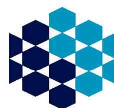
Dr Jim Livingstone
Director of Safety, Quality and Standards



Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

Rapid Response Report

Circular Reference: HSC (SQSD)03/10

Date of Issue: 30 March 2010

Subject:

Reducing harm from omitted and delayed medicines in hospital

For action by:
Chief Executives, HSC Trusts for cascade to:
- *Directors of Pharmacy*
- *Medical Directors*
- *Directors of Nursing*
- *Director of Mental Health and Learning Disability*
- *CSCG leads*

Chief Executive, HSC Board
Assistant Director of Pharmacy & Medicines Managements, HSC Board for cascade to
- *Pharmacy & Medicines Management Team*

Chief Executive RQIA for cascade to:
- *Independent hospitals and clinics*

For Information to:
Chief Executive, Public Health Agency
Director of Public Health, Public Health Agency
Director of Nursing, Public Health Agency
Director of Performance Management & Service Improvement, HSCB
Director of Integrated Primary Care Services HSCB
Assistant Director of Performance Management, HSC Board
Assistant Director, Primary Care, HSCB
Professor David Woolfson, Head of School of Pharmacy, QUB
Professor Linda Johnston, Head of Nursing & Midwifery, QUB
Professor Hugh McKenna, Head of Life & Health Sciences, UU
Dr Owen Barr, Head of School of Nursing, UU
Professor Paul McCarron, Head of School of Pharmacy, UU
Post Graduate Dean, NIMDTA
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development

Summary of Contents:
The purpose of this circular is reduce harm from omitted and delayed medicines in hospital

Enquiries:
Any enquiries about the content of this Circular should be addressed to:
Safety & Quality Unit
DHSSPS
Room D2.4
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: 028 9052 2239
qualityandsafety@dhsspsni.gov.uk

Related documents
HSC (SQSD) 27/08 Safety in Doses
http://www.dhsspsni.gov.uk/hsc__sqsd__27_08.pdf

Superseded documents

N/A

Status of Contents:
For completion of actions and assurance templates by 30 March 2011

Implementation:

Immediate

SQSD material can be accessed on:
http://www.dhsspsni.gov.uk/index/phealth/sqs.htm

Working for a Healthier People

Chief Medical Officer Group

Dear colleagues

Reducing harm from omitted and delayed medicines in hospital

Medicine doses are often omitted or delayed in hospital for a variety of reasons. Whilst these events may not seem serious, for some critical medicines or conditions, such as patients with sepsis or those with pulmonary embolisms, delays or omissions can cause serious harm or death. Patients going into hospital with chronic conditions are particularly at risk.

The content of the attached circular at Annex A has been reviewed by relevant professional colleagues in the Department and approved for regional dissemination.

I would ask you to bring this to the attention of relevant practitioners and key health and social care staff within your organisation. They should consider the best practice for their setting and take appropriate steps to minimise the risks to patients.

I would also draw your attention to the attached ‘assurance template’ which is a means of recording the response from the Trusts and Board in circumstances where SQS Circulars require action to be taken by a given date.

Yours sincerely

Dr J F Livingstone
Director, Safety, Quality & Standards

Annex A

REDUCING HARM FROM OMITTED AND DELAYED MEDICINES IN HOSPITAL

Issue

1. Medicine doses are often omitted or delayed in hospital for a variety of reasons. Whilst these events may not seem serious, for some critical medicines or conditions, such as patients with sepsis or those with pulmonary embolisms, delays or omissions can cause serious harm or death. Patients going into hospital with chronic conditions are particularly at risk.

2. A review of medication incidents by the National Patient Safety Agency (NPSA) in 2007 revealed that omitted and delayed medicines was the second largest cause of medication incidents reported to the Reporting and Learning System (RLS). The data highlighted that for some kinds of medicines, such as antibiotics, anticoagulants and insulin, an omitted or delayed dose can have serious and even fatal consequences.

National Context

3. The NPSA has reported that between September 2006 and June 2009, it received reports of 27 deaths, 68 severe harms and 21,383 other patient safety incidents relating to omitted or delayed medicines. Of the 95 most serious incidents, 31 involved anti-infectives (antibiotic and antifungals), and 23 involved anticoagulants. Wider evidence suggests that the true rate of harm may be much higher, as events such as these are often not reported.

4. Work on reducing risks with omitted and delayed critical medicines is needed over a long period. The NPSA is recommending a staged approach, with initial actions now focused on specific critical medicines and longer term work with stakeholders over the next two years to sustain improvements over time.

5. NPSA/2010/RRR009: Reducing harm from omitted and delayed medicines in hospital is available on: http://www.nrls.npsa.nhs.uk/resources/?entryid45=66720

Local Context

6. This circular is being brought to the attention of all HSC organisations and independent sector organisations who admit patients for in-patient treatment for immediate action. It is recommended that an executive officer, working with the chief pharmacist and relevant medical/nursing staff should:

    - identify a list of critical medicines where timeliness of administration is crucial. This list should include anti-infectives, anticoagulants, insulin,

resuscitation medicines and medicines for Parkinson’s disease, and other medicines identified locally;

- ensure medicine management procedures include guidance on the importance of prescribing, supplying and administering critical medicines, timeliness issues and what to do when a medicine has been omitted or delayed;

- review and, where necessary, make changes to systems for the supply of critical medicines within and out-of-hours to minimise risks;

- review incident reports regularly and carry out an annual audit of omitted and delayed critical medicines. Ensure that system improvements to reduce harm from omitted and delayed medicines are made. This information should be included in the organisation’s annual medication safety report;

- make all staff aware (by wide distribution of this circular) that omission or delay of critical medicines, for inpatients or on discharge from hospital, are patient safety incidents and should be reported.

Action Required

7. You will wish to bring the contents of this document to the attention of staff, particularly those involved in governance and risk management within your organisation. Organisations need to be aware of this best practice circular in order to assist in complying with the Quality Standards for Health and Social Care –

   - Criteria 4.3(i) (the appropriate management of risk);
   - Criterion 5.3.1(f)(viii) (ensuring safe practice in medicines management); and
   - Criterion 5.3.3(f) (implementation of evidence-based practice through guidance, for example, NPSA guidance).

8. HSC Trusts should take immediate action to implement this Rapid Response Report as outlined in paragraph 6 above by **30 March 2011**. Trusts should provide assurance on this action to the HSC Board by completing ***Section 2*** of the attached template.

9. The HSC Board should complete ***Section 1*** of the attached assurance template and forward to the Department by **27 April 2011**.

SQS CIRCULARS: ASSURANCE TEMPLATE FOR HSC BOARD AND TRUSTS

Circular number: HSC (SQSD) 03/10 Reducing harm from omitted and delayed medicines in hospital
For Implementation by: 30/03/2011
(Section 2 is to be completed by HSCT and forwarded to HSCB for consideration. Section 1 should then be completed by HSCB and forwarded to DHSSPS)

SECTION 1:

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 2 below, complies with the requirements of the above circular.

☐ I can confirm that the HSC Board is monitoring compliance with the above circular and has requested that further action is taken as follows:

I confirm that the 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: _____________________

SECTION 2:

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.

☐ I can confirm that the actions in the above correspondence have been partially implemented by the due date. Work is ongoing in the following areas:

☐ I can confirm that the organisation has been unable to implement any actions of the above circular for the following reasons:

I confirm that the 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: ______________________ (Name & contact details of person submitting response) on behalf of ______________ HSC Trust. Date: ____________________________