C.7 Medicines Governance Submission to IHRD

1. The UK Audit Commission's Report, 'A Spoonful of Sugar – medicines management in NHS hospitals', published in 2001, suggested that nearly 1,100 people died in the year 2000 in England and Wales alone as a result of medication errors or adverse reactions to medicines and that the number had increased five-fold in just ten years. Medication errors accounted for 20% of all clinical negligence litigation and were estimated to cost the NHS £500 million per annum in additional days spent in hospital.

2. The Department of Health publication, 'An Organisation with a Memory' (2000), recommended that action be taken to address specific categories of recurring adverse events. Two of the four targets set involved medication and included the aim that, by 2005, the number of serious errors in the use of prescribed medicines would be reduced by 40%.

3. Adverse incidents are identified as a major cause of preventable patient injury and have been estimated to occur in 10-14% of patients admitted to hospital. The epidemiological evidence suggested that up to 20% of these incidents were medication related. It was estimated that taking the level of hospital-based medicine-related incidents as 20% of a total incident rate of 10%, 2% of patients admitted to hospital would experience a medication incident. In 2000 there were over 300,000 admissions to acute care in Northern Ireland therefore 6,000 patients were, according to the above estimates, affected by a medication incident, requiring 51,000 extra hospital days at a cost of almost £15 million (assuming 8.5 days at a cost of £290/day). At least 50% of such adverse events were thought to be preventable. At a level of 30% preventability this represented a potential efficiency gain of £4.5 million across all hospitals in Northern Ireland.

4. The Northern Ireland Medicines Governance Project was designed to minimise the occurrence of medication-related adverse events in hospital through a systems-based approach to risk management.

5. The Regional Medicines Governance Team was established in August 2002 to minimise the risk of preventable medication related harm and to promote safe practice in prescribing, dispensing and administration of medicines in secondary care. The objectives of the team were: to increase levels of reporting; to manage medication incident data; to develop and implement medicines safety initiatives and to provide medication safety education for staff.

6. The team, based in and managed through Health and Social Care Trusts, consists of 6 pharmacists working in the acute sector who are involved with the promotion of medication incident reporting and have also developed processes for regional medication incident data management. This permits regional quarterly analysis of HSC Trust's reported medication incidents to identify prescribing, dispensing and administration trends and to produce regional learning recommendations. Feedback to trust staff is provided in the form of:

   - the regional medication safety today newsletter which is distributed to all medical, nursing and pharmacy staff;
   - safety memos; these act as a fast response method when the team has proactively identified a risk and are primarily targeted to: Heads of Pharmacy;
   - policy development e.g. methotrexate, warfarin;
   - medicines safety recommendations for insulin, methotrexate and warfarin;
   - best practice initiatives e.g. development of a regional Hyperkalaemia kit, Acute Medicines Kardex, Long stay Medicines Kardex; and
   - supporting development of the implementation of the medicines related NPSA Alerts and Rapid Response Reports both at regional and local levels e.g. omitted doses, epidurals, anticoagulants etc.

7. The team also provides a medicines safety training programme to QUB medical, nursing and pharmacy students and UU nursing students and provides a short session on medicines safety at the regional FY1 induction day. The team have contributed to the development of medicines safety modules on training and have also produced a medicines governance e learning package in

conjunction with the Northern Ireland Centre for Pharmacy Learning and Development (NICPLD).

8. In 2006, the extension of the team to primary care was piloted and in 2010, the Medicines Governance Team was extended into primary care. Coordinated through the HSC Board, there is currently one Medicines Governance Adviser working in each HSC Board Local Commissioning Group area (each area corresponds to Trust boundaries), and a regional team lead. The role of the primary care Medicines Governance Team is similar to that of the secondary care team, with an overall aim to enhance safe prescribing and systems. The primary care team has focused on a number of areas, including:

- Encouraging the reporting of adverse incidents from GPs and Community pharmacists;
- Establishing an anonymous adverse incident reporting system for community pharmacists;
- Following up individual adverse incidents to ensure learning and reduce the chance of a similar adverse incident by the same practitioner;
- Identifying and sharing learning from both named and anonymous adverse incidents s across practitioners via regular newsletters and medicines safety alerts
- Developing Standard Operating Procedures, processes and audits for safer systems in general practice, e.g. repeat prescribing, prescription security, medication review
- Providing training to a range of audiences to promote adverse incident reporting, learning and implementation of safe systems;
- Developing local learning resources and protocols for NPSA alerts to ensure their implementation in primary care;
- Developing systems and processes to oversee the safe management of Controlled Drugs in primary care;

9. The extension of the team to primary care has permitted a whole systems approach to medication safety. This includes processes for handling medication incidents identified at the interface; development of medication incident categorisation to permit trend analysis across both sectors; and the identification of and collaboration on joint safety initiatives which support implementation of NPSA[1] Alerts e.g. insulin passport, loading doses etc

10. A Regional Medicines Safety Subgroup was established by the HSC Board in 2010, replacing the previous Medicines Governance Steering Group. In addition to this Group providing strategic advice and support to the regional medicines governance teams, its overall aim is to identify, develop and oversee implementation of patient safety initiatives as they relate to medicines in NI. The Group also has links with the Patient Safety Forum, Trust Policy Collaborative and the Safety Quality Alerts Team.

Paediatric medicine initiatives/guidance

11. Activities undertaken by the Medicines Governance Team related to paediatric medicines include:

    a. newsletters dealing with calculation errors in prescribing paediatric doses;
    b. reconstitution of oral antibiotics;
    c. Calculating the volumes of medicines required to administer the correct dose of a liquid medicine;
    d. Presenting sample questions and answers on abbreviations for milligrams, micrograms and nanograms in paediatric medicines of small volume;
    e. Safety memos eg.

        Use of oral syringes in the administration of liquid medicines

        Risk of overdose with intravenous paracetamol

        Action to Minimise the Risks with Buccal Midazolam Preparations

[1] On 1 June 2012 the key functions and expertise for patient safety developed by the National Patient Safety Agency (NPSA) transferred to the NHS Commissioning Board Special Health Authority.

Documents to be provided to the Inquiry

1. Medication Safety Today. The Northern Ireland Medicines Governance Team Newsletter. Issue 20. August 2007

2. Medication Safety Today. The Northern Ireland Medicines Governance Team Newsletter. Issue 24. August 2008

3. Medication Safety Today. The Northern Ireland Medicines Governance Team Newsletter. Issue 19.

4. Northern Ireland Medicines Governance Team. Safety Memo 9. 16th August 2005

5. Northern Ireland Medicines Governance Team. Safety Memo 15. 30th June 2011

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