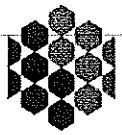
Safety, Quality and Standards Directorate
Chief Pharmaceutical Officer



Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

[redacted]
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ
Tel: [redacted]
Fax
Email: maura.briscoe[redacted]
Your Ref:
HSC (SQSD) 27/08
Our Ref:
Date: 10 April 2008

General Practitioners, Community Pharmacists
Chief Executives, HSS Boards
Chief Executive designate, HSC Authority
Chief Executives, HSC Trusts
Medical Director, HSC Trusts, for cascade to:
- CSCG leads

Regional Director of Public Health
Directors of Pharmacy, Boards and Trusts
Directors of Nursing, Boards and Trusts
Directors of Primary Care, HSS Boards
Chief Executive, RQIA, for cascade to:
- the independent sector
- relevant regulated establishments

Chief Executives, Special Agencies
Chief Executive, NICPPET
Chief Executive, MHC
Chief Executive, NIPEC
Chief Officers, HSC Councils
Director, NI Medicines Governance Team
Director, CSCG Support Team
General Manager, HSC Safety Forum

Dear Colleague

Re: National Patient Safety Agency: Safety in Doses; medication safety incidents in the NHS (PSO/04)

For Information:

In July 2007, the NPSA produced a detailed report on medication safety and related harm in the NHS. The report presents learning from almost 60,000 medicine-related incidents reported to NPSA between January 2005 and June 2006, as well as key messages from published research and data from other organisations such as the NHS Litigation Authority.

The report also details particular issues which emerged:

- injectable medicines (accounting for over half of reported deaths and severe harm medication incidents) – these have been addressed in recent NPSA guidance (see circular HSC(SQSD) 28/2007, which also makes reference to safer anticoagulant

therapy and promoting safer measurement and administration of liquid medicines via oral and other enteral routes).
- medication risks associated with transfers of care and the importance of accurate documentation (including medicine charts);
- problems with the availability and supply of medicines at the point where they are needed (including intubation and other essential medicines);
- medicines given outside normal ward round times or to patients with special medicine needs, such as children treated in general (non-paediatric) areas.

The report then goes on to identify seven key actions to improve medication safety, which are:

1. **Increase reporting and learning from medication incidents.**
   Increase reporting and learning from medication incidents and identify actions against local risks in an annual medication report.

2. **Implement NPSA safer medication practice recommendations.**
   Implement and audit the NPSA safer medication practice recommendations, including the alerts on anticoagulants, injectable medicines and wrong route errors referred to in circular HSC(SQSD) 28/2007.

3. **Improve staff skills and competences**
   Healthcare workers should ensure they have the required work competences and support to use medicines safely. Work competences for anticoagulant therapy, use of injectable medicines and paediatric infusions (see in relation to the latter circular HSC(SQSD) 20/2007) are set out in the NPSA safe medication practice work programme for 2007-08.

4. **Minimise dosing errors**
   Provide information, training and tools for staff to make calculations of doses easier, and target efforts towards high-risk areas (such as children) and high-risk drugs (such as insulin).

5. **Ensure medicines are not omitted**
   Identify current levels of omitted medicines and target areas for action (for instance, anticoagulation or other high-risk medication). Review medicine storage and medication supply chains.

6. **Ensure the correct medicines are given to the correct patients**
   Improve packaging and labeling of medicines and support local systems that make it harder for staff to select wrong medicines or give medicines to wrong patients.

7. **Document patients' medicine allergy status**
   Improve recording of patient allergies, and raise awareness amongst staff of high-risk products and the importance of knowing the patient's allergy status.

As the report highlights, four out of five of the incidents reported to NPSA occurred in a hospital setting, although most medication activity happens in the community (ie. general medical practice, community pharmacy, patient's own home, residential nursing home or nursing home). The report is therefore important to the primary care and independent care sector.

This is for information only but you may wish to use when considering policy and practice implementation in relation to medicines management.

The report can be accessed on

http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/directives-guidance/safety-in-doses/

Safer medication is everybody's business and small changes can make a real difference in reducing harm to patients.

Yours sincerely

Dr N Morrow
Chief Pharmaceutical Officer

Dr M Briscoe
Director, Safety, Quality and Standards