The Northern Ireland Medicines Governance Project

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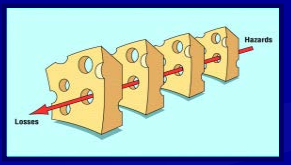
27th January 2005

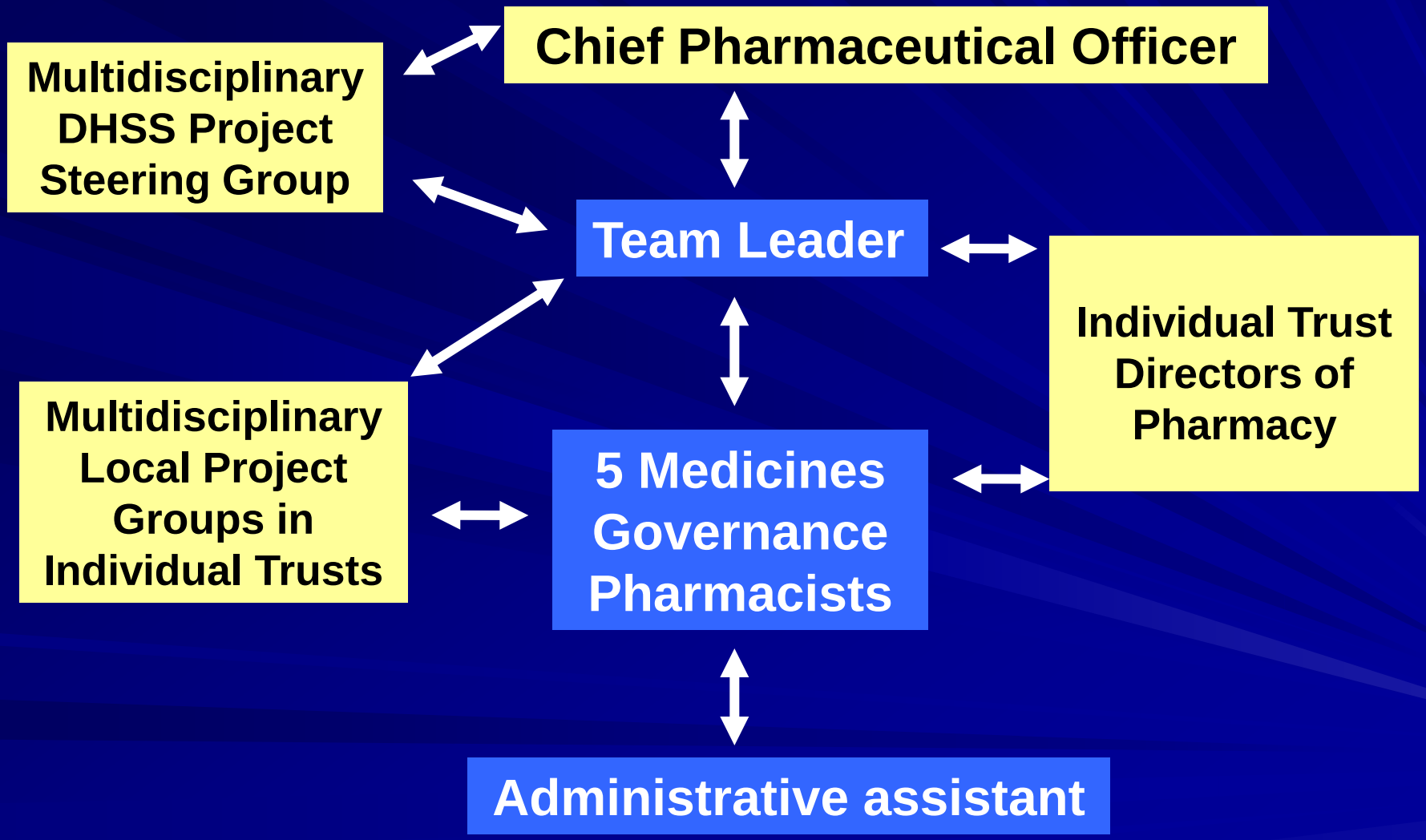


‘First, do no harm’

Medication incidents are the most common preventable cause of patient injury.

- 2-14% of patients admitted to hospital experience a medication incident and 1-2% of patients are harmed as a result of medication incidents.
- Medication incidents cost the NHS £500 million pa in additional days spent in hospital (Building a Safer NHS for Patients DOH 2001)

Team structure



Team aim

To minimise medication related risk in Northern Ireland Hospitals

Determining the safety culture

Questionnaire developed to discover

- The main barriers to incident reporting
- The perception of the current blame culture

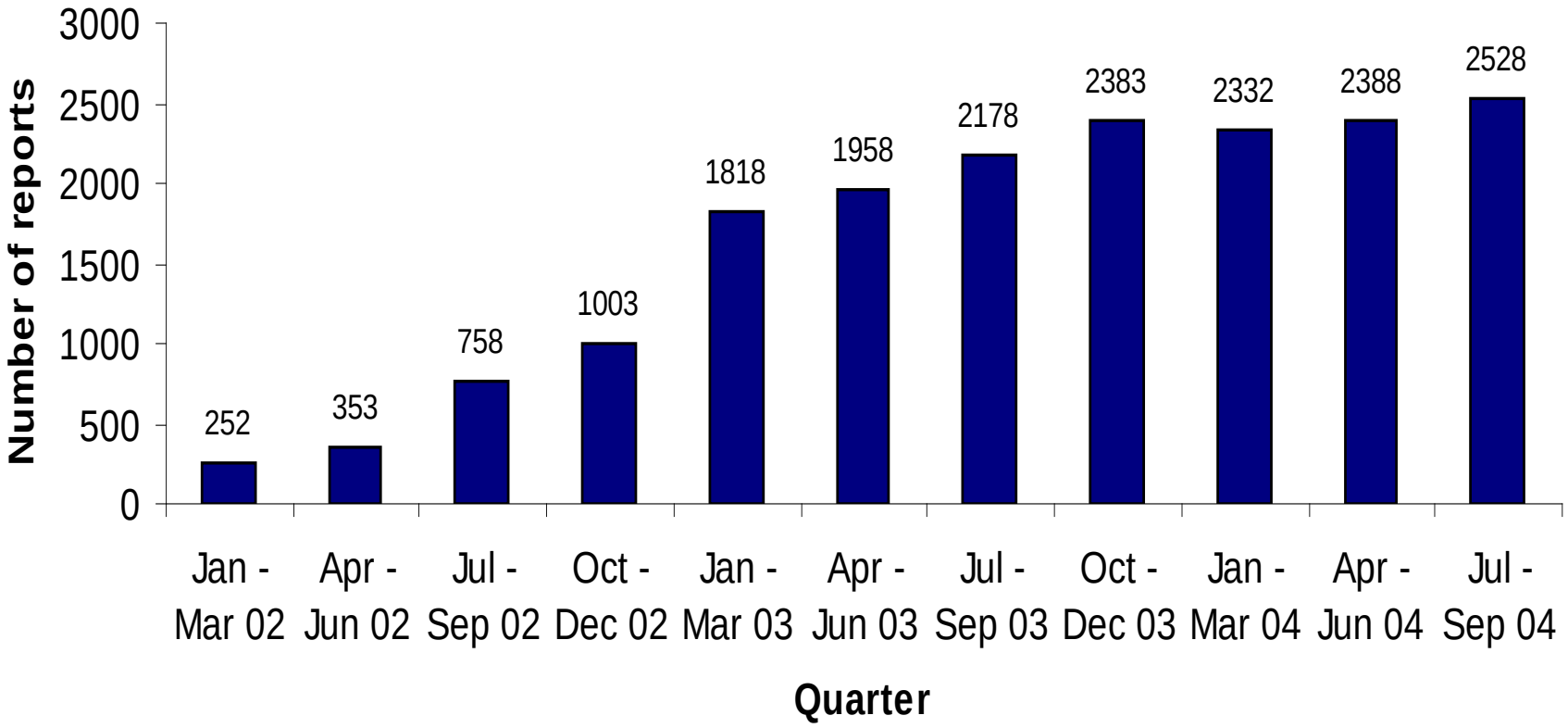
- 14,000 distributed to medical, nursing, pharmacy and senior management staff

Address under reporting

- Promote discussion of a ‘safety culture’.
- Raise awareness of importance of reporting.
- Review incident reporting policies and procedures.
- Educate staff on what and how to report.

Medication Incident Reporting

Figure one: Total number of medication incident reports



Management of medication incident data

Individual Trust and regional data can be analysed for:

- Near miss/adverse event ratio
- Common prescribing, dispensing, administration incidents
- Actual outcome for patients
- Risk rating

Reducing medication related risk

- Development and implementation of policies for safe medication use
- Development of safety memoranda
- Staff education and training

Policies for safe medication use

- The use of concentrated intravenous potassium solutions
- The prescribing and supply of warfarin tablets
- The use of oral methotrexate
- The use of oral syringes
- The documentation of allergy status

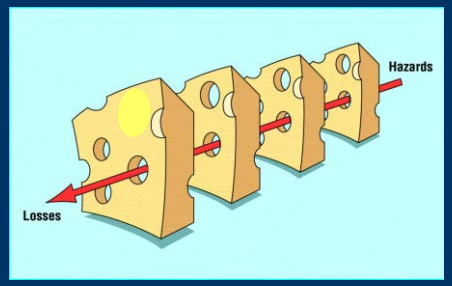
Safety memoranda

- Revaccination with Pneumovax ®
- Inadvertent bolus administration of vancomycin injection
- Change to labelling of dexamethasone injection
- Administration of phenytoin injection
- Changeover from BANs to rINNs
- Dosing of enoxaparin in renal impairment
- Change in packaging of Priadel® 200mg tablets

Staff education and training

- Trust incident feedback
- Undergraduate / postgraduate training
- Induction of new staff
- Newsletter
- Website

Medication Safety Today



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0.5g or 500 mg?

Writing medication strengths correctly can prevent medication incidents.

The BNF prescription writing guidelines set out the safe and acceptable way of writing strengths and also which abbreviations may be used.

Strength	Acceptable abbreviation
Gram	g
Milligram	mg
Microgram	Must be written in full
Nanogram	Must be written in full
Units	Must be written in full
Millilitre	ml or mL

- Quantities of 1gram or more should be written as 1g, etc.
- Quantities of less than 1gram should be written as milligrams.
- Quantities of less than 1milligram should be written as micrograms.
- The terms cubic centimetres, c.c., or cm^3 should not be used.

The following table gives some practical examples of the BNF guidelines.

RIGHT	WRONG
500mg	0.5g
150micrograms	0.15mg
150micrograms	150mcg, 150µg
12units	12u, 12iu
18mL	18cc

Be safe – use the right units

Yes = (1),(4),(5),(7),(9),(10)
No = (2),(3),(6),(8)

Allergy !!

Do you know which of these antibiotics can be given to a patient with a penicillin allergy?

1. Amikacin
2. Magnapen
3. Augmentin
4. Co-trimoxazole
5. Doxycycline
6. Tazocin
7. Ciprofloxacin
8. Co-amoxiclav
9. Septrin
10. Vancomycin

Answers at the bottom of the page

- **Anaphylaxis can be fatal**
- **If in doubt check it out!**

Additional inpatient prescription charts (Kardexes)/supplementary sheets

How many prescription charts and supplementary sheets do your inpatients have at the moment? Are they kept together?

- **All patients should have a main inpatient Medicines Prescription chart (Kardex).**
  - It is good practice to tag or staple the main Kardexes together if there are more than one. They should be labelled as 1 of 2, 2 of 2, etc.
  - It is considered good practice to keep all additional supplementary sheets with the main Kardex, for example, the anticoagulant/INR monitoring sheet (warfarin).
  - Ensure that medicines on additional supplementary sheets are prescribed on the main Kardex. Otherwise, for example, warfarin may be overlooked if it is written up on the anticoagulant/INR monitoring sheet only.

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Northern Ireland Medicines Governance Project

Currently drug related incidents, on average result in a patient staying an extra 8.5 days in hospital, an annual extra expenditure for the NHS totalling £1.1 billion. It is thought that between 40 and 70% of incidents could be avoided. The report 'An Organisation with a Memory' advocates a target of reducing serious errors in the use of prescribed drugs by 40% by 2005.

With this in mind the Northern Ireland Medicines Governance Project aims to provide a dedicated medicines risk management function throughout the acute hospital Trusts in Northern Ireland. 6 senior Pharmacists and an administrative assistant have been funded for a two-year period, commencing on the 1st August 2002.

The key objectives of the project are as follows:

- To prevent and protect patients from medicine related adverse events
- To reduce medicine related morbidity an its associated cost of treatment
- Limit the exposure of HPSS staff to litigation from adverse medication events
- To ensure that HPSS staff practice with optimal safety

The work of the Project Team will fall into two main related areas:

1. The development of the risk management process itself, including the identification, analysis, evaluation and treatment of medicines-related risk.
2. The development of 'good practice' policies exemplified through education and training, ward and pharmacy procedures and protocols.

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The future

- Permanent funding
- Maintain and progress ongoing work
- Proposed expansion into primary care

Learning from the past….

‘A patient was accidentally poisoned and died in 1888.’

‘Carbolic acid had been administered instead of the ‘Black Draught’.

‘It was recommended that poisonous and non poisonous substances should be supplied in different shaped bottles.’

‘The medical staff came out of the incident rather well and the nurse may be relied upon to profit from her recent unfortunate experience and exercise due caution in the future’