Hertfordshire and West Essex Integrated Care System

HWEICB (PMOT)
Medication Incidents

Anushka Uppal
Lead Pharmaceutical Advisor
Medication Governance, Quality & Safety

Risha Kohli
Pharmaceutical Adviser
Social Care Integration

November 2024

Working together
for a healthier future

What we will cover in this session

- What is a medication incident
- How to manage a medication incident
- Process for reporting CD incident
- How to reduce medication incidents
- How ICB can support
- Examples of incidents in care homes

Hertfordshire and West Essex Integrated Care System

237,287,788 Medication errors in England Annually of which 42% are in Care homes

7.2 medicines average patient in care home and 69.5% of patients had at least one error (RPS 2016)

Across all sectors over 50% occur during administration

30 to 70% of patients may experience errors or unintentional changes to their treatment when care is transferred (NICE 2015)

Useful links: Quality statement 4: Prescribing medicines | Medicines management in care homes | Quality standards | NICE
Recommendations | Managing medicines in care homes | Guidance | NICE

Hertfordshire and West Essex Integrated Care System

What is a medicines error/incident and where can this occur? As defined by CQC:

A medicines error is any patient safety incident, where there has been an error while:

- Prescribing
- Preparing
- Dispensing
- Administering
- Monitoring
- Providing advice on medicines

Medicines errors are not the same as adverse drug reactions.

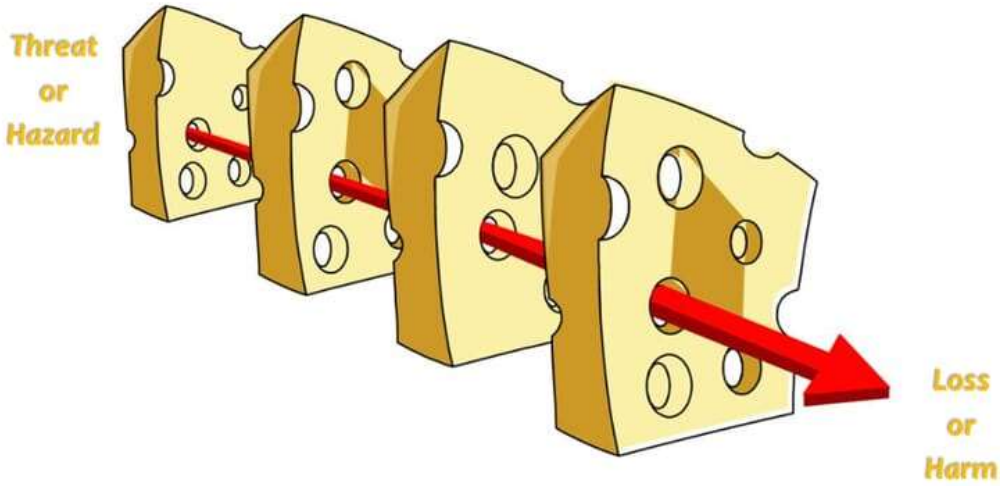
Importance of Medication Safety Management

- Medicines optimisation
- Saving lives and reducing harm
- Error reduction
- Less over-prescribing & reduction in polypharmacy
- Encourage a culture of error/incident reporting
- Improving practice through learning from errors/incidents
- Reducing medicines wastage
- CQC will ask about incident management

How to minimise the risk of medication errors:

Prescribing

- This can be from a hospital, GP or any prescriber error so important to carry out medicine's reconciliation
- Can include wrong dose, medication, allergy, formulation, interactions
- Care homes administration is the last safety net check before the medication is given
- Do not be afraid to question prescribing

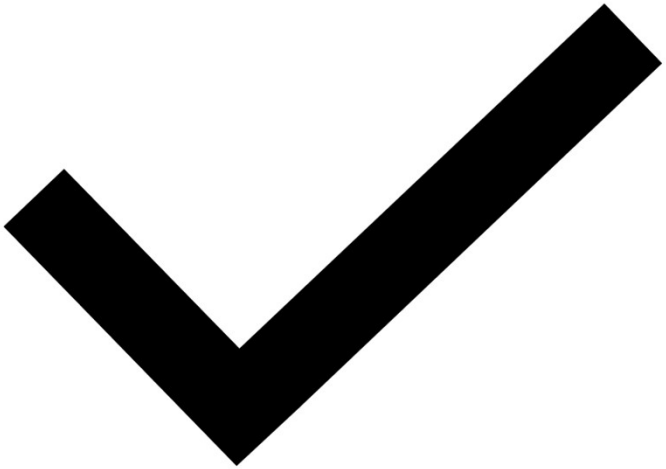


Preparing/ Dispensing

- Can come from anywhere – pharmacy, hospital
- Can happen in the care home
  - Crushing of tablets (covert good practice guide)
  - Mixing into an unsuitable substance
  - Measuring the wrong volume
  - Forgetting the medication that is not in the tray (e.g. in a fridge)
- Equipment is not cleaned causing cross-contamination
- Medication is stored incorrectly
- Medication is out of date
- Allergy status

Administering

- Right patient
- Right drug
- Right dose
- Right time
- Right route
- Right to refuse



Monitoring

- Blood tests
- Blood pressure / Pulse where required
- Mental state
- Pain score
- Bowel movement
- Weight
- Side effects
- Reviewing continued need

Resources available for medication support

Seek medical advice:

- Community Pharmacy
- GP surgery healthcare professionals
- EPUT, HPFT, HCT, HCPA

HWE ICB

- Good practice guidance
- Evidence based information – not Google!
- Follow advice on the drug label e.g. 30mins before food
- BNF
- Training sessions
- CQC website
- NICE guidance
- Shared decision-making - Herts and West Essex ICS

BRAN - benefits, risks, alternative treatments, what if I do nothing

https://www.hertsandwestessex.ics.nhs.uk/wp-content/uploads/2024/04/Its-Ok-to-Ask-leaflet-for-website.pdf

How to manage medication incident that has occurred

- Have local policy and follow this process
- Ensure ALL medication incidents are reported and documented (Internal, council, CQC, CDAO, GP/prescriber)
- Root cause analysis (why did it happen; can we prevent it happening again)
- Making Change
- Sharing learnings

What to do care homes need to have in place?

NICE guidance on managing medicines in care homes (SC1) states that care home providers:

"should ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors involving residents.“

NICE guidance for adults receiving social care in the community (NG67) states:

“When social care providers have responsibilities for medicines support, they should have robust processes for identifying, reporting, reviewing and learning from medicines-related problems.”

CQC advises care homes to have a Medicines policy - which includes a process for recording all medicines related incidents. This also includes all ‘near misses’ and incidents that do not cause any harm.

What to do care homes need to have in place?

Medicines policy

The policy should cover:

- whether to notify CQC
- which medicines related safety incidents to report under local safeguarding processes
- how to report the incident to the person, their family or carers
- how to handle referrals to regulators and other agencies, such as NMC.

CD incidents

Controlled drugs

Report incidents related to controlled drugs (including loss or theft) to your local NHS Controlled Drugs Accountable Officer (CDAO) at NHS England. You should also report incidents to the police (if necessary).

You must tell CQC if the incident meets the criteria of a statutory notification.

- Any incident with a CD needs to follow local policy plus needs to be reported to CDAO
  - https://www.cdreporting.co.uk/nhs/account/signin
  - Registration is required
  - Report to care home team (we can come support)
- If support is required reach out to your ICB care home pharmacist or technician

How the ICB PMOT team can support

- Direct to training resources
- Support home with specific training needs
- Support to the home manager where there is gaps in investigations
- Liaise on the wider MDT to support home investigation and outcomes
- hweicbenh.pharmacycarehomes@nhs.net

Examples of care home incidents (scenario 1)

Patient is on buprenorphine patch (changed every 3 days) new member of staff changes the resident's patch daily for 2 days.

On Day 2 regular member of staff notices that the patch should be changes every 3 days not daily and now they are short of patches for the month.

Examples of care home incidents (scenario 1)

What went well	What went wrong
• It was identified by the staff as an error. • Member of staff reports it to the manager. • They report it to the GP for clinical advice and to receive more patches. • They also report through their local safeguarding processes to the council, area manager and community pharmacy.	A month later ICB care home pharmacist was informed during routine audit visit. They identified that it was not reported to CD accountable officer and home immediately reported it.

Examples of care home incidents (scenario 1)

The Learning:

- Staff training
- Change of process – Reporting and operational
  - Reporting to CD accountable officer
- Carers to double check instructions when administering medications (two staff for CD medications)

Examples of care home incidents (scenario 2)

Chloramphenicol eye drops was prescribed for a week, during an audit the eye drops were found in the medication trolly, and resident was being administered on day 13.

Label and MAR chart instruction were not being read prior to administration.

Examples of care home incidents (scenario 2)

What went well	What went wrong
An audit took place to identify the error	• Home did not identify the error not reported as per home protocol • Date opened on eyedrops/creams/lotions not used • Stored incorrectly • Instructions not read

Examples of care home incidents (scenario 2)

The Learning:

- Checking and following instructions on MAR, label and product are vital
- Following your own incident management protocols
- Reporting appropriately
- Internal audits by senior member of staff to have oversight medication

Key Points

- Check
- Ask questions
- Document
- Report
- Engage with the patient
- Communicate
- Share learnings