Learning from medication incidents in Adult Critical Care

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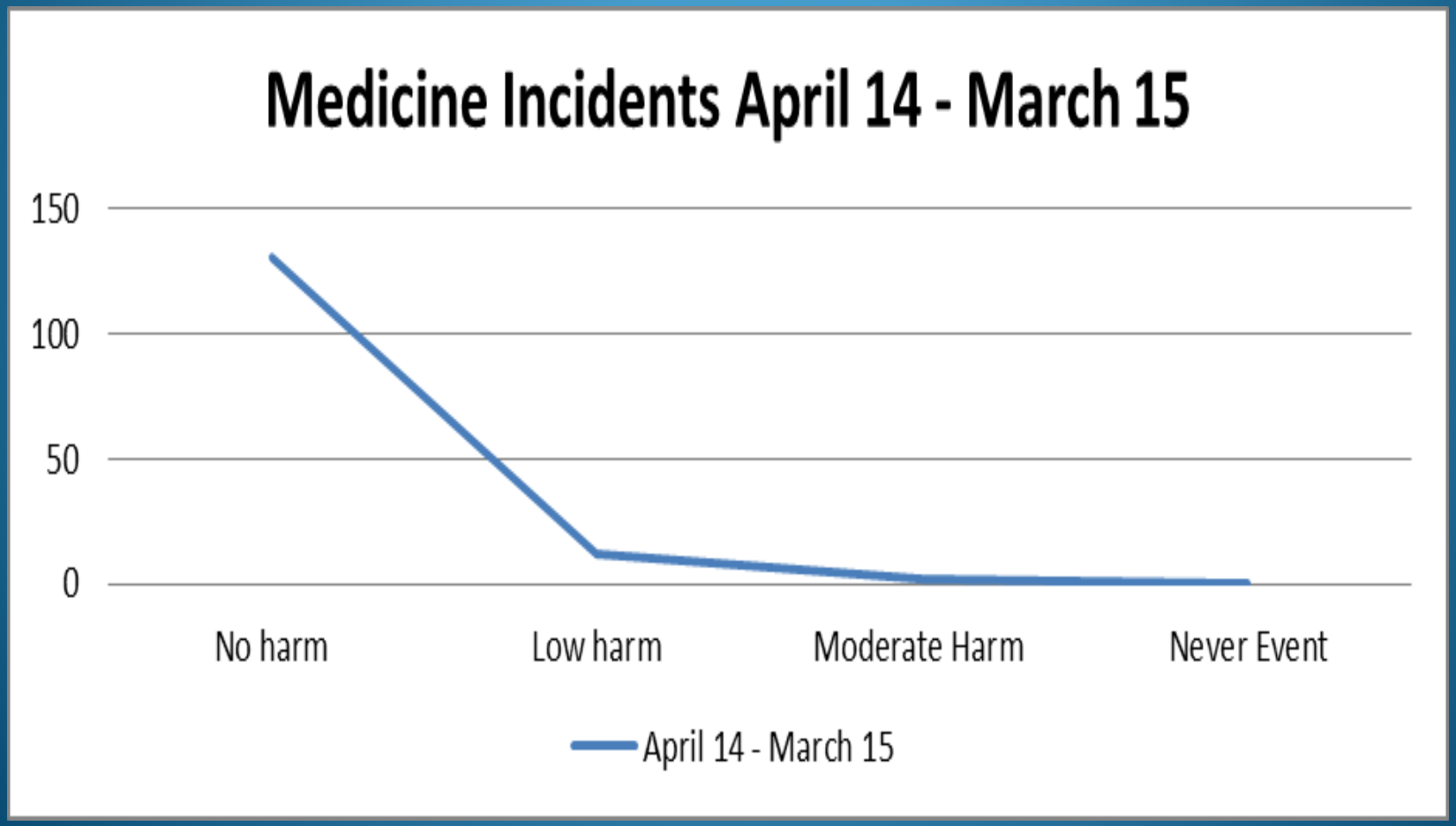
Aim

- To understand why medication errors occur
- Identify processes to improve medication errors
- Develop learning
- Reduce recurring themes.

A high reporting rate should not be interpreted as an unsafe organisation, and may actually represent a culture of greater openness.

National Reporting and Learning Systems (April 2015)

Medication incidents



Method

- Review Datix incidents
- Review investigations involving medication
- Identify any themes
- Engage the multi professional team
- Introduce Medicines Champions
- Use of handover tool
- Evaluation

Nottingham University Hospitals NHS

Adult Critical Care 14 Day Handover Communication Tool

Date: 26th January 2015

This information should be handed over by the Nurse In Charge to all nursing staff at the start of each shift				
Subject	**Additional Information**	**Day**	**Handed Over By Name/signature (NiC)**	**Handed Over By Name/signature (NiC)**
Medicines **Right patient**	• Identify patient correctly; talk to them • Ensure ID band matches unique identifying number • Check name & drug card matches ID band	Monday 26th		
		Tuesday 27th		
Medicines **Right Day, Time, Drug & Indication**	• Check all pages in drug chart, including 'once only' & 'as required' & additional charts • Prescription must be legible & signed	Wednesday 28th		
		Thursday 29th		
Medicines **Contraindications**	• Check allergy box on front of chart is completed & signed before administering drugs • If allergy present – check ID band is RED	Friday 30th		
		Saturday 31st		
Medicines **Second Checking**	• Responsibilities for 'second checking' • are equal for both practitioners. • As part of accountability handover take drug chart to infusions & follow lines.	Sunday 1st		
		Nurse in Charge Message: Please discuss with nurse In charge / Team Leader before asking for medical advice.		

Team Leader Responsibilities – To be delivered to Team Leaders after Handover in the clinical areas

1. (Information Giving) Ensure bedside checks are completed
2. (Check and Challenge) Ensure double signing on drugs chart & 24 hour chart as necessary
3. Ensure appropriate ID band on patients

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NHS Trust

Adult Critical Care 14 Day Handover Communication Tool

Date: 9th February 2015

This information should be handed over by the Nurse In Charge to all nursing staff at the start of each shift				
Subject	**Additional Information**	**Day**	**Handed Over By Name/signature (NiC)**	**Handed Over By Name/signature (NiC)**
Medicines **Infusions: Prescribed**	• Ensure infusions are prescribed • Utilise bedside pharmacy folders to check • Plan prescribing eg have enough crystalloid for night through to morning	Monday 16th		
		Tuesday 17th		
Medicines Infusions: **Equipment**	• Ensure correct use of pumps at bedside • Use of DERS on Alaris infusion pump • If on inotropes ensure line not aspirated by Dr for Blood Cultures	Wednesday 18th		
		Thursday 19th		
Medicines Infusions: **Timely**	• Ensure that patient safety is not compromised eg if fitting give drugs not continue washing! • Ensure all drugs are given in a timely fashion	Friday 20th		
		Saturday 21st		
Medicines **Second Checking**	• Responsibilities for 'second checking' are equal for both practitioners. • As part of accountability handover take drug chart to infusions & follow lines.	Sunday 22nd		
		Nurse in Charge Message: Please discuss with nurse In charge / Team Leader before asking for medical advice.		

Team Leader Responsibilities – To be delivered to Team Leaders after Handover in the clinical areas

1. (Information Giving) Ensure bedside checks are completed
2. (Organisation) Ensure appropriate ID band on patients
3. (Check and Challenge) Ensure double signing on drugs chart & 24 hour chart as necessary

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Adult Critical Care 14 Day Handover Communication Tool

Date: 23rd February 2015

This information should be handed over by the Nurse In Charge to all nursing staff at the start of each shift				
Subject	**Additional Information**	**Day**	**Handed Over By Name/signature (NiC)**	**Handed Over By Name/signature (NiC)**
Medicines **Infusions: Pumps**	• Ensure pumps are appropriately set up for infusions • Use of DERS • Prime lines through pumps to take up 'slack'	Monday 23rd		
		Tuesday 24th		
Medicines Infusions: **Lines**	• Ensure correct use of non pvc lines for drugs e.g. nimodipine • When changing infusion rate, ensure you follow the line through from the infusion to the correct pump	Wednesday 25th		
		Thursday 26th		
Medicines Infusions: **Infusions**	• Ensure infusions are changed prior to expiry – remember some drugs only have 24hr life • Ensure infusions are made up in time before they run out • Don't leave infusions in bed area for colleague to put it up – if you made it, put it up with 2nd check	Friday 27th		
		Saturday 28th		
Medicines **Second Checking**	• Responsibilities for 'second checking' are equal for both practitioners. • As part of accountability handover take drug chart to infusions & follow lines.	Sunday 29th		
		Nurse in Charge Message: Please discuss with nurse In charge / Team Leader before asking for medical advice.		

Team Leader Responsibilities – To be delivered to Team Leaders after Handover in the clinical areas

1. (Information Giving) Ensure bedside checks are completed

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Daily Safety Walk Round

CATEGORIES	PROMPTS	
Drug Chart	• Name, DOB, Hosp no, Ward, Allergy • Clear & legible	• Review dates • Pharmacy check
24 hr chart	• Fluid balance • Infusion rates signed	• Drug concentration completed • Matches prescription
Medicines Management Chart	• Omissions completed & signed • Plan in place to get drugs	• Critical drugs list – importance of
Infusions	• Lines labelled • DERS programmed	• 2 witness check • Drug compatibility
Controlled Drugs	• 2 signatures, 1 must be a registered practitioner to witness the preparation & administration	• Patients name, date, time • Enter correct CD balance in register
Education	• IV pack completed • Team Leader support • Pharmacist availability	• Pharmacist availability
Aware when a drug error occurs & is able to report on datix	• Check patient observations & condition • Inform Nurse in Charge • Inform medical staff	• Report on datix (check before submitting with NIC/B7) • Document all of the above in notes.
5 rights in administration	• Patient • Medicine • Date & Time	• Route • Dosage
Unavailable medication	• Double check not available on ward • Contact pharmacy to see if available	• If on drugs critical list, stress the importance of to pharmacy • Record on Medicines management chart reason for delay/omission

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Next steps improvement plan

- Pilot Audit (observational)
- Reduce Non compliance with policy
- Raise awareness of common themes
- Reiterate the 2nd checking drugs process
- Emphasise importance of CD's & infusion rate changes
- Ensure improvements are completed by same 2 nurses

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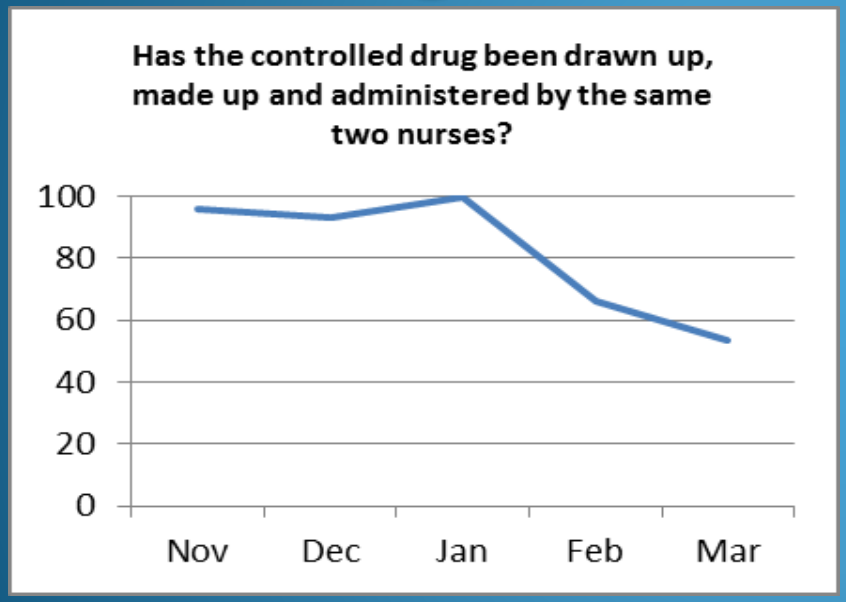
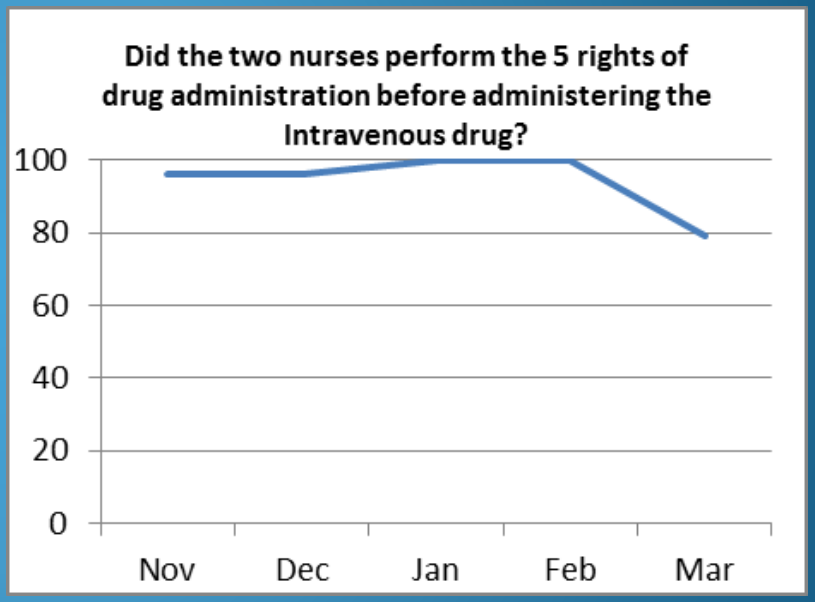
Findings


Has the controlled drug been drawn up, made up and administered by the same two nurses?
100
80
60
40
20
0
Nov
Dec
Jan
Feb
Mar


Did the two nurses perform the 5 rights of drug administration before administering the Intravenous drug?
100
80
60
40
20
0
Nov
Dec
Jan
Feb
Mar

Registered Audit

Current progress

Re audit June 17 – November 17

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Learning points

- Multi professional engagement is vital
- Short messages at handover
- Reinforce best practice
- Measure improvement by audit
- Don’t expect 100% in your results; the unexpected can occur
- Medicines Champions impact
- Continuous learning

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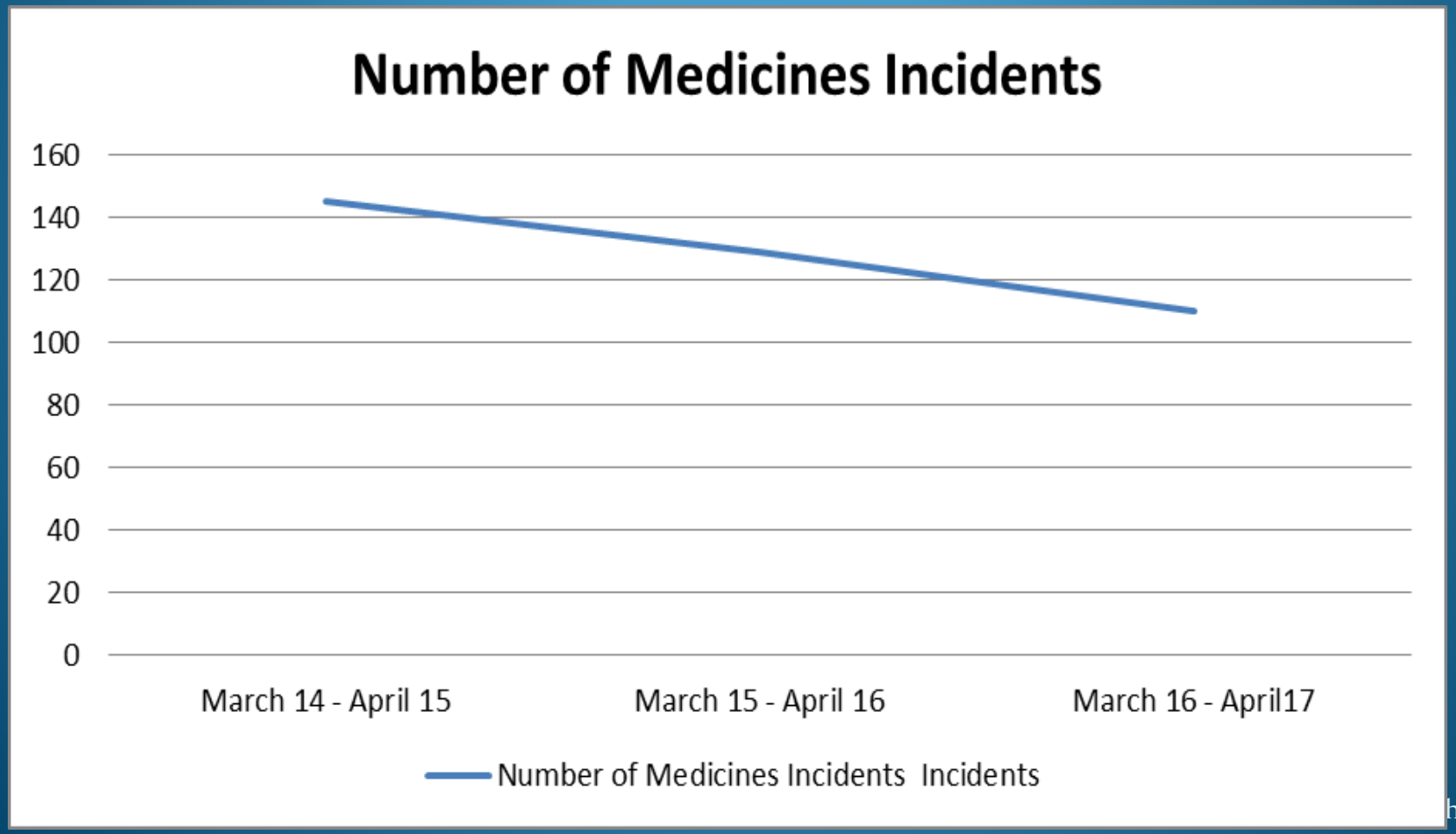
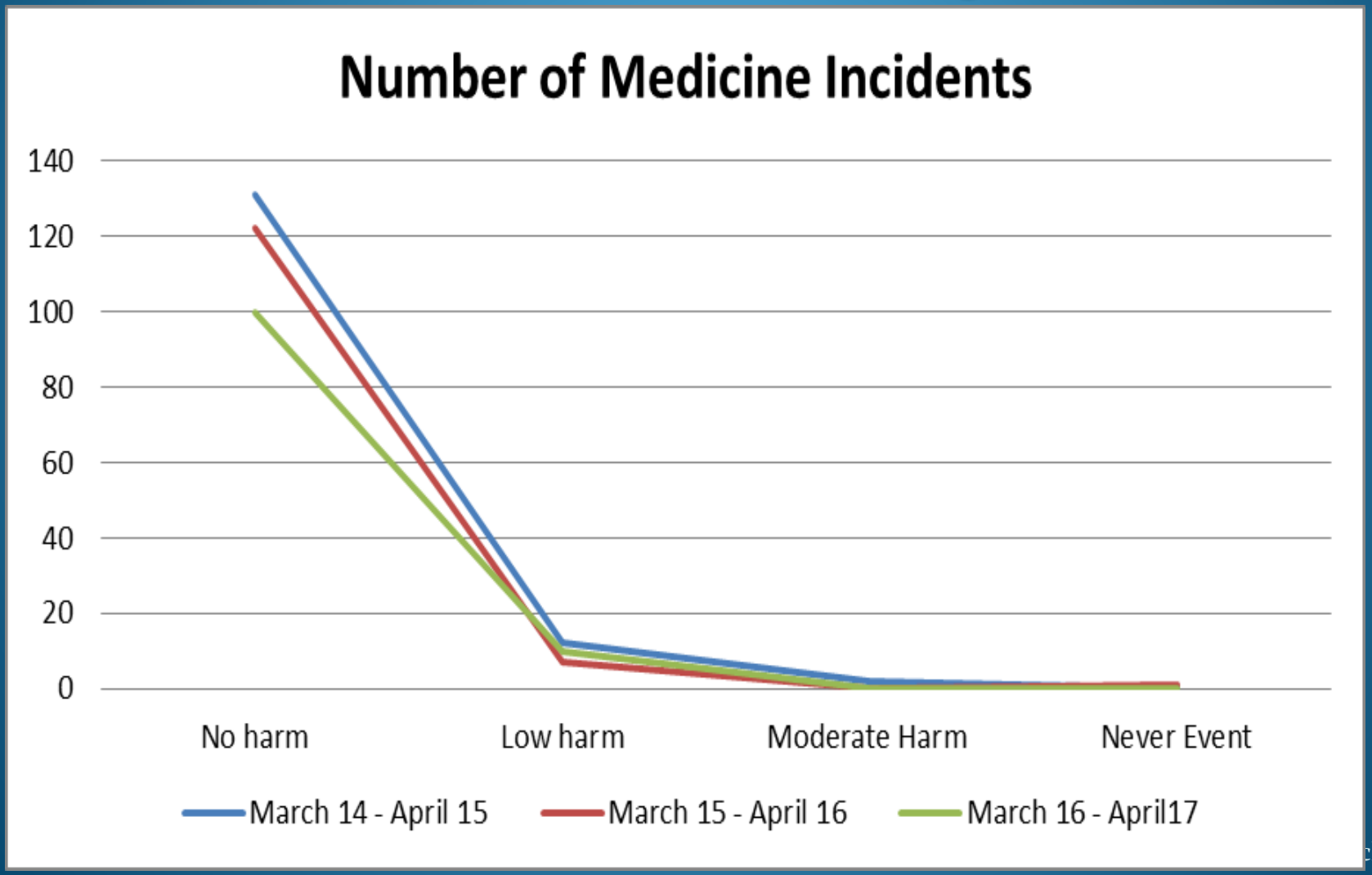
Medicines incidents 3 years



Level harm over 3 years



Conclusion

- Ongoing work
- Reduction in incidents reported
- Reduction in level of harm
- Harm not number of incidents
- Open culture
- No complaints from relatives

References

- National Reporting and Learning Systems (April 2015) Supporting Information for Organisation Patient Safety Incident Reports
- NHS England (March 2015) Medication Safety in the NHS
- NHS England (March 2014) Improving medication error incident reporting and learning