Chelsea and Westminster Hospital
NHS Foundation Trust

A Review Of Enquiries Received Which Involve A Medication Error

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Introduction

- Chelsea and Westminster NHS Foundation Trust's Medicines Information (MI) service provides information and answers a wide range of medication related queries for patients, healthcare professionals within the trust, and colleagues in primary care.
- As part of our work, we often identify or receive reports of medication errors. A medication error is defined as '*any preventable event that may cause or lead to inappropriate medication use or patient harm*'[1].
- Identifying recurring trends in errors reported through Medicines Information, and refining the processes for escalation and review, is key for improving patient care and preventing future incidents.
- The current Trust procedure, following identification of an error, is for a DATIX incident report to be completed (The DATIX system is used across NHS providers for local incident reporting). Timely completion of a DATIX report is vital to ensure that all relevant individuals and teams within the Trust are informed, allowing for appropriate learning, reflection, and improvements to be made.

Aims

- To retrospectively analyse the number of enquiries received at Chelsea and Westminster Medicines Information Centre where an error/incident occurred.
- To review if DATIX reporting is appropriately completed for all queries where an error has occurred.

Method

1. Data was extracted from MiDatabank retrospectively using the Reporter function[2]. Data was collected from 01/04/2023 to 31/03/2024
2. All enquiries in this time frame were manually reviewed to assess if an error had been reported. A summary of each query was documented allowing error categorisation.
3. The data was entered on an excel spreadsheet and analysed[3].
4. If DATIX reference numbers were documented within the MI report, this was noted in the data collection.

Results

- Between 01/04/2023 to 31/03/2024 the Chelsea and Westminster MI service received a total of 919 enquiries of which 103 enquiries there was an error reported (11%).
- Of the 103 enquiries:
  - 66 enquiries (64%) related to incorrect storage of medications
  - 23 enquiries (22%) related to incorrect documentation on a discharge summary
  - 11 enquiries (11%) related to incorrect supply of medications from pharmacy
  - 3 enquiries (3%) related to clinical errors which occurred at ward level
  - 20 enquiries (19%) had a documented DATIX reference number.

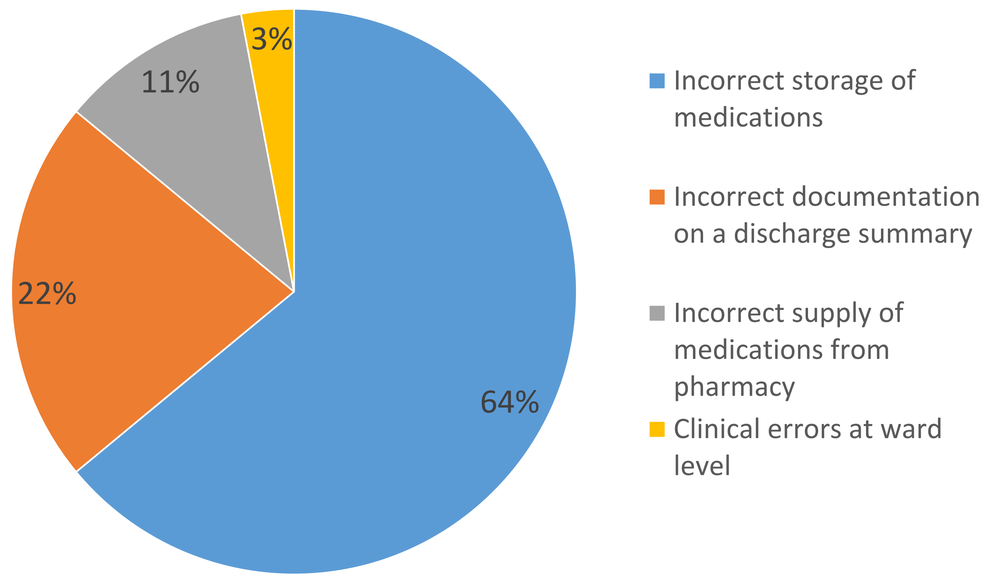

Fig 1: Pie chart to show the proportion of error type reported over a 1 year period.

Discussion

During the one year period captured within the data collection, 11% of all enquiries received related to a medication error. Of these, a large percentage (66%) related to incorrect storage of medications. This included fridge excursions where medications were exposed to higher or lower temperatures. 22% of enquiries related to incorrect documentation on a discharge summary, all of which had been reported by Primary Care Pharmacists. This included incorrect doses of medications, omitted medications, discrepancies between the clinical summary and medication list and missing documentation. 11% of enquiries related to the incorrect supply of medications from pharmacy, primarily the incorrect quantity.

The Trust policy is to complete a DATIX for any error that has occurred, in order to learn from mistakes. The number of DATIX's submitted (20) in relation to the enquiries may not be a true value as the responsibility for reporting does not solely lie with Medicines Information, therefore the DATIX incident reference number was not always recorded/logged on MIDatabank. This was a key limitation of the data collection for the documentation of a DATIX reference number. Despite this limitation, it is apparent that improvements can be made in both the completion and recording of DATIX reports; this will ensure that all errors are investigated in the appropriate manner and changes implemented to reduce the risk of recurrence.

Recommendations

- Following the review, we have added a new category in MIDatabank to be selected for any query associated with a completed DATIX report.
- This will allow quick search/ analysis of MI queries where a DATIX has been completed and recorded.
- We propose that further categories could be added for easy identification of all reports involving a medication error, subcategorising the type of error which occurred e.g. *Medication storage error*.

- We propose to develop a local SOP to standardise the procedure of incident reporting in Medicines Information
- This review highlighted the inconsistency in completion of DATIX reports, it is therefore necessary to determine which individual is responsible for reporting each type of medication error; whether that be the MI team or ward pharmacist etc.
- A process for ensuring the DATIX reference number is recorded for all enquiries is necessary.

- Medication errors received through MI should be reviewed on a quarterly basis and reported to the Trust Patient Safety Group.
- The reporting process will be streamlined by the addition of categories on MIDatabank as previously mentioned, allowing for quick analysis of data.
- The same information should be fed back directly to the Lead Directorate Pharmacists through a quarterly bulletin, highlighting key areas for improvement.

References

1. National Coordinating Council (NCC) for Medication Error Reporting and Prevention (MERP). IHI global trigger tool for measuring adverse events (second edition), 2009. Available: http://www.ihi.org/resources/Pages/OtherWebsites/NCCMERP.aspx [Accessed 26 Mar 2019].
2. COACS. MiDatabank Enquiry Manager v3.2.
3. Microsoft 365. Microsoft Excel Spreadsheet Software 97-2003