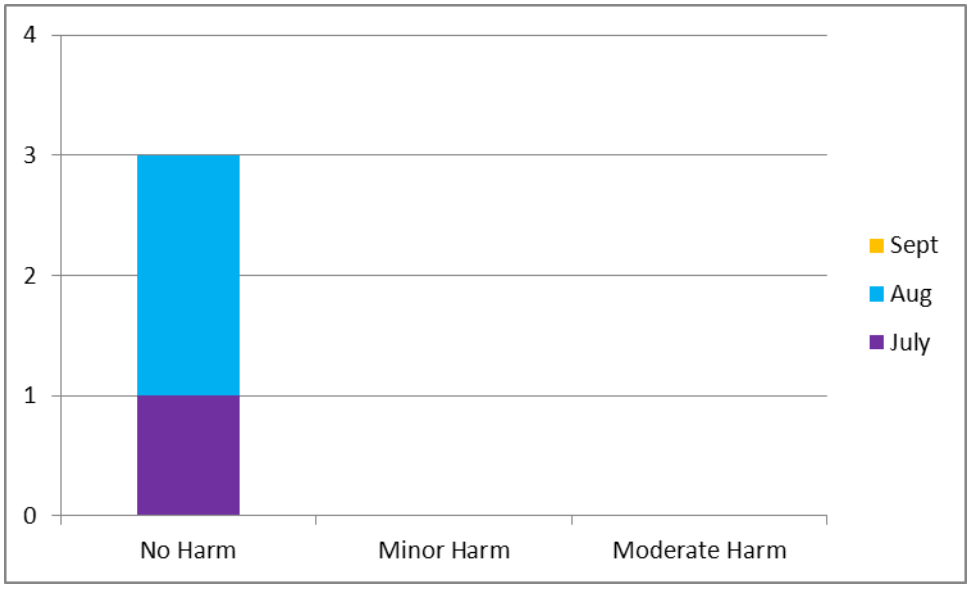
- Moderate incidents have occurred only on a community hospital ward and in GP Surgeries
- The highest number of incidents were reported in Patients Homes; however the majority of these were no harm or minor harm incidents

3. High Risk Medicines and Processes

3.1 Controlled Drugs

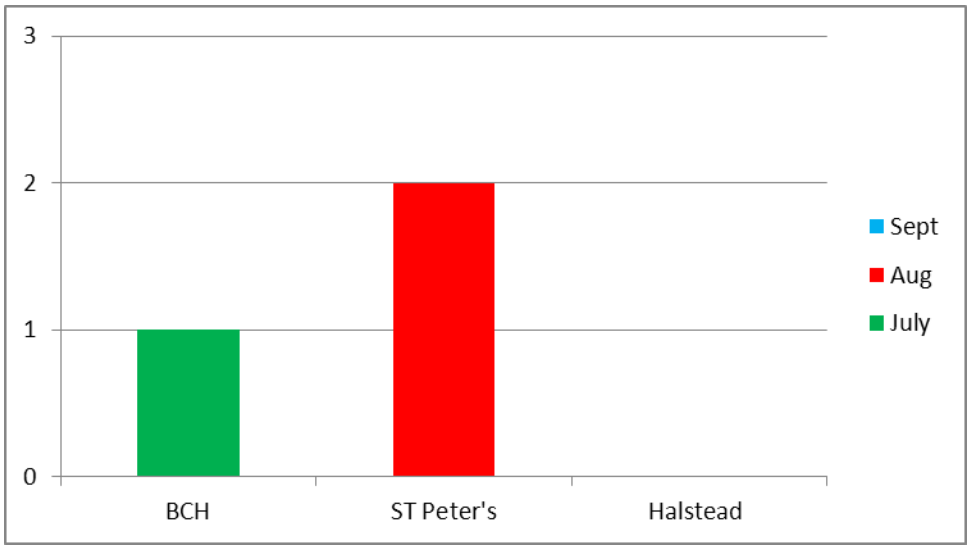
There were a total of 3 CD incidents during Q2 2014-15; all resulting in no harm

Fig 6: Controlled drug incidents by month and severity – Q2 (July 14 – Sept 14):



The following graph shows the location for controlled drug incidents for Q2 (July 14 – Sept 14)

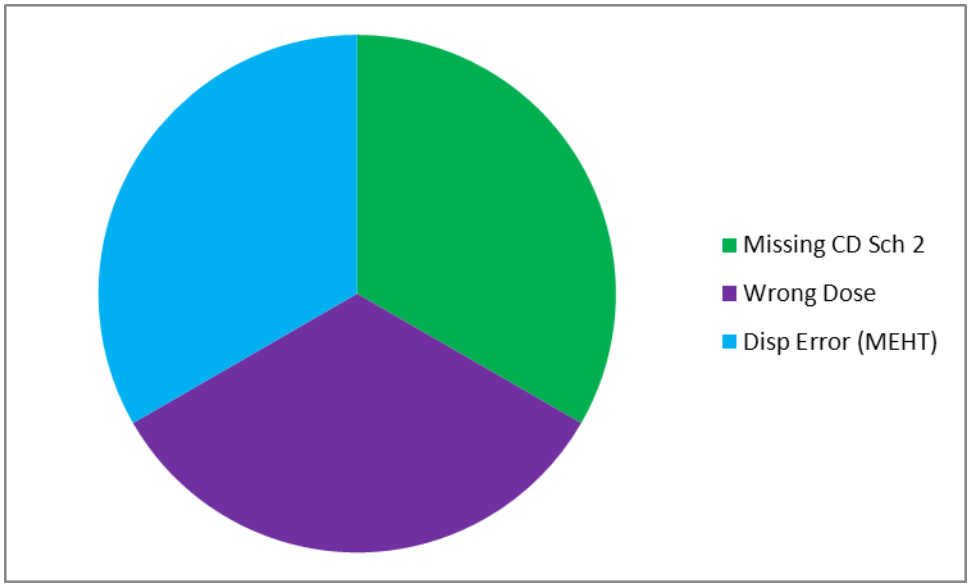
Fig 7: Location of controlled drug incidents for Q2 2014-15



- A total of three CD incidents were reported; all resulting in minor harm

The incident categories for CD incidents for Q2 2014-15 are as follows:

Fig 8: Controlled drug incident categories



- One of these incidents involved the loss of an oxycodone tablet that was eventually found

- Another incident resulted from a nurse administering a controlled drug prescribed previously (Zomorph 10mg) instead of the Morphine Sulphate currently prescribed (This incident happened the day after the medication was changed)

- The third was a dispensing error where Zomorph 60mg (60) were received instead of Zomorph 10mg from MEHT pharmacy.

3.2: Insulin incidents

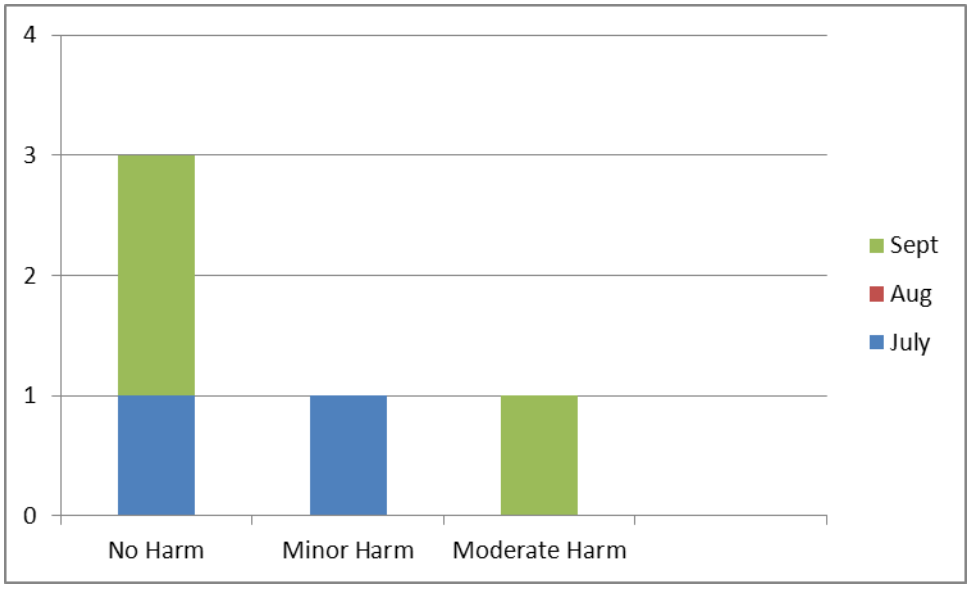
Insulin is a high risk drug that has been the subject of two NPSA patient safety alerts, one relating to the safe administration of insulin and one to introduce improved patient information and communication via the insulin passport.

This summary of current insulin incidents within Provide will help to identify current issues with insulin; particularly with administration and supplement the work of the insulin task group to support a further reduction in the number of insulin incidents.

All insulin incidents recorded for Q2 2014-15 were minor harm incidents

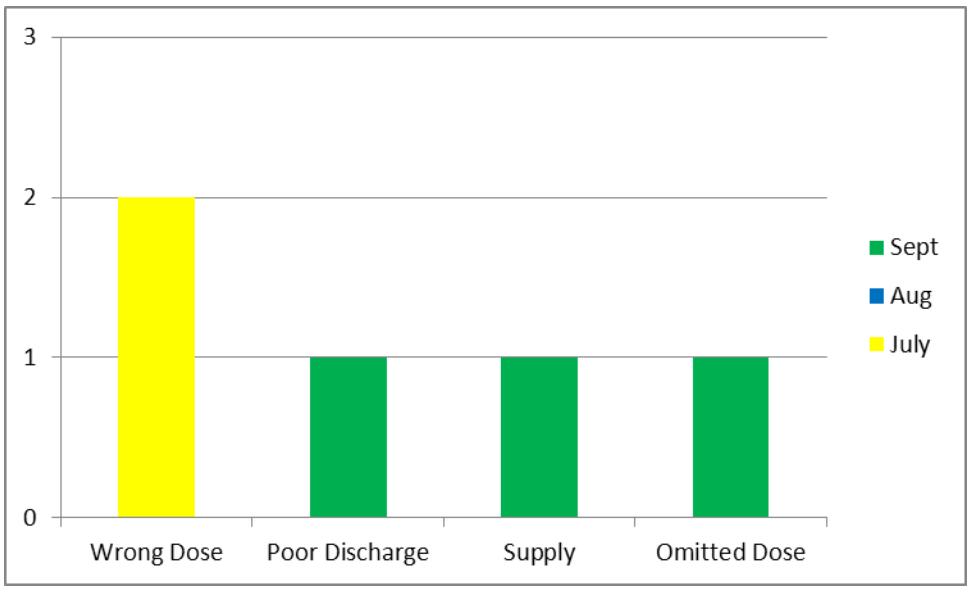
The insulin action plan was developed in October and has significantly supported a reduction in the number of insulin incidents after its launch.

Fig 9: Insulin Incidents and severity of Harm Q2 (July 14 – Sept 14)



- One Moderate harm incidents were reported during Quarter 2 relating to insulin Resulting from a poor discharge from MEHT and inaccurate discharge prescription which omitted insulin (Near Miss)

Fig 10: Insulin incidents by subcategory for Q2 (July 14 – Sept 14)



The incident of errors indicates that:-

- Although the majority of reported insulin incidents were due to administration errors, a high proportion if incidents related to poor discharge from the acute and supply issues
- A total of 5 insulin incidents were reported in Q2
- Both of the wrong dose incidents related to a double dose of insulin

Root Cause Analysis/ Guidance

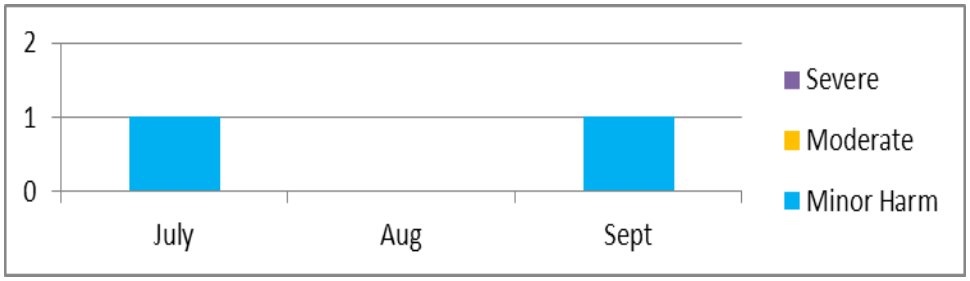
The medicines management team have developed a root cause analysis tool to support learning from all insulin errors. This was rejected at the Harm Free Care Group and will be revisited to go to MMC for approval in November.

3.2 Omitted and Delayed Doses

The National Patient Safety Agency (NPSA) issued a Rapid Response Report on reducing harm from omitted and delayed medicines in hospital (RRR009) in February 2010.

The annual audit of omitted and delayed critical medicines has been completed for 2013-14 to highlight system improvements required to reduce harm from omitted and delayed medicines and an action plan will be developed to reduce the incidence of delayed and /or omitted doses in practice.

Fig 11: Graph of number of missed or delayed doses (by severity) Q2 (July 14 – Sept 14):



- Two minor harm omitted dose incidents were reported for Q2 2014-15
- 8% of all reported incidents in Q2 were due to a delayed and/or omitted dose
- Both incidents were reported in a patients home

3.3 Anti-Infectives

Between September 2006 and June 2009 the NPSA received reports of 27 deaths, 68 severe harms and 21,383 other patient incidents relating to omitted or delayed medicines. Of the 95 most serious incidents, 31 involved anti-infectives.

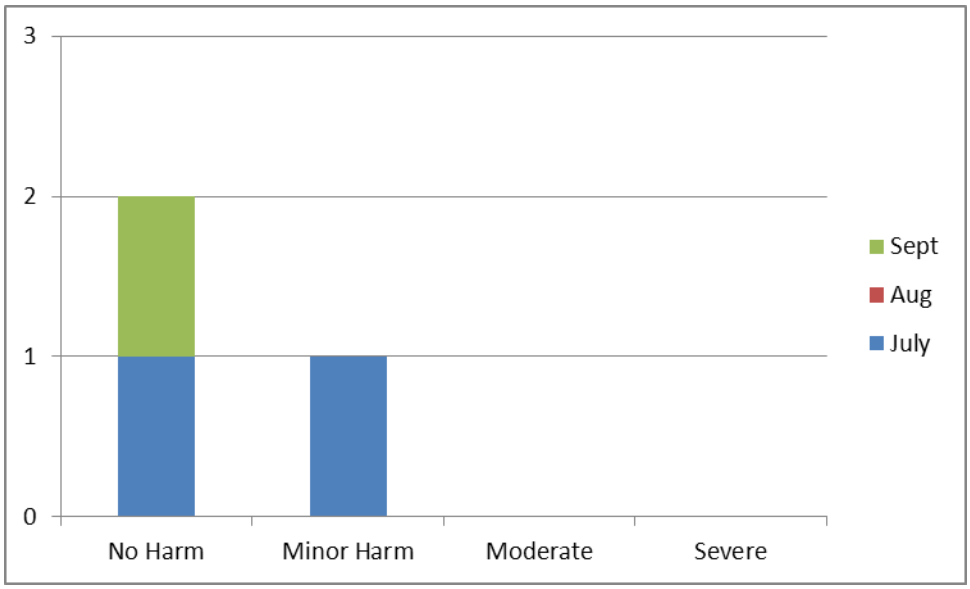
During Quarter 2; one antibiotic (septrin) had been delayed/omitted in a patients home, this was a prescription for Septrin, with repeated supply problems in the community; MEHT have stated that they are unable to supply as this medication is for hospital use only. The patient is very ill and there has been some investigation by the CCG Medicines Management team, however no solution has been found. Community pharmacies continue to struggle with the supply of this.

3.4: Anticoagulant Incidents

This Patient Safety Alert advised healthcare organisations to take steps to manage the risks associated with the prescribing, dispensing and administering of anticoagulants.

Anticoagulants are one of the classes of medicines most frequently identified as causing preventable harm and admission to hospital.

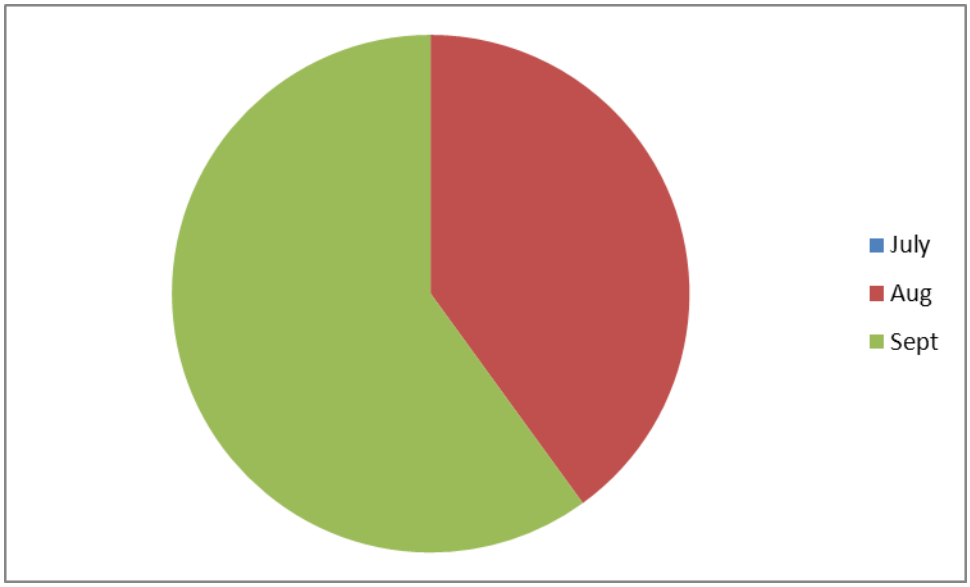
Fig 12: Anticoagulant Incidents and severity of Harm Q2 (July 14 – Sept 14)



- All incidents occurred in patients' homes
- Two out of the three incidents resulted from an omitted/delayed dose

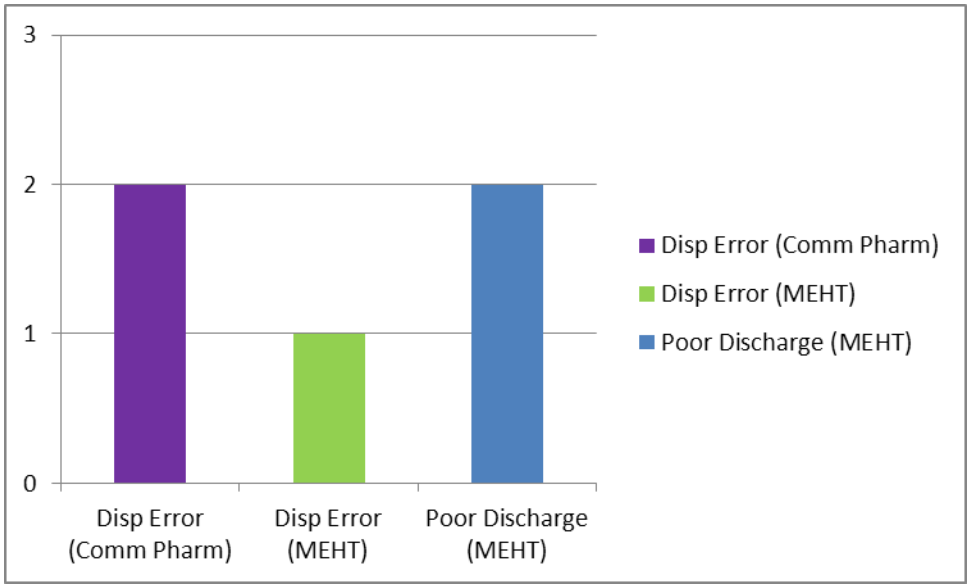
3.5 Near Misses

Fig 13: Near Misses and Severity of Harm Q2 (July 14 –Sept 14)



- A total of five reported incidents were a near miss; all incidents varied in locality and no clear pattern was identified
- All near miss incidents resulted in no or minor harm

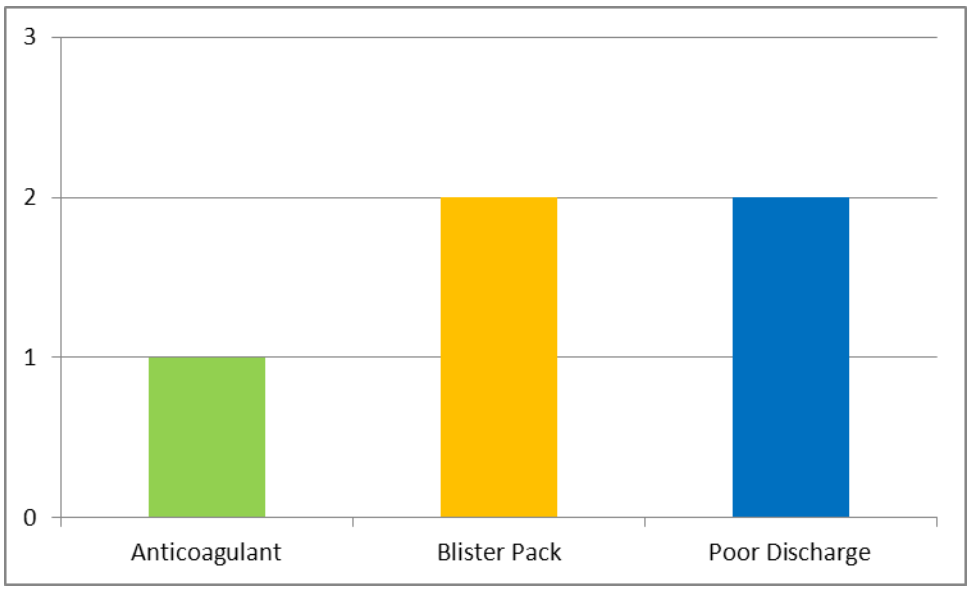
Fig 14: Near Misses Incidents Q2 (July 14 – Sept 14)



- The majority of reported near miss incidents were due to a secondary provider; resulting from poor discharge or dispensing errors identified by Provide.

- These incidents were identified before administration therefore mitigating harm to the patient

Fig 15: Near Miss Incidents by Sub-category Q2 (July 14 – Sept 14)



- One Near Miss event occurred due to Methotrexate being wrongly dispensed by MEHT pharmacy (Methotrexate 17.5mg in 0.35ml prefilled pen was dispensed instead of Methotrexate 7.5mg for a child).

- One Near Miss event occurred due to poor prescribing of Pramipexole at Broomfield Hospital (Pramipexole was prescribed as twice a day; however during medicines reconciliation at Halstead hospital it was identified that Pramipexole should have been prescribed three times a day except Wednesday and Friday where the dose was four times a day)
- Another Near Miss event resulted from a poor discharge from Lister Ward at MEHT; where the discharge letter received by St Peter's Hospital with inadequate notes was incorrect; this included the omission of insulin for an insulin dependent diabetic wrongly documented at non-insulin dependent. Altogether there were seven prescribing errors on the discharge letter; this included the omission of insulin, Senna and Ramipril, wrong dose of furosemide.

4. Summary

A total of 25 (one of which was reported twice) medicines incidents were reported for Quarter 2; of these 20% (5/25) of all were due to a near miss and another 20% were related to insulin.

Fewer CD incidents were reported on Quarter 2. One of these incidents was due to a dispensing error at MEHT where Zomorph 60mg was dispensed instead of 10mg.

All MEHT errors are reported to the Chief Pharmacist for further investigation; the incident with Methotrxate was investigated and although provide has not received a copy of the prescription written by the paediatric rheumatologist; assurance has been received to confirm the prescription was dispensed accurately and this incident was the result of a prescribing error.