SQS CIRCULARS: ASSURANCE TEMPLATE FOR HSC BOARD AND TRUSTS

Circular number: HSC (SQSD) 17/10: Preventing fatalities from medication loading doses

SECTION 1:

To: Chief Executive, HSC Board

[ ] I can confirm that the required actions set out in the above circular have been implemented in full by the due date.

[X] I can confirm that the actions in the above correspondence have been partially implemented by the due date. The issues impacting on full implementation along with the timescales for resolving these issues are set out in the box below:

DHSSPS / NPSA Actions:

1. All medicines used by the organisation that are likely to cause harm if loading doses and subsequent maintenance doses are not prescribed and administered correctly are risk assessed and used to produce a list of critical medicines (which contain speciality sub sections). This must include warfarin, amiodarone, digoxin, phenytoin and any other medicines identified locally.
2. There is effective communication regarding loading doses and subsequent maintenance dose regimens when prescribing, dispensing or administering critical medicines. This should include handover of patients between healthcare organisations. Tools such as loading dose prescription charts, handover and clinical protocols and patient held information should be considered.
3. Clinical checks are performed by medical, nursing and pharmacy staff (when available) so that loading doses are correct. Appropriate information should be available to support these checks.
4. Healthcare professionals in the community know when to challenge abnormal doses of the identified critical medicines.

WHSCT Action to date:

- Work has yet to properly commence on this rapid response report, although guidance does exist within the Trust to aid prescribing decisions for:
    i. Warfarin – Anticoagulant prescription and administration record
    ii. Gentamicin – Chart in use in NNICU and currently piloting adult version. Antimicrobial guidelines also provide advice on dosing.
    iii. Unfractionated heparin – Chart on WHSCT intranet
- Discussions are also taking place to ascertain whether this issue can be driven regionally to support a consistent and standardised approach across all Trusts. Regional Medicines Safety Subgroup to discuss.

[ ] I can confirm that the organisation has been unable to implement any actions of the above circular for the reasons set out in the box below. (The actions being taken/required to resolve or clarify the issues preventing implementation and the timescales for this should be outlined):

I confirm that the HSC Trust's Chief Executive and designated senior manager have been advised of this response and are content that it should be submitted to the HSC Board.

Response submitted by: _Daryl Connolly on behalf of WHSCT Trust. Date: 5th August 2011

SECTION 2:

To: Director, Safety, Quality & Standards Directorate, DHSSPS

I note the response from the Trust and –

[ ] I can confirm that the HSC Board is content the action(s) taken, referred to in Section 1, complies with the requirements of the above circular.

[ ] I can confirm that further action, as outlined in the box below, is needed to ensure compliance with the requirements of the above circular

I confirm that the HSC Board's Chief Executive and designated senior manager have been advised of this response and are content that it should be submitted to the Department.

Response submitted by: _____ (Name & contact details of person submitting response)

on behalf of HSC Board. Date: _____