



Incident Reporting

Data from the National Reporting and Learning System (NRLS) indicates one fifth of all incidents reported in NHS Leeds relate to medication use. This far exceeds the national average of 6%.

This is a direct result of staff having an increased awareness of incident reporting following the recent training sessions, and partly due to the new IR1 forms having a dedicated medication section.

[Incident forms](#) can be found on the PCT website www.nhsleeds.nhs.uk under Trust Policies—Corporate—Incident Management and Guidance.

Please continue to report incidents and help to raise patient and medication safety throughout Leeds.

When medication incidents are received they are all reviewed to identify potential countermeasures to prevent recurrence, and for any learning that can be shared with other practitioners.



Learning from an incident - A patient recently received the wrong dose of insulin.

Following an incident in which the morning dose of insulin was given at teatime, the following learning has been highlighted.

This incident was partially due to amendments made on the patients medication chart, and also due to not having all the patients medication notes to hand prior to administering the dose.

It is suggested that where possible prescribers write medications onto prescription charts in a logical sequence. E.g. the morning dose should appear before the evening dose. However this may not always be possible, especially when amendments are made.

In this situation prescribers are reminded to

Sharing Medication Incident learning.

Learning from incidents is disseminated to staff via PharmFax Safety editions and the Care Services Quality Newsletters. Information is also provided to Service Leads via the Medicines in Managed Services Group meetings to feedback to staff at team meetings.

Safer Medication Practice Information is posted onto the [medicines management website](#) along with other useful medication related topics.

The NHS Leeds Medicines Management Team work closely with Leeds Teaching Hospitals NHS Trust, The Leeds Partnership Foundation Trust, Leeds City Council Social Care Departments and NHS Leeds staff and Contractors to share and learn from medication incidents. We also network with our neighbouring PCTs to share and learn from our joint experiences.

This all contributes to the safe and legal use of medicines

Insulin Incident

clearly annotate the STOP and START dates on the prescription charts.

Practitioners are also reminded to check both the prescription chart and administration records prior to administering medicines. This provides a double check to ensure the medicine is due and the dose corresponds with the prescription chart and administration record.

It was also noted that the Handling and Use of Medicines Procedure (HUMP) for Administering Medicines may not always be available to staff when required.

For information

HUMPs are available from NHS Leeds i-net [medicines and prescribing policies page](#).



Alternate day dosing

A local incident highlighted the potential problems connected with alternate day dosing regimes stored in compliance aids.

The patient should have received an alternating daily dose of Lithium dispensed in weekly monitored dose systems e.g. 800mg taken on alternate days and 400mg on the days in between. They received 4 identical weeks supply of the medicine starting with 800mg each Monday. This meant they received 800mg every Sunday and Monday which resulted in Lithium toxicity. This error is to be shared with pharmacies to promote the best practice of, one nominated person with a deputy be responsible for filling compliance aids



PCT Medicines Code

The NHS Leeds Medicines Code 2nd edition is now approved for use.

The Medicines Code advises and directs NHS Leeds employees and contractors to the most current medication legislation and local policies and procedures to ensure the safe and legal use of medicines by all.

The format has been updated to make it more user friendly and provides an overview of the topic with links providing more in-depth information.

The Code is available electronically from the Medicines Management webpage. A link from the PCT i-net also directs staff to this page.

Hard copies are available on request from the Medicines Management Team 0113 203 3469/402



Fridge Incidents Reminder

Staff are requested to complete an incident form when reporting fridge failures or breaks in the cold chain. For the period July to December 2008 more than 40 fridge incidents were reported to the Medicines Management Team, but only 11 incident forms were actually submitted



Discharge Information

Patients have been prescribed incorrect drugs and doses and newly initiated treatments have been omitted.

Recent incidents have indicated the need for prescribers to ensure they have the most recent discharge advice note or information available when issuing repeat prescriptions for patients. It is particularly relevant for those recently discharged from hospital or other care settings.

A pilot scheme where Discharge Advice Notes are faxed directly to GPs is being trialled. This will considerably speed up the time taken for this information to reach the practices.



Medication Information

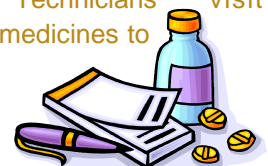
Therapists are advised not to write medication information for domiciliary patients

Patients identified as having difficulty self medicating should be referred to the Intermediate Care Team for a medication assessment.

Therapist are asked not to write medication instructions for patients as this may lead to further confusion.

An incident was reported where the therapist incorrectly annotated the dosage information onto a medication reminder. This resulted in the patient taking twice the intended dose.

The Intermediate Care Pharmacy Technicians visit patients having difficulty with their medicines to advise on alternative options.



How to contact us ☎ 0113 203 3402 or ✉ medicines@nhsleeds.nhs.uk