Chelsea and Westminster Hospital
NHS Foundation Trust

Implementation of a Medication Safety Agenda at Two Hospital Sites in Response to the World Health Organisation Patient Safety Challenge on 'Medication without Harm'

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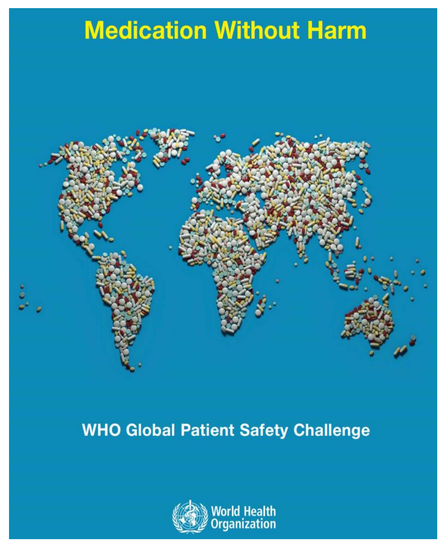
Introduction

The 3rd global patient safety challenge:
to reduce severe, avoidable medication related harm by 50% by 2022

Approximately 237 million medication errors occur in the NHS in England every year, resulting in a cost of £1.6 billion



Aims

- To increase and embed medication safety awareness and education
- To address under-reporting of medication-related incidents, with feedback
- To embed medication safety in education programmes and clinical practice
- Medication safety initiatives introduced and ongoing since 2017, following the merge of two hospital organisations

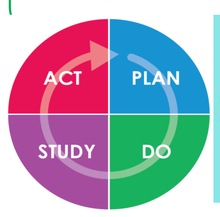
Methods and Interventions

Medication safety metrics changed to allow benchmarking with peers as per NHS Improvement's Model Hospital data

Monthly analysis of medication-related incidents with harm, exploring reasons for under-reporting

- *Following medication safety awareness, medication incident reporting increased by 5% and 21% at each hospital site*
- *Incident reporting rates doubled at one site*
- *Local targets were achieved for reported medication-incidents per 100,000 finished Consultant episodes and medication-related incidents with harm*

'Plan, Do, Study, Act' model applied to improve transfer of care from hospital to rehabilitation unit following externally-reported incidents



Medication safety group introduced with local strategy, involving junior medical staff for frontline feedback

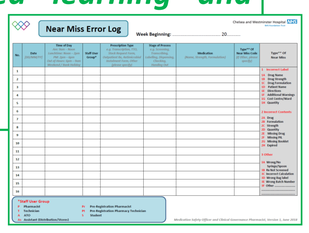
Structured leadership to deliver the local medication safety agenda

Hospital-wide education on lessons learnt from incidents

Optimisation of incident reporting system to improve staff feedback following investigations

Datix

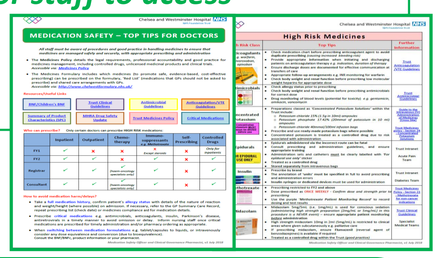
Near-miss error log introduced in pharmacy with shared learning and feedback



Mitigation of medication-related risks
e.g. medications safe storage action plan

Medication safety bulletins, patient safety newsletters and top tips guide introduced covering focal themes
e.g. high risk medication, resources, prescribing tips, patient safety alerts

Medication safety resources for staff to access



Medication safety awareness weeks held to increase awareness on focal themes
e.g. reporting of suspected adverse effects, medication safety resources, high risk medications

'Safe prescribing' mandatory induction training for junior doctors to support prescribing of high risk medicines and compliance to patient safety alerts

Electronic missed doses real-time report developed to tackle omitted and delayed doses of critical medications

Achievements

- Introduction of a medication safety agenda across two hospital sites
- Multi-disciplinary medication safety group driving and leading the local medication safety agenda
- Assurance on delivering the WHO global challenge on *'medication without harm'*, with interventions for priority areas: ***high risk medications, high risk situations, polypharmacy and transitions of care***
- Monthly analysis of medication safety data to allow learning, collaboration and benchmarking against peers
- Positive staff feedback on bulletins/newsletters with staff involvement/engagement
- Staff training programmes embedded with safe prescribing education

Conclusion

- Robust and sustainable medication safety interventions implemented at two hospital sites
- Positive and open medication safety culture striving to reduce avoidable harm from medication incidents

Next Steps / Key Messages

Collaborative multidisciplinary working raising the profile of pharmacists acting as Medication Safety Officers

Implementing medication safety measures from NHS Patient Safety Strategy 2019

Initiatives for safer culture, safer systems and safer patients

Reference

1) *World Health Organisation. Medication without Harm – Global Patient Safety Challenge on Medication Safety. Geneva (2017)*

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