Local initiatives to improve drug safety

Lord Darzi’s definition of quality — the watchword among politicians and civil servants at the moment — is split into three concepts: safety, patient experience and outcomes. In the first in a series of features, Dawn Connelly finds out about some local initiatives to improve medicines safety

Ensuring safe and appropriate access to medicines is pharmacists’ primary responsibility and elements of the core role, such as clinical review of prescriptions, interventions, medicines use reviews, advising GPs and nurses, and informing patients, are concerned with this end. But inevitably errors still happen.

The National Patient Safety Agency’s latest “Safety in doses” report (PJ, 12 September 2009, p263) revealed that 86,085 medication incidents occurring in England and Wales were reported in 2007. Most serious incidents were caused by errors in medicines administration (41 per cent) and prescribing (32 per cent). Eighteen per cent of all reported incidents related to the preparation and dispensing process, as did 16 per cent of incidents that led to death or severe harm.

There are a number of national initiatives aimed at improving medicines safety, including the yellow card reporting system and the NPSA’s reporting and learning system, a new version of which — Patient Safety Direct — is due to be launched in 2012.

A relatively new project, the Patient Safety First campaign, a joint initiative by the NPSA, The Health Foundation and the National Institute for Innovation and Improvement, has a high-risk medicines component and has garnered support from over 96 per cent of acute trusts and 62 per cent of non-acute trusts since its launch in 2008.

The decriminalisation of dispensing errors is also likely to improve medicines safety by encouraging a blame-free culture and prompting wider reporting of, hence learning from, dispensing errors.

As well as these national initiatives pharmacists are doing a lot locally to help improve medicines safety.

Joint working

Steve Brown, director of pharmacy at University Hospitals Bristol NHS Foundation Trust and associate director for medicines management at NHS South West, explains that NHS South West has been working with the Association of the British Pharmaceutical Industry on an innovative project to improve medicines safety. “The Department of Health published guidance a couple of years back to encourage joint working between the NHS and the pharmaceutical industry,” explains Mr Brown. “Following its publication, the ABPI approached NHS South West to see how the guidance might be implemented,” he adds.

Patient safety was identified as a shared priority and the South West Medicines Safety Partnership was formed. Three projects were subsequently identified in the areas of drug allergies, medicines reconciliation and drug shortages, says Mr Brown, explaining that all three have produced good results and have the potential for national roll out (see Panel). The programme was led by Jill Loader (also associate director for medicines management at NHS South West), and each project was co-chaired by an NHS and pharmaceutical industry lead. In addition, all 18 acute trusts in the South West are participating in a quality and patient safety programme in partnership with the Institute for Healthcare Improvement. This programme will initially look at two areas: anticoagulants and medicines reconciliation, says Mr Brown. “We hope to develop the programme to include missed doses, an area that was highlighted as a problem in the recent NPSA report ‘Safety in doses’,” Mr Brown adds.

“Patient safety is a key element and a major part of our work within the South West Medicines Safety Partnership projects

The drug allergies project aimed to reduce preventable harm to patients with a known allergy to a medicine and resulted in a campaign called “Medicines allergy matters”. Having identified pharmacists as being ideally placed to establish accurate information on allergy status, the project group developed campaign materials designed to improve understanding of medicine allergy for patients attending community and hospital pharmacies. The materials included a patient held record card and a letter for the patient’s GP to ensure accurate recording of allergy status in the primary care records.

The medicines reconciliation project looked at developing innovative solutions to medicines reconciliation in settings with a lack of access to pharmacists, for example, mental health trusts and community hospitals. It resulted in the development and piloting of a reconciliation form, an e-learning package for non-pharmacy staff, a package of assessment tools to allow staff to test their existing competencies and aptitude for medicines reconciliation and the development and testing of a transferable medicines reconciliation launch event, together with support materials.

The drug shortages project has resulted in the development of an electronic system to gather and disseminate information across the South West with the aim of minimising risk to patients associated with lack of supply. The system is co-ordinated by the regional procurement pharmacist via a password-protected website, which provides trusts with early notification and guidance, including advice on alternative therapeutic strategies, risk assessment, use of robust communication plans and the potential to manage stock across the region during a shortage to minimise risk.

Further details can be accessed at www.swmit.nhs.uk/SWMSP_Project.htm

“Medicines allergy matters” campaign poster displayed in pharmacies

South West Medicines Safety Partnership projects

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West. All of these initiatives are happening in parallel and have given us an opportunity to work jointly with the pharmaceutical industry as well as our colleagues in primary care and the community to take the patient safety agenda forward,” he says.

NHS South West has also successfully implemented a peer review programme focused on venous thromboembolism prophylaxis, and future workstreams are currently being planned.

Transfer of care
Transfer between care settings has been identified by the NPSA as a time when there is a significant risk of medication errors occurring. An initiative in Darlington that led to a dramatic reduction in medication errors among elderly patients moving between care settings recently won the Royal Pharmaceutical Society’s first medicines safety award (PJ, 12 September 2009, p262).

The initiative involves a patient-held booklet that contains information about the patient’s conditions and treatment. Margaret Ledger-Scott, clinical director of medicines management and chief pharmacist for County Durham and Darlington NHS Foundation Trust, who led the team that implemented the project, says that, following the success of the first booklet, the team has been working with NHS North East and is now piloting a similar booklet aimed at patients with diabetes.

A senior pharmacy technician at the trust is also leading a project to help diabetic inpatients to identify their usual insulin and devices, explains Mrs Ledger-Scott. “Patients know what insulin they are on but they can’t remember the name of it,” she explains. In addition, staff on non-specialist wards are often unfamiliar with the insulins and devices that are available, Mrs Ledger-Scott points out. A booklet has been developed that contains pictures of different insulins and devices — allowing patient to identify their insulin — and related product information aimed at nursing and medical staff. The booklet is currently being printed and will be piloted across the trust in the coming weeks.

Redesign
Community pharmacist Mak Johal, of Chapel Healthcare in Farnborough, Surrey, has done considerable work within his pharmacy on medicines safety.

Two years ago, with the aim of improving safety, Mr Johal decided to redesign his pharmacy and install a robot. An audit before the refit showed that picking errors were high and Mr Johal believes that cramped conditions in the small dispensary contributed to this. “The business has grown rapidly over the past 10 years and we now dispense around 10,000 to 11,000 items per month. The old dispensary was not suitable for this level of activity.”

The dispensary was completely refurbished to create a large, modern space. “I see the dispensary as the hub of the business and I needed to feel comfortable in it. The new dispensary is about four metres by seven metres and the extra space has really helped the workflow,” explains Mr Johal.

He adds that 90 per cent of his stock is now in the robot and says that automation has practically eliminated dispensing errors.

Mr Johal has made several other changes, which he believes have improved safety. Concordance, he says, is central to medication safety and achieving concordance requires effective communication. Mr Johal explains that there is a sizeable population of Ghurkas who have settled in the area and says he has taken on a Nepalese pharmacist as a technician to improve communication with these patients about their medicines. “This has really helped with concordance,” he adds. The technician hopes to qualify as a pharmacist in the UK within the next few years.

Taking the lead
Medication errors account for a substantial amount of NHS resources. With the impending financial difficulties facing the NHS and the Government’s current focus on quality, improving medicines safety is an area in which pharmacists can take the lead, both at a national level and through development of local schemes.