Risk Management in Pharmacy : Policy, Evidence and Practice

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The Risk of Errors?

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Adverse events with medicines

- Every day 1m patients are treated successfully by NHS acute services through complex interactions of people, skills, technologies and drugs
- 96% acute services in 2004 recorded 974,000 reported incidents and near misses
- 300,000 incidents of HAIs
- Average incidents of adverse events is 8.9% (3.8-16.6%)

(ref National Audit Office, Oct 2005)

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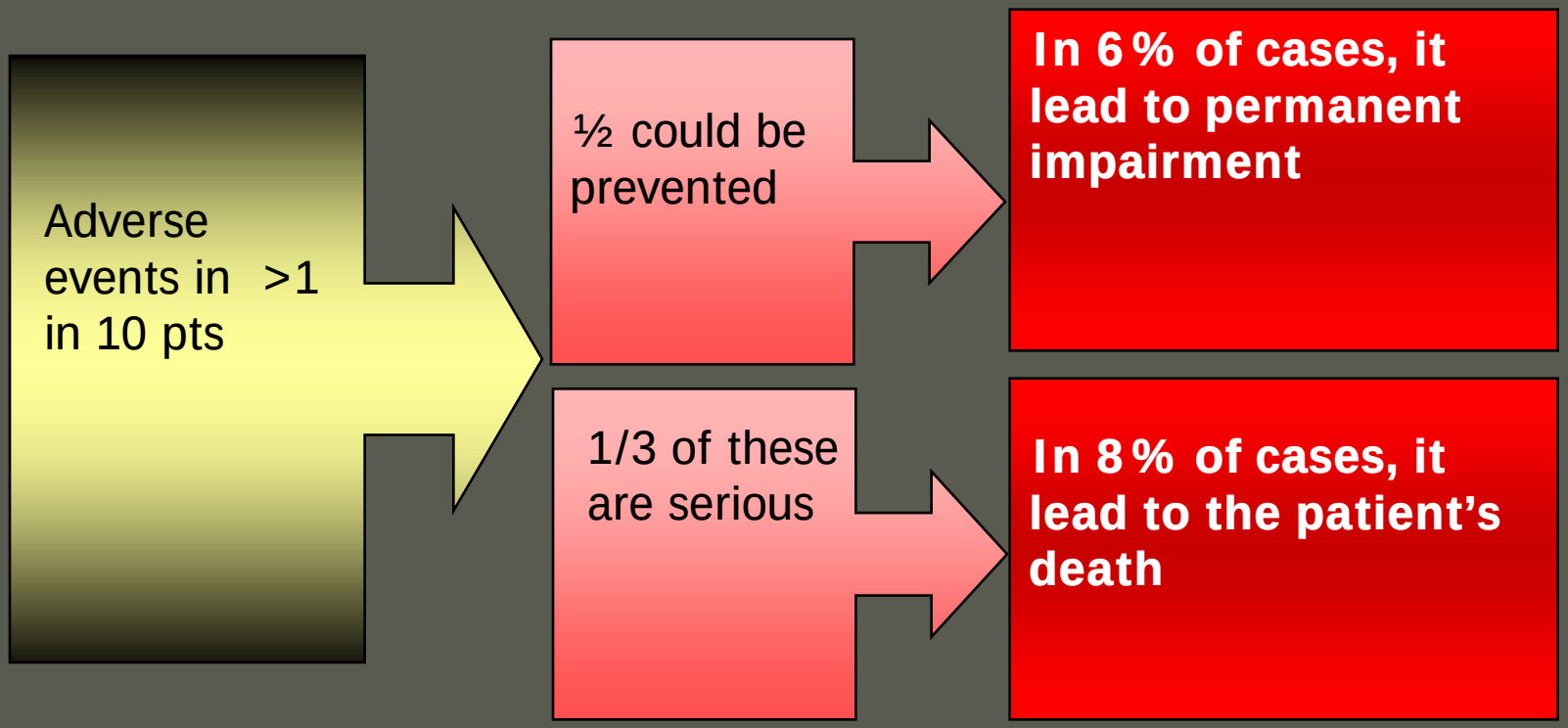
Deadly Toll of Medication Errors



What is clear [illegible] o more about them

NHS National Patient Safety Agency

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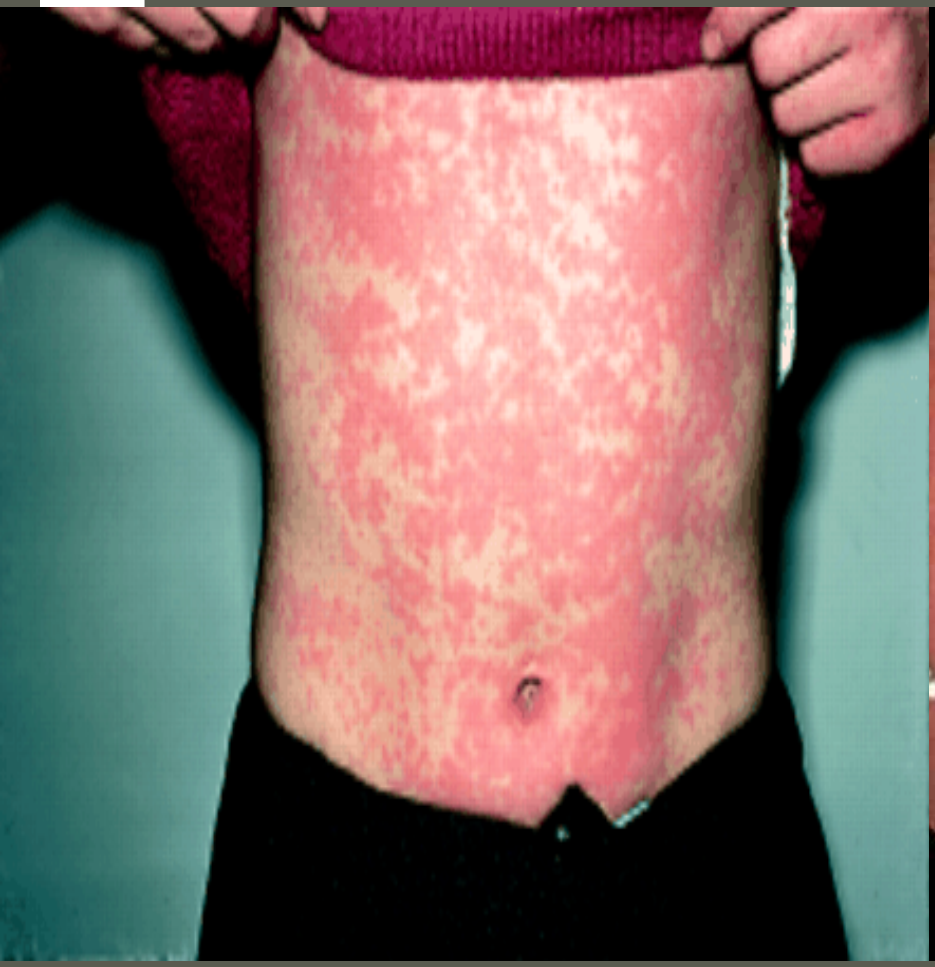
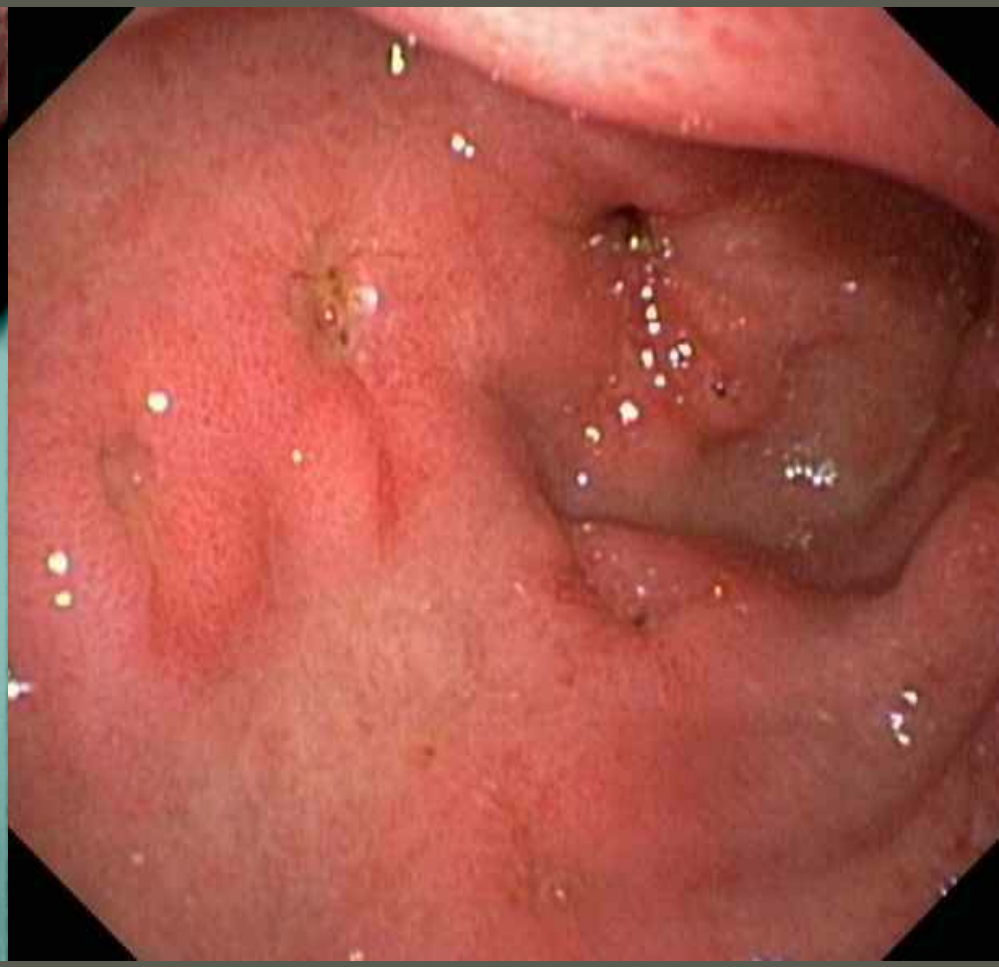
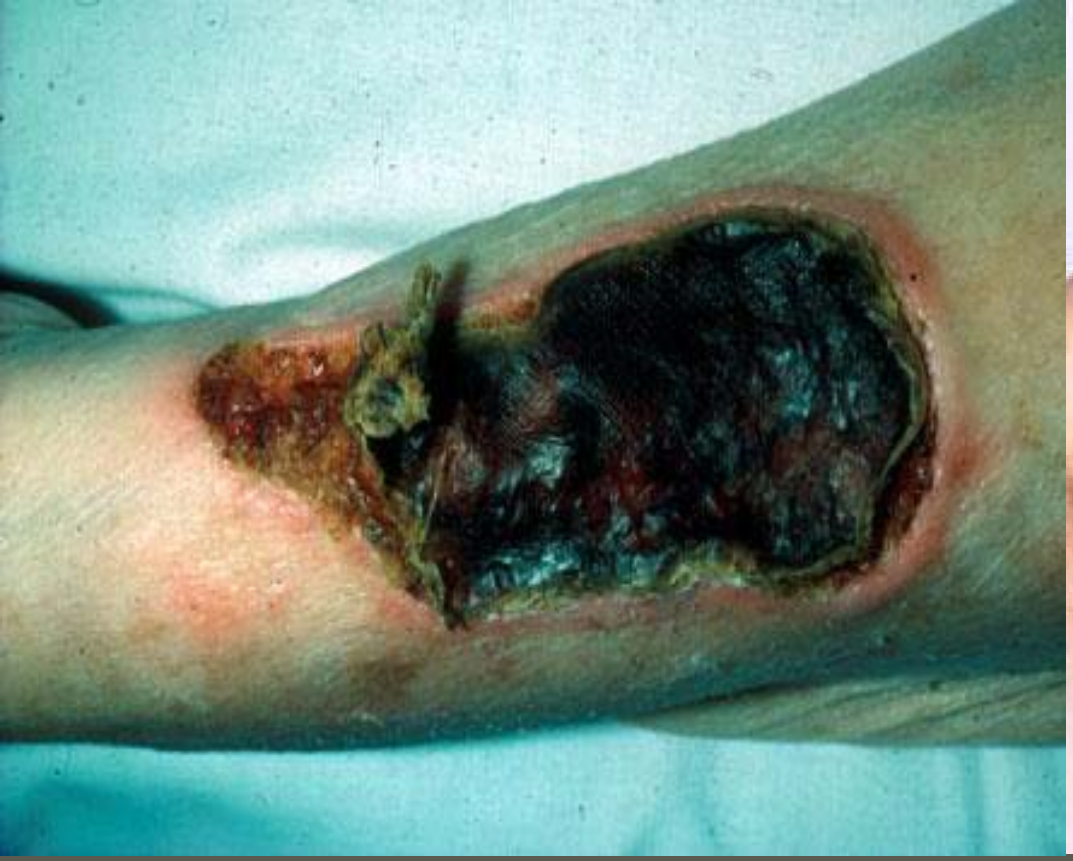
Adverse events and errors



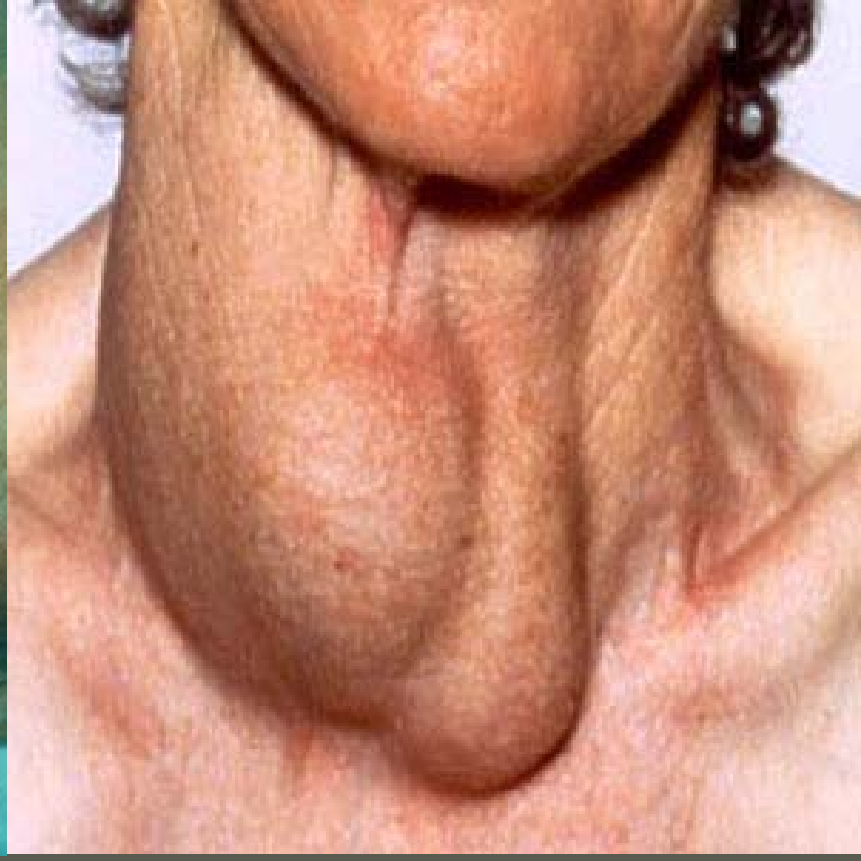
Penicillin Rash:Erythematous maculopapular eruption



Peptic Ulcer following NSAID



Extravasation following antibiotic infusion



Amiodarone goitre

EVENING STANDARD
02/02/01

'Wrong' leukaemia jab teenager dies in hospital

THE teenager who was mistakenly injected with an anti-cancer drug into his spine while being

DAILY MAIL
03/02/01

Cancer boy dies after blunder over injection

TWO junior doctors who mistakenly injected an anti-cancer drug into an 18-year-old's spine could face manslaughter charges after the teenag… yesterday.

Leukaem… Jowett n… sciousnes… a coma f…

By **Sarah Harris**

following the mistake on January 4 and the hospital launched its own inquiry.

The QMC … as University Hos… legal actio…

vein. We now wish to be left to grieve in peace.'

Ten other patients are known to have died since 1985 after similar errors at other hospitals.

The Jowetts' solicitor, Paul Balen, said: 'My clients have …ppalled to learn so many …ve suffered as a …istakes.'

SUNDAY TELEGRAPH
11/02/01

Patient dies followin fatal injection blund

A HOSPITAL patient who was wrongly injected with painkiller into a vein rather than into the spine died yesterday.

by JENNY BOOTH

…gise unreservedly to the fam… …ily for this error and offe…

into the patient's … experienced … anaesthetist. H…

THE EXPRESS
03/02/01

Doctors may face death charges after drug-blunder teenager dies

BY ANTHONY MITCHELL

TWO doctors could be charged with man… slaughter charges after…

…nising death from the anti-cancer drug in… jected on January 4. Yesterday the app…

Crown Prosecution Service. The hospital, which once treate… Prince …

…ly" Wayne, from … worth …

INDEPENDENT
03/02/01

Teenage patient dies after doctors' injection mistake

DOCTORS could face …ges over the …

BY JEREMY LAURANCE
Health Editor

…been appalled to learn that …er families have …

sorry. We apologis… …servedly ... and would… …press our deepest s… He added: "A s… take was made wi…

Doctors will make mistakes

GUARDIAN
03/02/01

Teenager given wrong drug dies

Clare Dyer
Legal correspondent

Two doctors could face manslaughter charges after …

The medical centre suspended two junior doctors after the incident and an investigation was launched. A police investigation is continuing …

GUARDIAN
20/04/01

Drug mix-up killed leukaemia sufferer

THE EXPRESS
13/02/01

But a simple failsafe system is all it takes to stop drug errors such as the latest two cases in the news

Teenager dies after drug error

Donna Horn: Doctor was blamed for her death

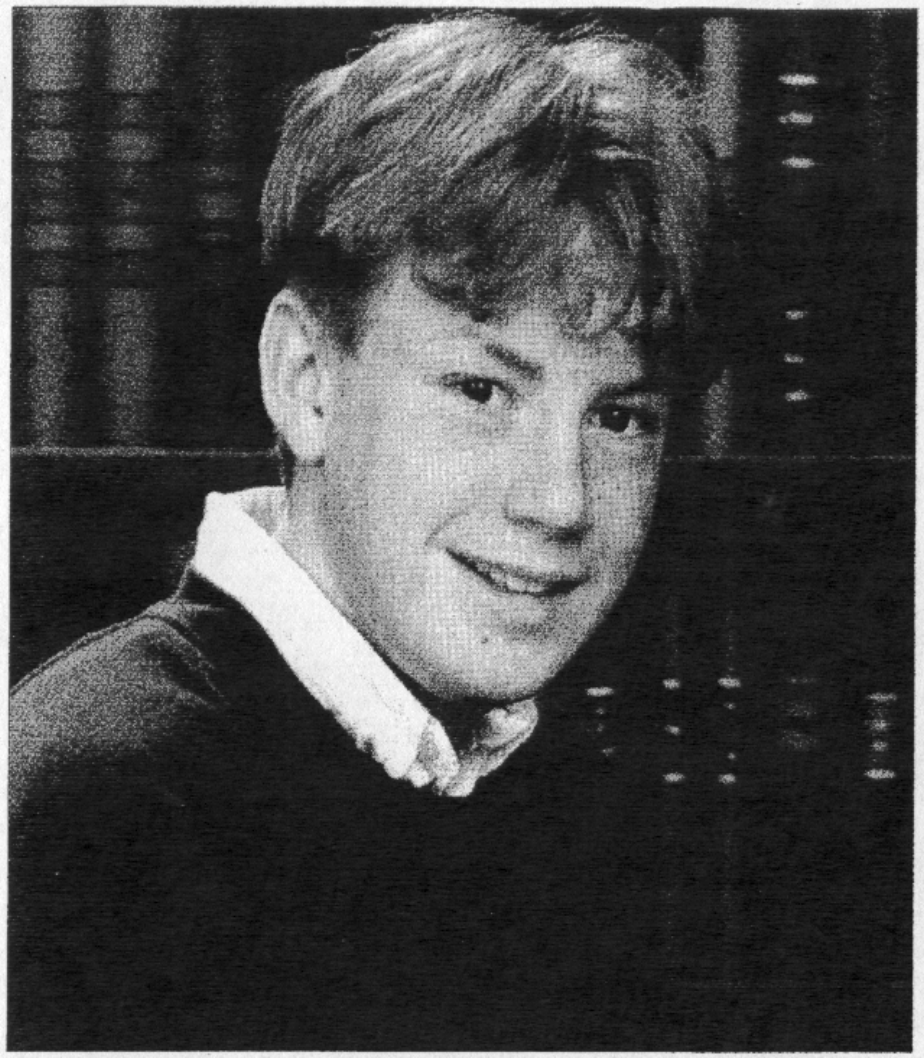
AT THE age of 23, Donna Horn from Wellingborough, Northamptonshire, achieved her ambition to visit Disney World in Florida.

Making the trip in 1998 was a triumph for Donna, but it was not without its difficulties. Her wheelchair made the journey far from easy and she was suffering from a chest infection.

But while she was away, the illness deteriorated and she died. Doctors said her paralysis had probably aggravated the chest infection which finally killed her.

What also came out at this week's inquest into Donna's death, however, was that the paralysis itself was the result of a medical blunder.

At the age of 15, Donna, like Wayne Jowett, the 18-year-old who died yesterday in Nottingham, had been fighting the blood cancer leukaemia. She had been diagnosed three years earlier and, like Wayne, she



Wayne Jowett, who died after doctors injected an anti-cancer drug into his spine

FROM PAGE 1

campaigners who want the rules tightened up so that the same mistake is not made again. And they are already realising with growing horror that Wayne is not the first to die in this wholly preventable way.

Paul Balen, the family's solicitor, said: "My clients have been appalled to learn that so many other families have suffered as a result of similar mistakes."

He said that Wayne had been in remission at the time of the blunder, indicating that the blood cancer appeared to be under control.

Two junior doctors at the hospital have been suspended and the police have been called in to investigate Wayne's death.

John MacDonald, the chief executive of the Queen's Medical Centre, admitted his staff and the hospital had let the Jowett family down.

Mr MacDonald said: "We have failed Wayne and his family and for that we are deeply sorry. We apologise unreservedly to the family and would like to express our deepest sympathy."

He added: "A serious mistake was made when Wayne's drug treatment was administered wrongly."

Mr MacDonald said staff had been reminded to follow strict protocols and procedures for administering such drugs to patients. He said: "A full internal inquiry has already been started to discover what went wrong. And if there are any lessons to be learnt from this then they will be."

Nottinghamshire police said they had been called in to investigate the circumstances surrounding the death.

A Department of Health spokesman said: "We are very sorry to hear of the tragic case of this young man. This is a rare and catastrophic event which has happened in this and other countries over the last 20 years.

"It is potentially avoidable and a major new initiative is being taken to try to address a problem which has not been solved by previous action."

The new initiative includes introducing a mandatory system for reporting mistakes.

Specific work on wrongly-administered spinal injections is being led by Professor Kent Woods, director of the NHS Technology Assessment Programme.

Mr Jowett's death today came just a day after the inquest on a 23-year-old Northamptonshire woman who died after a doctor in Leicester made a similar mistake. Donna Horn, who had also been receiving treatment for leukaemia, was injected in the spine with Vincristine by Dr Peter Greally.

He admitted yesterday: "It was a genuine mistake from a lapse in concentration."

jtrueland@scotsman.com

said: "It was a genuine mistake from a lapse of concentration."

After completing his evi-

How a lifesaver becomes a killer

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Cambridgeshire NHS
Health Authority

METHOTREXATE TOXICITY

AN INQUIRY INTO THE DEATH OF A CAMBRIDGESHIRE PATIENT IN APRIL 2000

CAMBRIDGESHIRE HEALTH AUTHORITY

JULY 2000

DH Department of Health

An organisation with a memory

Report of an expert group on learning
from adverse events in the NHS
chaired by the Chief Medical Officer

An organisation with a memory

Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer

DH Department of Health

Building a safer NHS for patients

IMPLEMENTING AN ORGANISATION WITH A MEMORY

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Errors from poor communication?

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Example 1

Unintentional discrepancies between supplies of prescribed drugs highest in supplies obtained in the community following discharge

This formed the focus of the intervention

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Example 1

Medical In-patients were recruited into CONTROL or TRIAL cohorts

TRIAL cohort discharged with information on medicines for their community pharmacist

Consensus panel judged the CLINICAL SIGNIFICANCE of the observed discrepancies

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Summary Findings

	CONTROL GROUP	TRIAL GROUP
Patients	237	264
Drugs	1328	1408
Discrepancies	795 (59.9%)	622 (44.2%)
Unintentional Discrepancies	700 (52.7%)	454 (32.2%)
Potentially significant Unintentional Discrepancies	139 (10.5%)	92 (6.5%)
Clinically significant Unintentional Discrepancies	27 (2.0%)	17 (1.2%)

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Effectiveness of the Intervention

	NNT	RRR
Prevention of a potentially clinically significant discrepancy	7	54%
Prevention of a clinically significant discrepancy	19	37%

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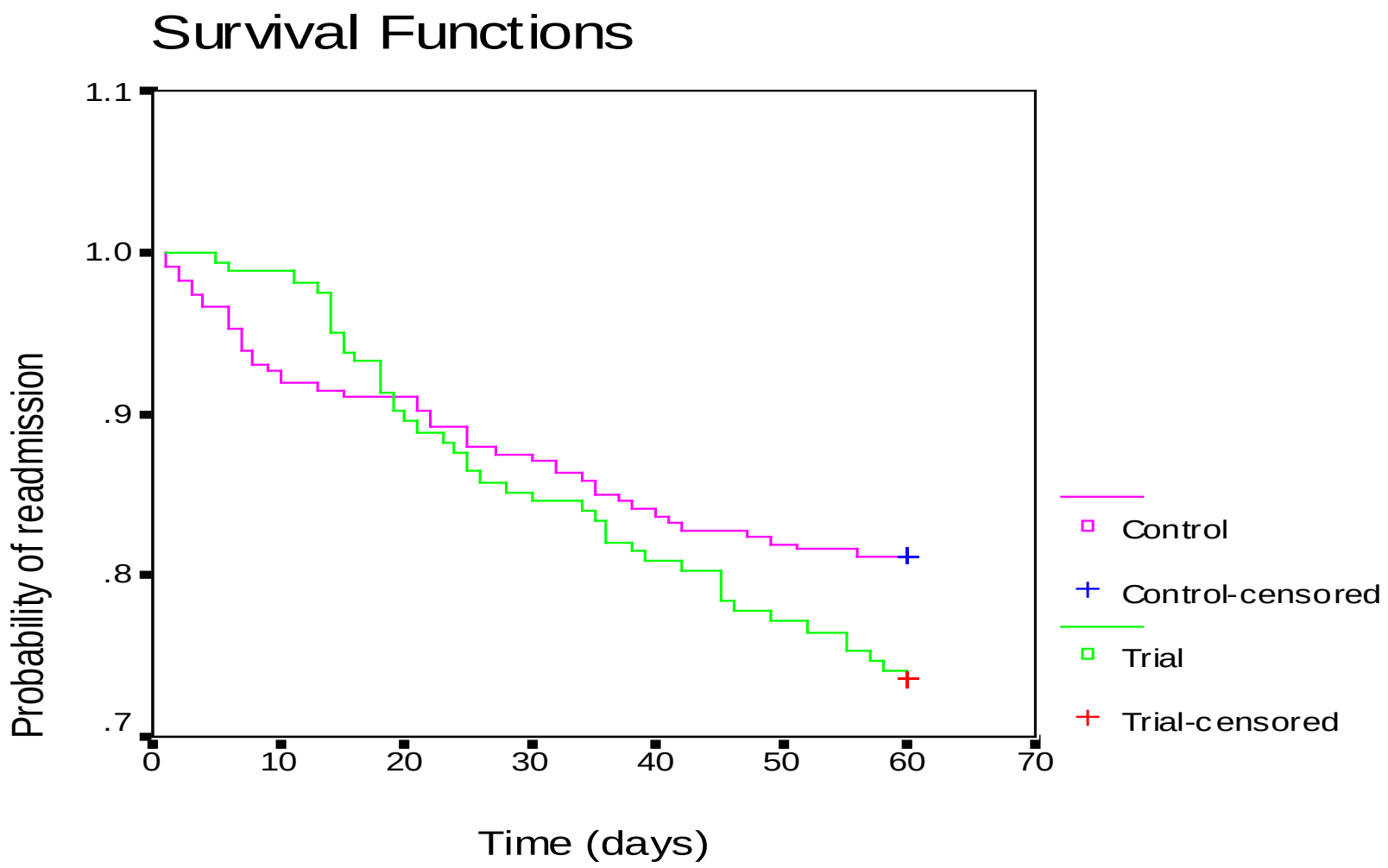
Example 2

–How to prioritise patients who are more at risk of readmission?

TRIAL cohort discharged with detailed information on medicines for their community pharmacist



Probability of readmission following discharge.
The cross over suggests that time itself is a factor (dependent variable)
There is weak effect (log rank p=0.105, outside significance, but of interest)

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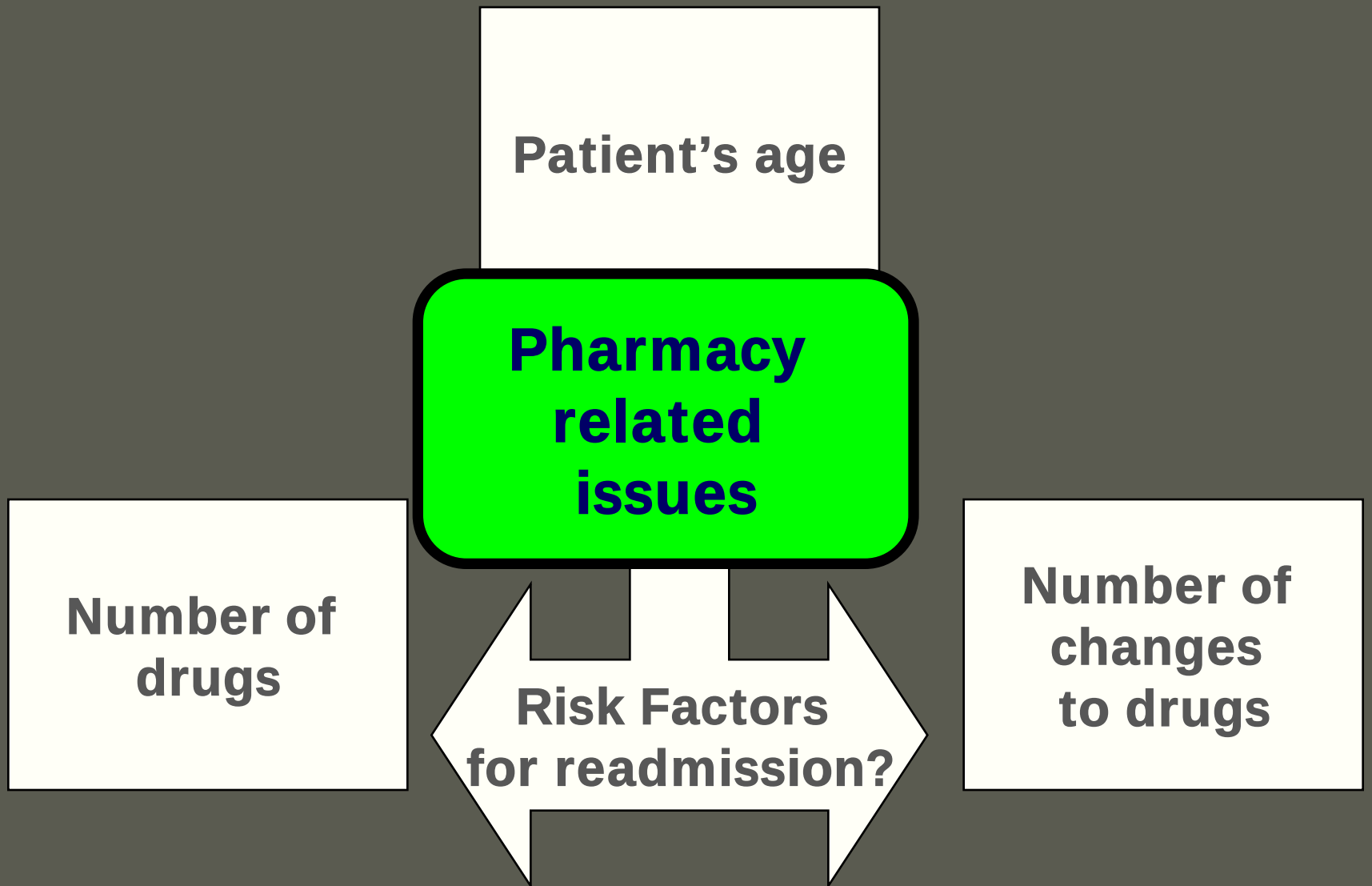
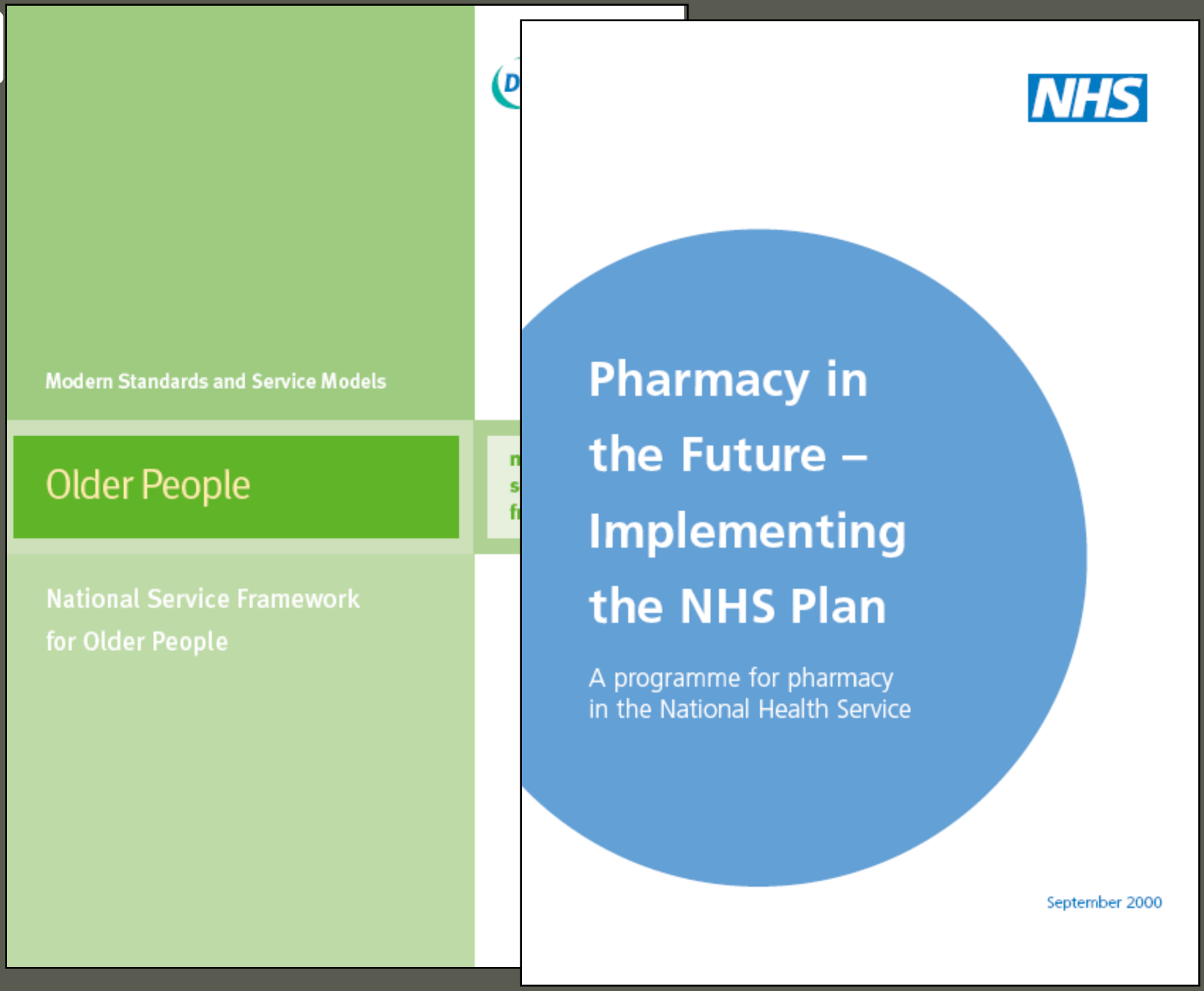
Example 2 conclusions




Modern Standards and Service Models
Older People
National Service Framework
for Older People
NHS
Pharmacy in the Future – Implementing the NHS Plan
A programme for pharmacy in the National Health Service
September 2000

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The real issue…patient outcome

What policy makers, managers, the profession need:

- Knowledgeable practitioners
- Medicines focussed
- Patient centred
- Experts in drugs

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Foster Report (July 2006):

- Re-emphasises the need for competence linked with performance assessment
- Emphasises the need for re-validation:
  - Ongoing evaluation of an individual's fitness to practice
  - Both formative and summative

Department of Health. The regulation of the non-medical healthcare professions. A review by the Department of Health. July 2006.

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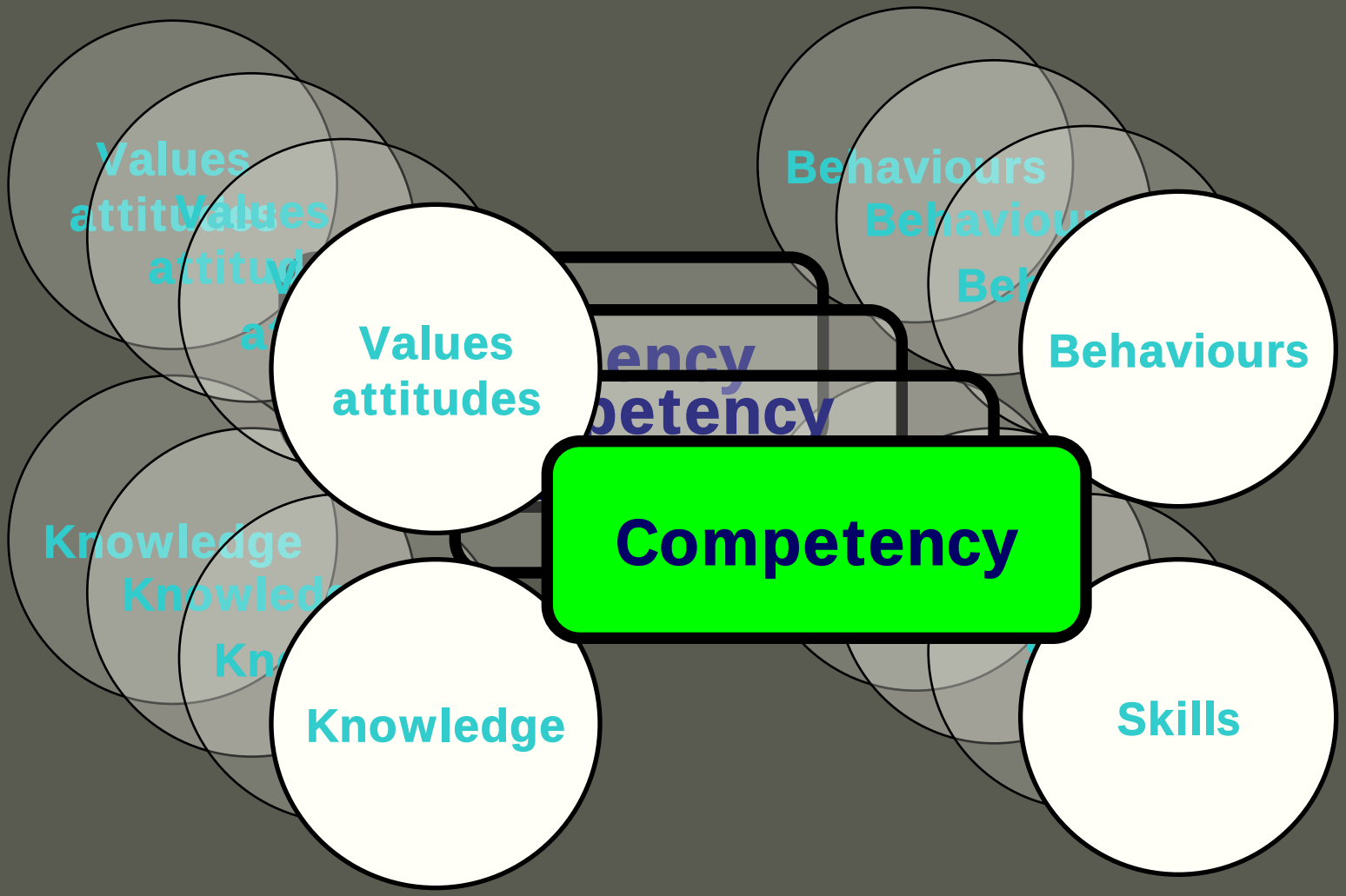
"Competence" is a complex construct…



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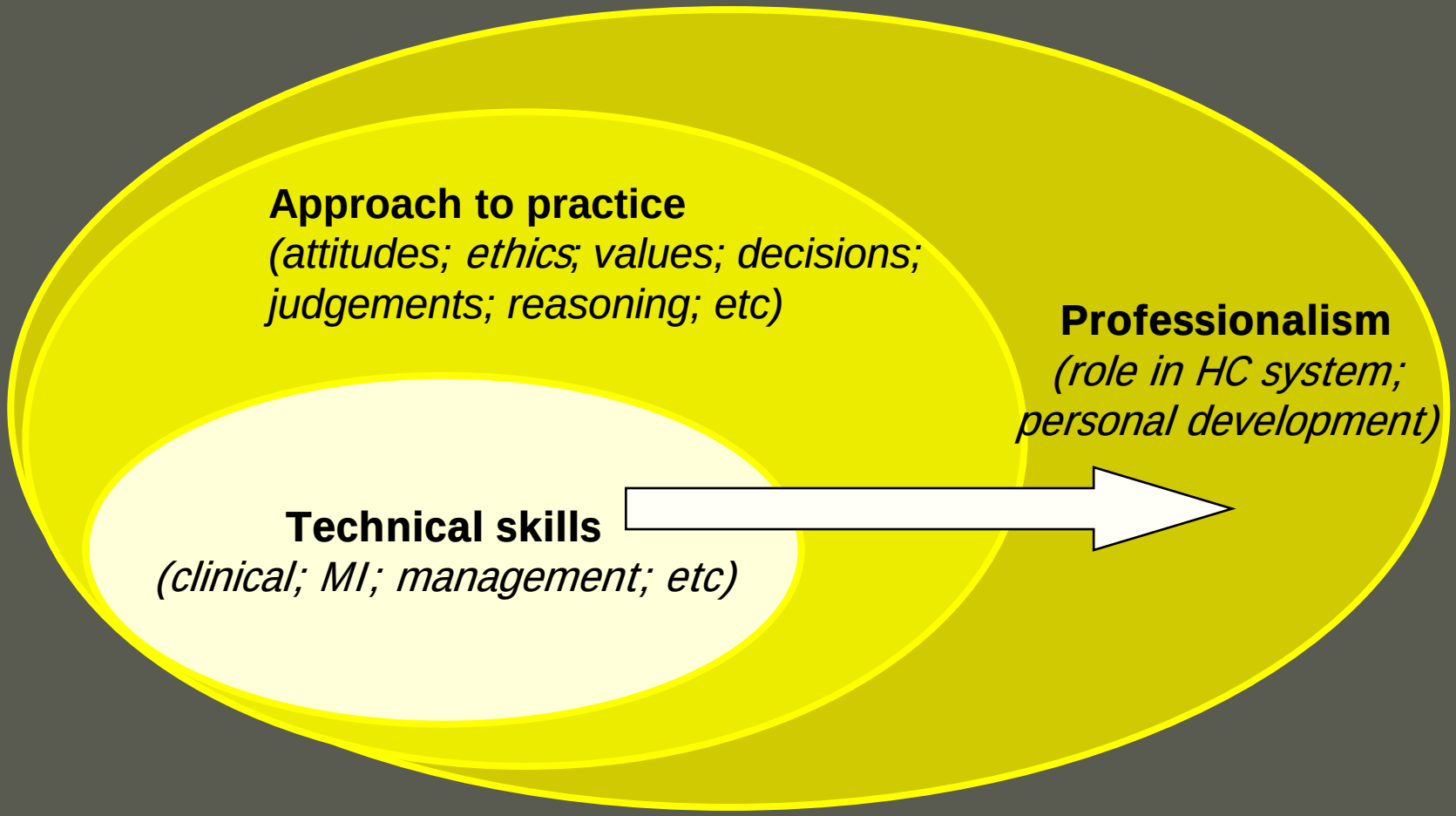
Theory into practice... (outcomes)

...the competent and reflective practitioner



Guidance for
the Developm
Consultant Ph

HM Government

DH Department of Health

Pharmacy in England

Building on strengths – delivering the future

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Pharmacy and risk management: Policy, Evidence and Practice

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