EAHP – Keynote Thursday 26th March 2015

Developing a safety culture and how to progress effectively

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Conflict of interest statement

- No conflict of interest

Definitions

- **Patient safety**

  the prevention of errors and adverse effects to patients associated with health care

  http://www.euro.who.int/en/health-topics/Health-systems/patient-safety

- **Safety Culture**

  the way patient safety is thought about, structured and implemented in an organisation

- **Safety climate**

  is a subset of safety culture and concern staff perceptions of safety in relation to management support, supervision, risk- taking, safety policies and practices, trust and openness

  http://www.health.org.uk – Does safety culture affect patient outcome 2011

Evidence of preventable harms in hospital

	Study	Study focus (date ofadmissions)	Number of hospital admissions	Number of adverse events	Adverse event rate (%)
1	United States (Harvard Medical Practice Study)	Acute care hospitals (1984)	30 195	1 133	3.8
2	United States (Utah–Colorado study)	Acute care hospitals (1992)	14 565	475	3.2
3	United States (Utah–Colorado study)[a]	Acute care hospitals (1992)	14 565	787	5.4
4	Australia (Quality in Australian Health Care Study)	Acute care hospitals (1992)	14 179	2 353	16.6
5	Australia (Quality in Australian Health Care Study)[b]	Acute care hospitals (1992)	14 179	1 499	10.6
6	United Kingdom	Acute care hospitals (1999–2000)	1 014	119	11.7
7	Denmark	Acute care hospitals (1998)	1 097	176	9.0

Source: World Health Organization, Executive Board 109th session, provisional agenda item 3.4, 5 December 2001, EB 109/9.

a Revised using the same methodology as the Quality in Australian Health Care Study (harmonising the four methodological discrepancies between the two studies).
b Revised using the same methodology as Utah–Colorado Study (harmonising the four methodological discrepancies between the two studies).
Studies 3 and 5 present the most directly comparable data for the Utah–Colorado and Quality in Australian Health Care studies.

Preventable deaths in English acute hospitals

- Retrospective case record reviews of 1000 adults who died in 2009 in 10 acute hospitals
- Reviewers judged 5.2% of deaths as having a > 50% of being preventable (11,859) patients
- Poor clinical monitoring 31%,
- Diagnostic error 30%,
- Drug or fluid management 21.1% (2,502)

Hogan H, Healey F, Neale G, et al. BMJ Qual Saf (2012). doi:10.1136/bmjqs-2012-001159

Medicine related admissions to hospital

Review of 18,820 unplanned admissions to a hospital in the UK found 1,225 (6.5%) admissions involved an adverse drug reaction. It was judged that in 80% cases the ADR directly led to the admission. The majority (72%) of ADR-related admissions were judged as avoidable, including medication errors. The median bed stay was eight days, accounting for 4% of the hospital bed capacity. The projected annual cost of such admissions to the NHS was £466 million.

Pirmohamed M, et al BMJ, 2004:329:15-19 do1:10.1136/bmj.329.7456.15

Almost 13 000 unplanned admissions to a hospital in the Netherlands were screened, of which 714 (5.6%) were medication related. Almost half (46.5%) of these admissions were potentially preventable.

Leendertse AJ et al. Arch Intern Med. 2008;168(17):1890-1896. doi:10.1001/archinternmed.2008.3

Example 1 of a medication error report

Baby dies after blundering doctors gave him TWELVE times the normal dose of epilepsy drugs

A seven month old baby boy died after doctors gave him 12 times the correct amount of anti-epilepsy drugs he should have received in 24 hours, an inquest heard.

Lucas Holzscheiter died in hospital as a result of a massive accidental overdose

http://www.dailymail.co.uk/news/article-1289437/Baby-died-doctors-gave-12-times-normal-dose-epilepsy-drugs.html

Example 2 of a medication error report

Mother of four dies after blundering nurse administers a TEN times drug over doses

A mother of four died after a nurse at a trouble-hit hospital gave her ten times the amount of a drug she was supposed to receive.

Arsula Samson, 80 had a heart attack in hospital after she was give an over dose of potassium chloride injection

http://www.dailymail.co.uk/health/article-1359778/Mother-dies-nurse-administers-TEN-times-prescribed-drug.html

Example 3 of a medication error report

Two cancer patients died just hours after being given medication overdoses

Two cancer patients died hours after being given overdoses of drugs used to combat side effects of treatment.

Paul Richards 35, and Baljit Singh Sunner 36 died hours after being given up to five times the recommended doses. They were both being treated for different forms of cancer

There was confusion over amphotericin injection having different forms and doses. Fungizone is prescribed 1 mg per kg patients weight and Ambizone and Abelcet with doses of 3 – 5 mg per Kg

http://www.dailymail.co.uk/news/article-472707/Two-cancer-patients-died-just-hours-given-medication-overdose.html

Example 4 of a medication error report

Diabetic patient unlawfully killed after newly qualified nurse gave her TEN times too much insulin

A diabetic pensioner was injected with ten times too much insulin

Margaret Thomas aged 85 years was injected with 3.6ml of insulin instead of 0.36ml

http://www.dailymail.co.uk/news/article-1165072/Diabetic-patient-unlawfully-killed-newly-qualified-nurse-gave-TEN-times-insulin.html

Example 5 of a medication error report

Widow, 71, died after doctors ignored penicillin warning

A grandmother died in hospital after doctors gave her penicillin even though her notes and drug chart made it clear that she was allergic to the drug.

June Cutmore was even wearing a red wristband to draw attention to her allergy.

The 71 year old widow went into anaphylactic shock and died after being injected with Augmentin

http://www.dailymail.co.uk/news/article-1080842/Widow-71-died-doctors-ignored-penicillin-warning.html

World Health Assembly Resolution WHA55-18, 2002

World Health Organization | Patient Safety
A World Alliance for Safer Health Care

- all workers accept responsibility for the safety of themselves, their co-workers, patients and visitors
- prioritise safety above financial and operational goals
- encourage and reward the identification communication and resolution of safety issues
- provide organisational learning from accidents
- Provide appropriate resources, structure and accountability to maintain effective safety systems

http://www.who.int/patientsafety/about/wha_resolution/en/

Manchester Patient Safety Framework (MaPSaF)

The levels of patient safety culture explained

Level	Description
A – Pathological	Why do we need to waste our time on patient safety issues?
B – Reactive	We take patient safety seriously and do something when we have an incident.
C – Bureaucratic	We have systems in place to manage patient safety.
D – Proactive	We are always on the alert/thinking about patient safety issues that might emerge.
E – Generative	Managing patient safety is an integral part of everything we do.

http://www.nrls.npsa.nhs.uk/resources/?entryid45=59796

MaPSaF 2

Evaluation sheet (sample)

Dimension of patient safety culture	A	B	C	D	E
1. Commitment to overall continuous improvement					
2. Priority given to safety					
3. System errors and individual responsibility					
4. Recording incidents and best practice					
5. Evaluating incidents and best practice					
6. Learning and effecting change					
7. Communication about safety issues					
8. Personnel management and safety issues					
9. Staff education and training					
10. Team working					

T = Team O = Organisation

MaPSaf 3

Dimension	Description
1. Commitment to overall continuous improvement	How much is invested in developing the quality agenda? What is seen as the main purpose of policies and procedures? What attempts are made to look beyond the organisation for collaboration and innovation?
2. Priority given to safety	How seriously is the issue of patient safety taken within the organisation? Where does responsibility lie for patient safety issues?
3. System errors and individual responsibility	What sort of reporting systems are there? How are reports of incidents received? How are incidents viewed – as an opportunity to blame or improve?
4. Recording incidents and best practice	Who investigates incidents and how are they investigated? What is the aim of recording the incident?
5. Evaluating incidents and best practice	How are any incidents evaluated? What recognition is there of safe practice? How is the resultant data used?
6. Learning and effecting change	What happens after an event? What mechanisms are in place to learn from the incident? How are changes introduced and evaluated?
7. Communication about safety issues	What communication systems are in place? What are their features? What is the quality of record keeping to communicate about safety like?
8. Personnel management and safety issues	How are safety issues managed in the workplace? How are staff problems managed? What are the recruitment and selection procedures?
9. Staff education and training	How, why and whom are education and training programmes about patient safety developed? What do staff think of them?
10. Team working	How and Why are teams developed? How are teams managed? How much team working is there around patient safety issues?

EAHP statements 2014 SECTION 5: PATIENT SAFETY AND QUALITY ASSURANCE

1. The 'seven rights' (the right patient, right medicine, right dose, right route, right time , right information and right documentation) should be fulfilled in medicines related activities in the hospital
2. Hospital pharmacists should ensure the development of appropriate quality assurance strategies for medicine use processes to detect errors and identify priorities for improvement
3. Hospital pharmacists should ensure their hospitals seek review of their medicines use processes by an external quality assessment accreditation programme, and act on reports to improve the quality and safety of these processes.
4. Hospital pharmacists should ensure the reporting of adverse drug reactions and medication errors to regional or national pharmacovigilance programmes or patient safety programmes
5. Hospital pharmacists should help decrease the risk of medication errors by disseminating evidence based approaches to error reduction including computerised decision support

http://ejhp.bmj.com/content/21/5/256.full.pdf+html

Performance metrics in hospital pharmacy

- indicate the range of services, workload, costs, quality, safety and outcomes
- prompt and track service improvements where necessary
- demonstrate the contribution that hospital pharmacy is making to those outside the department
- Recommended use of performance metrics Included in FIP Basel Statements

Cousins D. Current status of the monitoring of medication practice. Global conference on the future of hospital pharmacy. Am J Health-Sys Pharm. 2009; 66 (suppl 3): S49-56

EAHP Survey 2014

- Survey distributed via EAHP social media channels and by email directly to official delegates of EAHP Member associations.
- 190 survey forms completed
- Hospital pharmacists in 36 countries completed survey
- Largest numbers of responses from:
  - Spain (16), France (15), Germany (15)
- Smallest numbers of responses (1) from:
  - Cyprus , Denmark, Luxemburg, Hungary, Luxemberg, Macedonia, Russia, Netherlands
- Unknown country of origin in 4 responses

D. Cousins The use of service performance measurement in European hospital pharmacies. Eur J Hosp Pharm 2014. 21: 285-287

Use Of Metrics For Medicines Distribution

Activity	Yes (%) Service provided n = 190	Data collected (%) In previous 12 months	Shared outside (%) pharmacy department
Supply of ward stock medicines	82.4	73.5	62.7
Supply of medicines for named patients	48.9	80.6	66.7
Supply of medicines for outpatients	57.9	60.9	47.3
Supply of medicines for discharge	45.35	44.2	33.7

D. Cousins The use of service performance measurement in European hospital pharmacies. Eur J Hosp Pharm 2014. 21: 285-287

Use of Metrics for Medicines Manufacture and Preparation

Activity	Yes (%) n = 190	Data Collected (%)	Shared outside (%)
Sterile medicines	47.4	78.9	53.3
Aseptic medicines	56.8	78.7	52.8
Non – sterile medicines	79.5	70.2	42.4
Quality control	57.4	63.3	22

D. Cousins The use of service performance measurement in European hospital pharmacies. Eur J Hosp Pharm 2014. 21: 285-287

Use Of Metrics For Pharmacy

Activity	Yes (%) N = 190	Data collected (%)	Shared outside (%)
Cost of medicines	94.7	96.1	88.6
Cost of devices	53.7	94.1	77.5
Cost of consumables	42.1	71.3	46.3
Cost/number of pharmacy employees	64.7	74.8	59.3

D. Cousins The use of service performance measurement in European hospital pharmacies. Eur J Hosp Pharm 2014. 21: 285-287

Use of Metrics For Clinical And Safety

Activity	Yes (%)	Data collected (%)	Shared Outside (%)
Medicines information	81.6	43.9	27.7
Adverse reaction reports	78.4	54.4	38.9
Medication error reports	58.4	78.4	62.2
External accreditation	52.6	56.0	42.0

D. Cousins The use of service performance measurement in European hospital pharmacies. Eur J Hosp Pharm 2014. 21: 285-287

Summary From EAHP Survey On Performance Metrics

Performance metrics collected

- Finance
- Manufacturing
- Distribution
- Clinical / safety

Data collected

Data shared

Much more performance metric data concerning clinical pharmacy and medicines safety could be collected used and reported by hospital pharmacies in Europe

D. Cousins The use of service performance measurement in European hospital pharmacies. Eur J Hosp Pharm 2014. 21: 285-287

European hospital pharmacists should be able to answer:

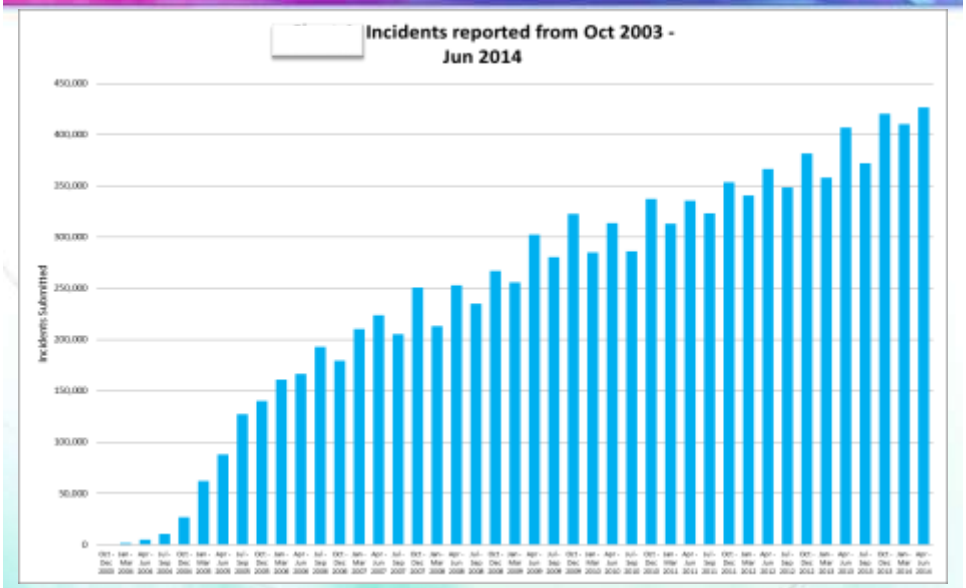
- The number and types of ADR and medication errors reported in their hospital / clinical area / department – last year/quarter/month
- The most serious risks to patient safety
- What has been done and is being done to address these risks both locally, nationally and internationally
- What is their own role in improving patient safety
  - Reporting ADR and medication errors
  - Assisting with their analysis
  - Develop solution to improve patient
  - Assisting with the implementation of safer practice

National Reporting and Learning System in England and Wales

- The NHS in England introduced the National Reporting and Learning System in 2003.
- Reports of patient safety incidents are collected and used by health care providers and then uploaded into the national NRLS data base.
- A patient safety incident is where a patient has been harmed or there as a potential for harm (near miss). All types of incidents are reported from wrong diagnosis, mixed-up test results, medicine and device incidents to sexual safety incidents.

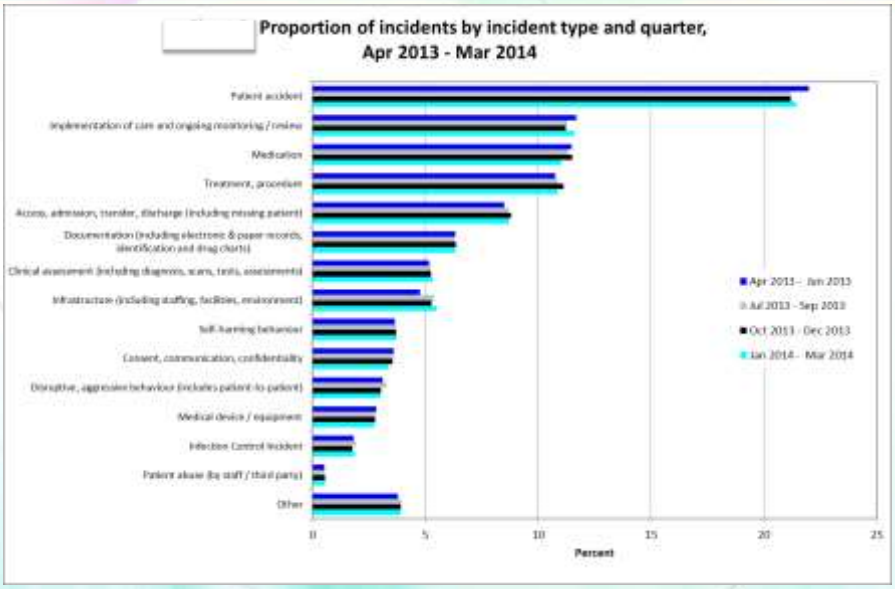
http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident

Number of incidents reported to the NRLS each quarter



http://www.nrls.npsa.nhs.uk/resources/type/data-reports/?entryid45=135304

Incident types reported to the NRLS



http://www.nrls.npsa.nhs.uk/resources/type/data-reports/?entryid45=135304

Analysis of incidents reported to the NRLS 2005 - 2010

Year	Total number of incident reports*	Number of medication incident reports†	Medication incident reports as a percentage of all incident reports received
2005	517415	42398	8.19
2006	742418	64484	8.69
2007	874148	79118	9.05
2008	986981	94280	9.55
2009	1118336	113837	10.18
2010	1198701	132069	11.02
Total	5,437,999	526,186	

Cousins D, Gerrett D, Warner B. Br J Clin Pharmacol. 2012:; 74: 597-604
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3477327/

Analysis of NRLS Medication Incident Reports 2005 – 2010

Actual clinical outcome	Incidents	Percent of medication incidents
Death	271	0.05
Severe	551	0.10
Moderate	17421	3.31
Low	68578	13.03
No harm	439318	83.46
N/A	240	0.05
Total	526379	100.00

Cousins D, Gerrett D, Warner B. Br J Clin Pharmacol. 2012:; 74: 597-604
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3477327/

Analysis of NRLS Medication Incident reports 2005 – 2010

Stage of medication process	Incidents	Percent of medication incidents
Administration of medicines	263228	50.01
Prescribing of medicines	97097	18.45
Preparation / dispensing of medicines	87057	16.54
Other	48410	9.20
Monitoring / follow-up of medicine use	23648	4.49
Advice	3537	0.67
Supply or use of over-the-counter (OTC) medicine	3045	0.58
N/A	240	0.05
(blank)	117	0.02
Other / Unspecified	48410	9.20
Total	526379	100.00

Cousins D, Gerrett D, Warner B. Br J Clin Pharmacol. 2012:; 74: 597-604
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3477327/

Analysis of NRLS Medication Incident reports 2005 – 2010

Category of error	Incidents	Percent of medication incidents
Omitted and delayed medicine	82028	15.58
Wrong dose or strength	80170	15.23
Wrong medicine	48834	9.28
Wrong frequency	44165	8.39
Wrong quantity	28764	5.46
Mismatching between patient and medicine	21915	4.16
Wrong / transposed / omitted medicine label	13755	2.61
Patient allergic to treatment	11695	2.22
Wrong formulation	11254	2.14
Wrong / omitted / passed expiry date	10998	2.09
Wrong storage	10447	1.98
Unknown	10024	1.90
Wrong method of preparation / supply	9840	1.87
Wrong route	7934	1.51
Contra-indication to the use of the medicine in relation to medicine or condition	7632	1.45
Adverse drug reaction (when used as intended)	5939	1.13
Wrong / omitted verbal patient directions	1383	0.26
Wrong / omitted patient information leaflet	1156	0.22
Blank	129	0.02
Other/not specified	118317	22.48
Total	526379	100.00

Cousins D, Gerrett D, Warner B. Br J Clin Pharmacol. 2012:; 74: 597-604
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3477327/

Patient safety alerts

http://www.england.nhs.uk/ourwork/patientsafety/psa/

New EU Directive on Pharmacovigilance

Under the new EU Directive 2010/84/EU1 that came into force in July 2012.

The term 'adverse drug reaction' (ADR) was redefined 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.'

National pharmacovigilance centres are required to expand their activities to include reporting and learning systems for medication errors.

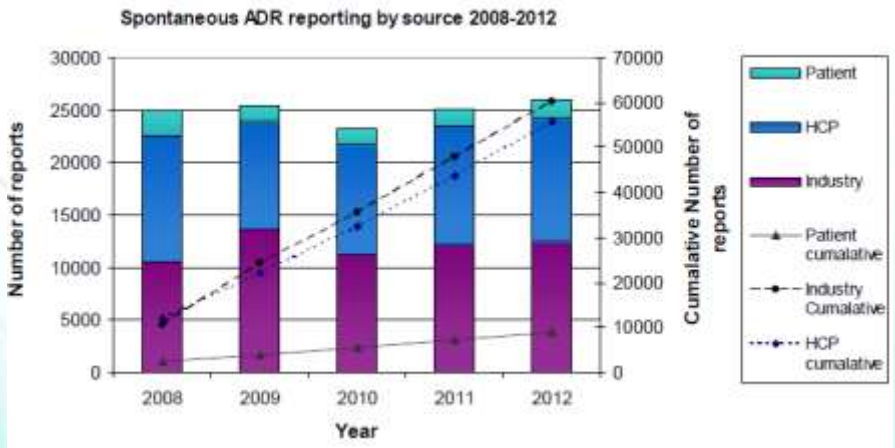
http://ec.europa.eu/health/files/eudralex/vol1/dir_2010_84/dir_2010_84_en.pdf

http://www.ema.europa.eu/ema/index.jsp?curl=pages/special_topics/general/general_content_000570.jsp

D Cousins. Initiatives to Identify and Mitigate Medication Errors in England. Drug Safety. 2015: D10.1007/s40264-015-0270-3
http://link.springer.com/article/10.1007/s40264-015-0270-3

UK ADR reports 2008 - 2012

MHRA



http://www.england.nhs.uk/2014/03/20/med-devices

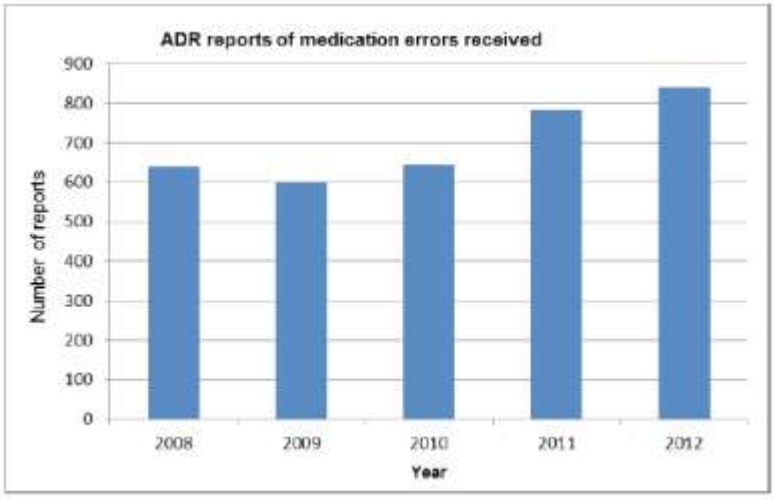
UK ADR reports 2008 - 2012

MHRA

http://www.england.nhs.uk/2014/03/20/med-devices

UK ADR reports 2008 - 2012

MHRA



http://www.england.nhs.uk/2014/03/20/med-devices

Other drivers for change

- Some poor quality reports to the National Reporting and Learning System
- Need to increase numbers of reports from primary care and the independent sector including home health care companies
- The Berwick Report on Patient Safety In England 2013. The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning
- WHO FP7 monitoring medicines project and EMA – recommend closer working between patient safety organisations and national pharmacovigilance centres
- Good Vigilance Practice in Pharma – how about something similar for healthcare provider organisations?

http://www.england.nhs.uk/2014/03/20/med-devices

Data quality issue	NRLS field name	Description	% of total
Delayed report	IN01	Date of incident. Incident reported more than four weeks after the incident	53%
Data not recorded	MD05	Medicine name	32%
Data not recorded	MD06	Proprietary name	99%
Data not recorded	MD10	Manufacturer	99.9%
Data miscoded	MD01	Use of the term 'other' in the medication process field. Options include: prescribing/preparation/dispensing, administration, monitoring etc	12%
Data miscoded	MD02	Use of the term 'other' in type of medication error. Options include: wrong patient, medicine, route, dose frequency, quantity, omitted etc	25%
Data not recorded	ST01	Staff type reporting the incident. Options include doctor, nurse pharmacist etc	71%
Quality of data	IN07	Review of free text description of what happened, death or severe harm reports.	7% of incidents stated very little meaningful information to aid learning. 18% did not report the reaction to the error that led to harm.
Data not recorded	IN010	Actions taken to prevent recurrence	49%
Data not recorded	IN11	Apparent causes	69%
Data miscoded	PD09	Clinical outcome codes indicating death or severe harm	44%

http://www.england.nhs.uk/2014/03/20/med-devices

Patient Safety Alert - initiative

http://www.england.nhs.uk/ourwork/patientsafety/psa/

http://www.england.nhs.uk/2014/03/20/med-devices

Patient Safety Alert - objectives

NHS England and MHRA are working together to simplify and increase reporting, improve data report quality, maximise learning and guide practice to minimise harm from medication errors by:

- sharing incident data between MHRA and NHS England reducing the need for duplicate data entry by frontline staff;
- providing new types of feedback from the National Reporting and Learning System (NRLS) and MHRA to improve learning at local level;
- clarifying medication safety roles and identifying key safety contacts to allow better communication between local and national levels; and,
- setting up a National Medication Safety Network as a new forum for discussing potential and recognised safety issues, identifying trends and actions to improve the safe use of medicines. The network will also work with new Patient Safety Improvement Collaboratives that will be set up during 2014.

The Yellow Card Scheme for reporting suspected adverse drug reactions to the MHRA will continue to operate as normal.

Actions (Target date for completion 12 September 2014)

http://www.england.nhs.uk/2014/03/20/med-devices

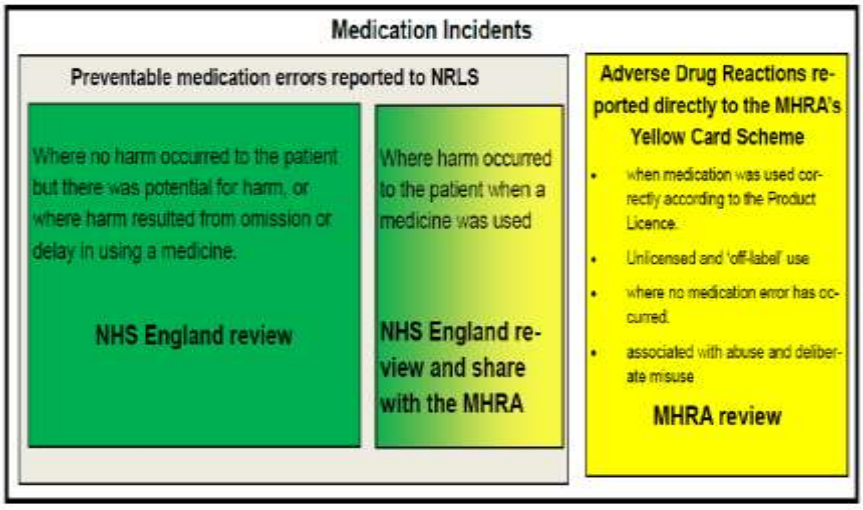
Patient Safety Alert – Required actions

All *large** healthcare providers including NHS Trusts, community pharmacy multiples, home healthcare companies and those in the independent sector should:

1. identify a board level director (medical or nursing supported by the chief pharmacist) or in community pharmacy and home health care, the superintendent pharmacist, to have the responsibility to oversee medication error incident reporting and learning;
2. identify a Medication Safety Officer (MSO) and email their contact details to the Central Alerting System (CAS) team. This person will be a member of a new National Medication Safety Network, support local medication error reporting and learning and act as the main contact for NHS England and MHRA; and,
3. identify an existing or new multi-professional group to regularly review medication error incident reports, improve reporting and learning and take local action to improve medication safety.

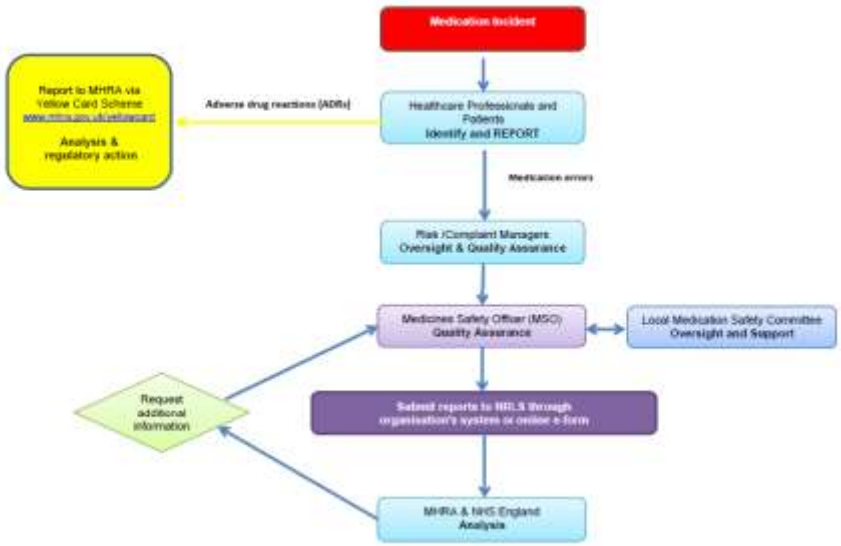
http://www.england.nhs.uk/2014/03/20/med-devices

Oversight by agencies of medication incident reports



http://www.england.nhs.uk/2014/03/20/med-devices

Recommended process for medication incidents



http://www.england.nhs.uk/2014/03/20/med-devices

Role of medication safety officer

Responsibilities should include the following:

i. active membership of the National Medication Safety Network;
ii. improving reporting and learning of medication error incidents in the organisation;
iii. managing medication incident reporting in the organisation. This may entail reviewing all medication incident reports to ensure data quality for local and national learning and where necessary to investigate and find additional information from reporters. Also, to authorise the release of medication error reports to the NRLS each week;
iv. receiving and responding to requests for more information about medication error incident reports from the Patient Safety Domain in NHS England and the MHRA;
v. work as a member of the medication safety committee to deliver the responsibilities listed in 7.1.4; and,
vi. supporting the dissemination of medication safety communications from NHS England and the MHRA throughout the organisation.

http://www.england.nhs.uk/2014/03/20/med-devices

Role of the medication safety committee

Committee responsibilities should include the following:

i. improving reporting and learning of medication error incidents in the organisation;
ii. analysing incident data, audit and other data to identify, prioritise and address medication risks to minimise harm to patients;
iii. identifying, developing and promoting best practice for medication safety. This will include supporting the implementation of external patient safety guidance from NHS England, MHRA, NICE and other organisations - implementation will require coordination and support for process and system changes to reduce the likelihood of serious medication errors occurring and recurring, providing regular feedback to clinical staff, patient care areas and hospital committees on medication risks and planned action to minimise these risks;
iv. coordinating education and training support to improve the quality of medication error incident reports and safe medication practices; and,
v. assisting in development and review of medication-use policies and procedures.

http://www.england.nhs.uk/2014/03/20/med-devices

Role of national medication safety network

- **Objectives for the network are to:**
- Improve reporting and learning of medication incidents by educating and training Medication Safety Officers in patient safety science and disseminate relevant research and information concerning new risks and best practice.

- **Specific improvements include to:**
- increase the number of reports of medication incidents;
- improve the timeliness of report submission;
- improve the quality of reports,
  - NRLS data fields completed;
  - Accuracy of use NRLS codes;
  - Description of the incident – sufficient for learning;
- increase the number of new safety issues detected;
- implement local actions to minimise harms from identified risks; and,
- measure improvements to safer practice.

http://www.england.nhs.uk/2014/03/20/med-devices

Support For Medication Safety Officers

- regular online meetings
- email discussion groups and online information forums
- conferences/workshops

to discuss topics identified at local and national level. These will include; the identification of new risks and best practices to minimise these risks, implementing patient safety guidance and improving incident reporting, quality and learning.

Numbers of MSO's identified

- 363 organisations have identified a MSO in
  - Acute care
  - Mental health
  - Learning disabilities
  - Community and Ambulance
  - Community pharmacy
  - Independent healthcare
  - Home healthcare
  - Healthcare commissioners

Medicines optimisation dashboard

NHS England launches medicines optimisation prototype dashboard

12 June 2014 - 10:02

NHS England today (12 June) launches the Medicines Optimisation Prototype Dashboard, designed to encourage CCGs and trusts to think more about how well their patients are supported to use medicine and less about focusing on cost and volume of drugs.

The prototype dashboard brings together in one place data from across sectors in areas such as medication safety, uptake of NICE approved medicines and utilisation of community pharmacy services.

http://www.england.nhs.uk/2014/06/12/mo-dash

Medication safety dashboard

Total number of medication incidents reporting harm

Total number of medication incidents

The new metric provides an indication of preventable harms occurring and a surrogate measure of reporting culture

Better reporting and learning, especially of no harm incidents, will help to enable action to minimise preventable harms from medicines

New regulation

NHS Litigation Authority

New NHS LA Duty of Candour Guidance

WHAT IS CANDOUR?

- Recognising when an incident occurs that impacts on a patient in terms of harm.
- Notifying the patient something has occurred.
- Apologising to the patient.
- Supporting the patient further.
- Following up with the patient as your investigations evolve.
- Documenting the above discussions and steps.

WHAT TRIGGERS THE STATUTORY DUTY OF CANDOUR

- The death of a patient when due to treatment received or not received (not just their underlying condition).
- Severe harm – in essence permanent serious injury as a result of care provided.
- Moderate harm – in essence non-permanent serious injury or prolonged psychological harm.

WHEN MIGHT IT ARISE?

- Whilst the patient is an in-patient, i.e. at the "bedside".
- When a patient is back at home following discharge or via community based care.
- Following a patient's death.

WHAT DOES CANDOUR LOOK LIKE?

- Open discussions between the patient and the healthcare provider when things go wrong.
- Acceptance by healthcare staff that open conversations will take place at an early stage.
- Reduction in overly defensive approaches to information sharing about incidents in relation to the patient in question.
- Engaging the patient with the outcome of investigations; and
- An apology in relation to the incident.

Homecare Medicine Services

Comparison of incident type nrls vs homecare

NRLS Incident Type 2005 - 2010	% incidents	Homecare Incident Type Aug – Dec 2014	% Incidents
Omitted and delayed medicines	15.58	Omitted and delayed medicine	55.52
Wrong dose or strength	15.23	Wrong patient	10.74
Wrong medicine	9.28	Wrong quantity	7.06
Wrong frequency	8.39	Wrong dose	7.36
Wrong quantity	5.46	Wrong medicine	3.99
Wrong patient	4.16	Wrong storage	3.07

Root cause of majority of omitted medicines – delayed prescriptions from hospitals

The future

- Preventable harms are still occurring in European Hospitals – and improvements in patient safety culture and climate are required
- Hospital pharmacists have a key role in patient safety involving medicines and medical devices
- Improved governance of reporting and learning required European Hospitals
- There is a key role for medication and medical device safety officers
- Medication and medical device safety network enables two way communication and supports the activities of safety officers
- EAHP can support members and hospital to evolve and find new ways of reporting, learning and working together
- There is a need for European and national infrastructure to support patient safety

Safety is no accident!