Ashford and St. Peter's Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS
5th September 2018

TITLE	**Medication Safety**
EXECUTIVE SUMMARY	This paper provides an update on medication safety including learning from incidents and an infographic for the month of June.
The Council is asked to:	Note the update
Submitted by:	Sue Tranka, Chief Nurse
Date:	September 2018
Decision:	For Noting

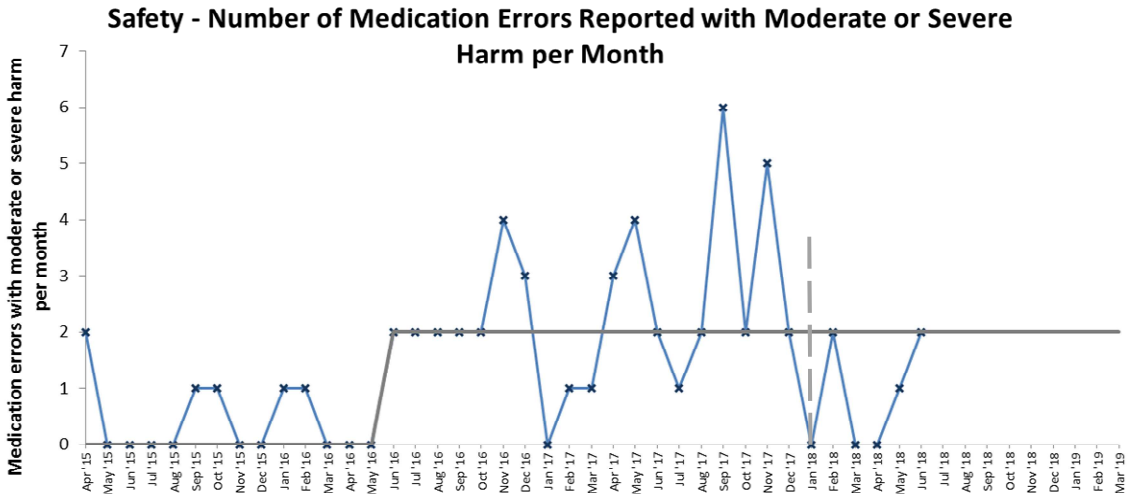
Ashford and St. Peter's Hospitals
NHS Foundation Trust

IMPROVING MEDICATION SAFETY:
REDUCING HARM TO PATIENTS RESULTING FROM MEDICATIONS ERRORS AND SERIOUS INCIDENTS

Our quality priority for 2018/2019 is to become a learning organisation in order to eliminate avoidable harm to our patients and to provide an excellent patient experience, and the focus of the work for this year is improving medication safety.

The medication safety improvement programme began in January 2018 and (aligning with the national drive to reduce harm caused by medicines) our aims are to:

i) Reduce medication safety incidents that result in moderate or severe patient harm by 30% by March 2019
ii) Increase reporting of incidents with 'no harm' by 30% by March 2019



Since January 2018, there have been five confirmed medication incidents which resulted in moderate patient harm. Moderate harm is where the patient needs professional intervention, this can range from advice to treatment. There is a further case under review.

In June 2018 there were two confirmed medication incidents which resulted in moderate patient harm, which we have detailed below.

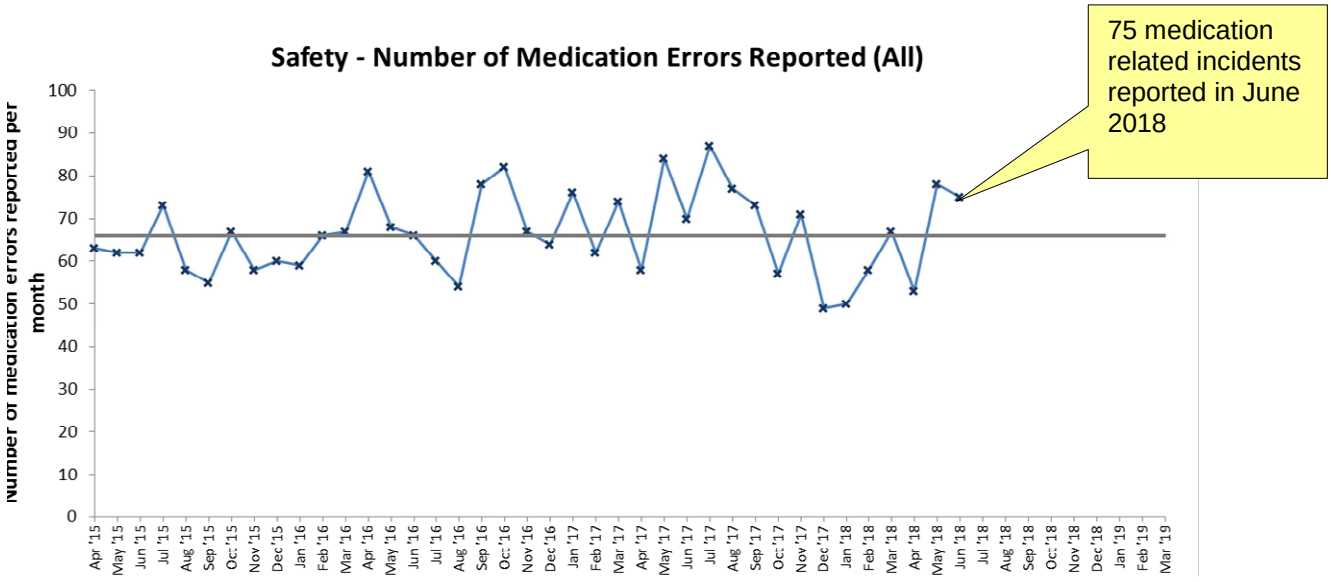
The first incident relates to a patient attending the Emergency Department with a chest infection who was administered IV antibiotics and subsequently developed an anaphylactic reaction. At the time, no documented history of allergy was apparent in information resources available across health services. It later transpired that the GP practice had a hand-written note of penicillin allergy which had not been transferred to electronic records. The GP will be reviewing processes to ensure this cannot reoccur with other patients.

In the second incident, a patient with poor kidney function was prescribed Oxycodone (a powerful painkilling drug), which they had never taken before. Post-surgery the patient experienced a low respiratory rate and was transferred to Surgical High Dependency Unit for monitoring. This incident is being investigated and the initial learning from this will be shared with all teams in the month ahead.

As well as aiming to reduce the number of medication-related incidents that result in patient harm, the programme is also aiming to increase reporting of all incidents, and specifically those that result in no harm.

It is important to note that, although this is not an outcome measure, this is an important 'proxy measure' for improving the learning culture, in which all members of the team are encouraged to report incidents and near-misses in pursuit of improvement in patient care.

In June 2018 there were 75 medication-related incidents reported, of which 5 resulted in patient harm of 'low' severity. Low severity means minor illness or injury that does not necessarily need medical intervention.



As part of the improvement programme, a small project group has been working to raise the profile of medication safety improvement and to support clinical teams with their own improvement efforts.

In the last month, the team have been working to test an approach to responding to incidents which includes face-to-face sharing of learning and understanding of systems-errors, where more than one element of care is involved. This work has been supported by the Patient Safety Team.

Further work includes:

- Auditing omitted doses and understanding the root-causes of errors relating to omissions (missed doses).
- Forming a Venous Thromboembolism Medication team specifically to reduce harm from omissions of the blood thinning drug Enoxaparin.
- Testing updated and simplified Insulin guidelines in the Emergency Department.
- Shadowing drug rounds and working with nursing teams to identify areas for improvement in these.
- Compiling and sharing key medication safety messages and infographics (see Appendix B)
- Embedding the new adult, inpatient drug chart and commencing work on the proposed children's drug chart.
- Supporting medication safety week with the Patient Safety Team.

LEARNING FROM MEDICATION INCIDENTS - GENTAMICIN

Gentamicin is a commonly used, very effective antibiotic, however care must be taken with dosage, as the main side-effects are dose-related and affect the kidneys and hearing.

There have also been two patient safety incidents in 2018 related to Gentamicin and the common factors from both of these incidents relates to the calculation of the dose required. This needs to take into account a patient's weight, height and kidney function. The prescriber needs to ensure they adjust the dose to include changes in these parameters.

There are a number of learning points from these incidents which will be shared with the teams involved; however, all teams are also being asked to use the Trust's gentamicin calculator for every prescription.

The calculator is a tool available on every Trust computer that automatically adjusts the dose based on a patient's weight, height and kidney function as well as highlighting maximum doses allowed. Based on this learning, there will be further communication and teaching on the use of the Gentamicin calculator. This teaching was included in the junior doctor induction in early August.

Quality of Care
Creating a learning organisation and culture of continuous improvement to reduce repeated harms and improve patient experience.

'Becoming a learning organisation'

JUNE 2018 - MEDICATION SAFETY UPDATE

NHS
Ashford and St. Peter's Hospitals
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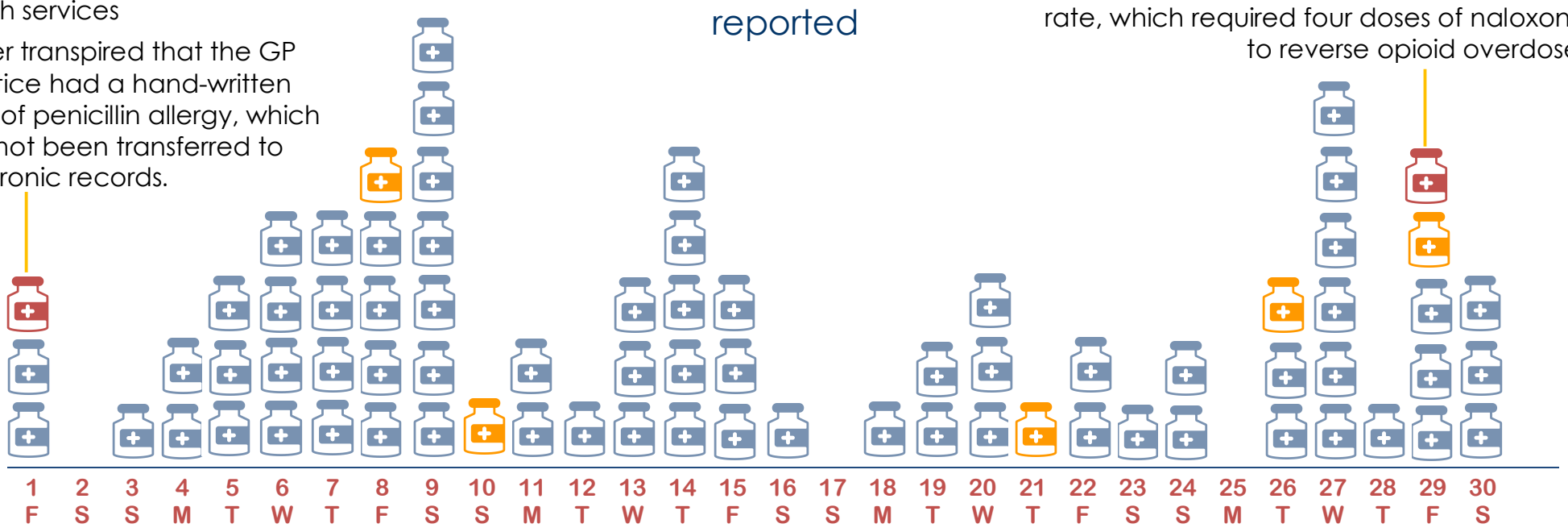
75

Medication related incidents reported

In ED, a patient prescribed co-amoxiclav IV, experienced a life-threatening anaphylactic reaction. At the time, no documented history of allergy was apparent in information resources across health services

It later transpired that the GP practice had a hand-written note of penicillin allergy, which had not been transferred to electronic records.

An 81 year old woman with poor renal function was NEWLY prescribed oxycodone modified release 10 mg BD. Post-surgery the patient experienced a low respiratory rate, which required four doses of naloxone to reverse opioid overdose.

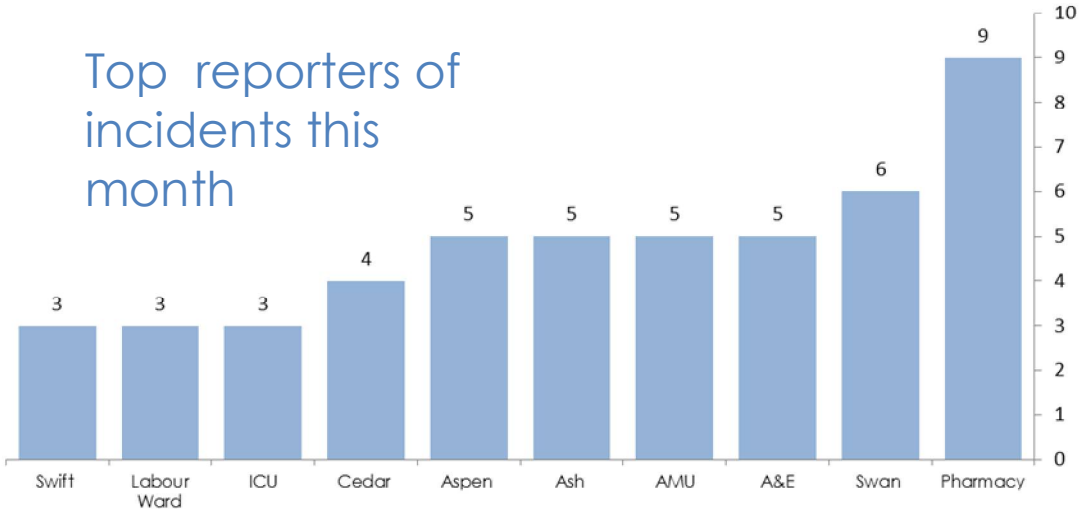


= Medication incident recorded with NO HARM

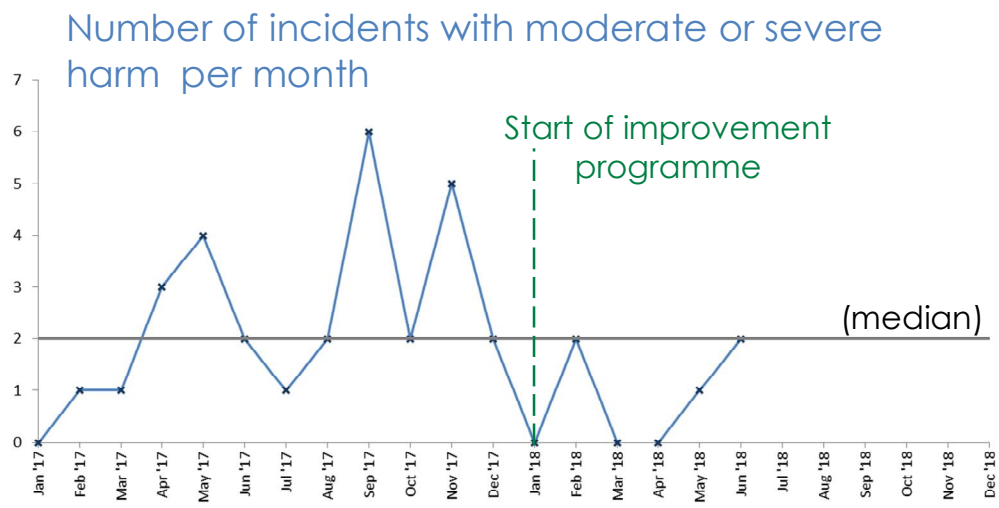
= Medication incident recorded with LOW HARM

= Medication incident recorded with MODERATE or SEVERE HARM

Top reporters of incidents this month



Number of incidents with moderate or severe harm per month



LEARNING FROM INCIDENTS: GENTAMICIN

Gentamicin is a commonly used, very effective antibiotic, however care must be taken with dosage, as the main side-effects are dose-related (nephrotoxicity and ototoxicity).

A gentamicin dose should take account of a patient's weight, height and renal function. Adjusting for these parameters is particularly important when a patient's mass is >20% above their ideal body weight (IBW) and/or where there is renal impairment.

RECENT INCIDENTS

In 2017 there were 10 incidents involving Gentamicin, 4 of which led to patient harm. In 2018, there have been 2 patient-safety incidents in which incorrect, high doses of gentamicin have been prescribed and administered.

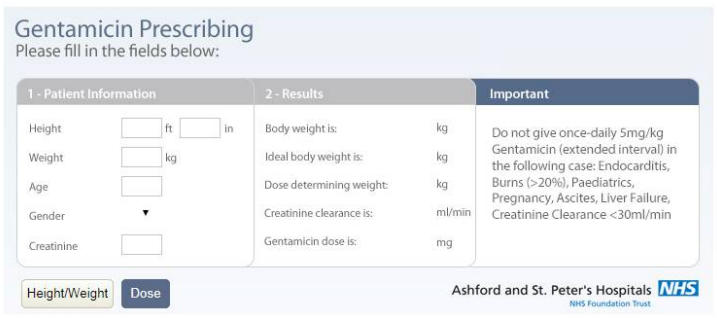
In one incident, a patient was prescribed and administered a 650 mg dose of gentamicin.

The maximum dose of gentamicin in this Trust is **480 mg** in a 24 hour period.

ALWAYS USE THE GENTAMICIN CALCULATOR

The Trust's gentamicin calculator automatically adjusts the dose based on the patient's weight, height and renal function. Please use this safety measure:

http://www.dapsglobal.com/SPHCalc/index.html



REPORTING INCIDENTS

One of the aims of the medication safety programme is to increase reporting of all incidents, and specifically those that result in no harm.

This is an important measure for an improving and learning culture, in which all members of the team are encouraged to report incidents and near-misses in pursuit of improvement.

Please report all incidents involving medicines, regardless of whether they cause harm or not.

Please report all incidents on Datix.

To find out more or to get involved in the medication safety programme please get in touch with any member of your Divisional Governance Team