COVID-19 INSIGHT

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STATE OF CARE

COVID INSIGHT

MEDICINES SAFETY IN NHS TRUSTS

Medicines safety is a priority for CQC and improving safety in NHS trusts is a crucial aspect of the wider medicines' safety agenda.

An estimated 237 million medication errors occur in the NHS in England every year. In March 2017, the World Health Organisation launched its third global patient safety challenge, 'Medications without harm', with the aim of reducing severe avoidable medication-related harm by 50% in five years.

In response to this, NHS England also launched the Medicines Safety Improvement Programme.

Medicines safety is a key focus of our regulatory work with trusts – it aligns with the 'Safety through learning' aspect of our strategy, and our commitment to help reduce avoidable harm.

In March 2021 we published our look at the safe and effective use of medicines at NHS trusts, considering NHS hospital pharmacy services during the pandemic. This report came from our routine engagement with hospitals' chief pharmacists. Between May and July 2021, we did a review of medication safety in 95% of England's NHS trusts. This was focused on the role of medication safety officers (MSOs). We spoke with MSOs, pharmacy and trust leaders in acute, community, mental health and ambulance NHS trusts.

Background

An alert published by NHS England and the MHRA in 2014 required all trusts to have an MSO and a medical device safety officer (MDSO). The aim of this alert was to help ensure:

- there is a clear lead for medication safety
- communication about medication safety between local and national levels would be improved
- medication error incident reports would be regularly reviewed, including by multi-professional groups
- a focus on improvements in incident reporting
- learning and local actions needed to improve medication safety are taken.

Medication safety officer

All NHS trusts we spoke with had a named MSO. In most cases the role was undertaken by a senior pharmacy professional. Other healthcare professionals also held the role, including doctors and nurses.

The time spent on the MSO role varied, with some describing it as their primary role while others described a maximum time spent on the role as “a couple of hours every other week” due to other work commitments. We were told that a lack of time and resources were the key challenges of the role. While organisations have their own specific requirements, national guidance on minimum resourcing for MSOs is likely to be helpful in improving medication safety and reducing avoidable harm in NHS trust settings.

Overall, MSOs told us they help make the use of medicines safer – they respond to medicines safety alerts and help to improve reporting of medicines incidents; they supported investigations so that lessons could be learned, and they ensured actions from learning were shared with frontline staff.

A team approach

In some trusts, we found that a multi-professional team-based approach was encouraged, which aimed to include more junior members of the pharmacy team, doctors and nurses. We heard that a benefit of this approach included an enhanced ability to engage in the topic of medicines safety with frontline staff across all professions. It also proved a more effective way of generating a more holistic understanding of medicines related incidents and issues:

> “[We] recruited a medicines management nurse lead within the pharmacy team, who amongst other things does medicines awareness work, promotes reporting of incidents, and any learning that comes from it – it’s been very successful.”

We heard that an effective working relationship between the MSO and the MDSO can optimise how both medicines and devices safety is managed in trusts. But we found that relationships between MSOs and MDSOs was varied. Some MSOs were not aware of who the trust’s MDSO was, or even if there was one in place within their organisation. Within other trusts the MSO and MDSO collaborated effectively, coordinating responses to alerts and patient safety incidents.

Medicines governance

We heard that most MSOs were listened to and were able to escalate medicines concerns effectively through trust governance systems. Where support for the role from trust leaders was given, this helped to develop a strong culture around medicines safety.

Most trusts had a medicines safety committee or equivalent, with multi-professional representation, including doctors, nurses and allied healthcare professionals.

Some MSOs shared positive examples of support for their role from trust and pharmacy leadership:

> "We are involved at board level and the medicines safety report goes to quality committee. [We are] regularly in touch with medical director and chief nurse on areas of medicines safety and risk. We also work with the associate director of patient safety who leads that workstream."

> "The medical director is chair of the medicines safety committee. [They are] very 'switched on'... We meet every two to three months to talk about the agenda and direction of travel. Very useful... [we] have improving representation at the medicines safety committee – quite good from all areas of the trust, including medical and nursing representation."

We also heard that in some providers the engagement of other professions in medicines governance committees remained a challenge and that unclear governance structures meant that information about medicines safety did not flow effectively between committees. This meant there was limited executive oversight of certain medicines risks. Where we found specific risks in relation to medication safety, these were escalated in line with our procedures.

We know that ensuring patients' voices are heard is important in helping to improve medicines safety. Good practice would include having a patient representative on the medicines safety committee, but very few trusts took this approach.

Incident reporting and learning

All MSOs described how they monitored the reporting systems for medicines incidents and near misses. We were told a multi-disciplinary team approach helped engagement of frontline staff across professions and promoted sustained, positive change. MSOs said that where they felt there was a good trust-wide medicines safety culture, this supported people to report and learn from incidents.

Some MSOs explained their participation in serious incident reviews. Mortality reviews are undertaken to help understand the care a person received before they died. Where medicines are involved in these reviews, a senior member of the pharmacy team can provide expert advice and help facilitate learning. Our review found that the pharmacy team were not always actively involved in mortality reviews. that comprised a medicines safety element.

Those with digital systems acknowledged that there were different barriers and challenges than with paper-based systems. These included a reliance on technology when manual checks might have been more appropriate, challenges when staff who were unfamiliar with a particular digital system rotated to a different trust, as well as risks associated with the simultaneous use of multiple digital clinical systems, particularly when they were not always interoperable. MSOs told us they anticipated that the change from paper based to electronic systems would lead to better oversight of medicines use and safety.

Learning across national and local networks

In the conversations we had with MSOs, we asked about how they worked within local and national MSO networks. We were interested to see how teams collaborated across interfaces, as a result of learning.

> “We try to standardise our practices by working collaboratively within the local area, we have standardised our e-learning on medication safety for our junior doctors so that when they rotate across the different trusts, there's some sort of consistency and uniformity.”

The national MSO network was described as well-established and monthly online meetings were deemed well represented and a useful place to share learning. Some described how incident reviews and learning presented at online sessions had been taken back to their trust, reviewed and actioned. This demonstrated the value of learning from other trusts' experiences in helping to improve medicines safety:

> "Really like the monthly calls, helpful when others bring issues to light that you feel you may need to keep an eye on or investigate too."

Local networks were more varied, in both how well established they were and their approach. Some areas had good, regular local meetings where learning was shared, and actions were completed collaboratively:

> "The regional MSO network is very active, lots of expertise, shared learning, even do shared audit across the patch [such as] an anticoagulant audit in 2019."

In well-established local meetings, attendance included not only NHS trusts but also schools of pharmacy, clinical commissioning group (CCG) colleagues and other medicines leads from the area. This promoted more effective local system working and sharing of learning.

However, this was not in place everywhere, with some MSOs describing a less established network – some had email correspondence only, or infrequent, poorly attended meetings. This resulted in a reactive approach, rather than a proactive medicines safety agenda.

A small number of MSOs told us that there was no time available for them to participate in either local or national networks.

MSOs from some non-acute trusts told us that it was a challenge to get their voice heard and often meetings were not relevant to their sector within both local and national networks. We heard that in response to this, some groups such as ambulance MSOs, described how they were developing their own national network to share ambulance specific learning.

Learning within NHS trusts

We heard how engagement with front line staff and good visibility of the MSO provided valuable learning opportunities and a means to improve the medicines safety culture. Also, MSOs described how engagement and partnership with front line staff helped to generate effective solutions which ensured sustained positive changes. This included improving incident reporting, as part of a drive for an open and supportive culture:

> "Doubled number of incidents being reported over last five years. Fostering open culture to encourage reporting. Lots of work looking at trends and these are discussed at medicines event review group. Shared learning is circulated across the trust in succinct form based on feedback people [were] not necessarily accessing long bulletins."

Where incident review policies were described as following a 'just culture', root cause analysis ensured people were treated fairly.

Quality improvement (QI) methodology was described by some MSOs as a developing concept in their trust. Others talked through examples where a QI approach has helped ensure a holistic review of a particular medicines safety concern, and fostered the development of sustainable solutions:

> "We had experienced an increase in date checking incidents [out of date medicines] which led to a QI project and the overhaul of the medicines expiry date checking programme… it needed a rethink and was changed to a more widespread role which could be managed in the event of sickness, holidays. [We] also, produced a business case for automated cabinet for the emergency cupboard."

Another MSO described how QI had helped action a safety alert for a medicine called sodium valproate. This was a focus of the 'First do no harm' report by Baroness Cumberlege. This medicine must only be prescribed for women of childbearing age in certain circumstances, and the report highlighted the need for women in receipt of the drug to be continuously assessed and monitored. This QI method included working with other partners in the local health and care system:

> "On the valproate issue we have led a QI programme to make sure proper assessments are conducted. We created a virtual caseload [on an electronic prescribing and records system] and pathways so that people can be recalled annually when referred by the GP. There is also a care plan for each person. We have implemented a dashboard to follow progress. [We] worked closely with the CCG and digital teams to implement this, we hope to show an improvement in the number of people who have been reviewed, and also an improvement in how GPs can refer in. [We are] holding weekly check-ins to monitor progress."

Missed doses of medicines can have detrimental effects on people's health. Many trusts described missed doses as an ongoing challenge. One MSO described how they had implemented QI to help with reducing missed doses:

> "Using QI we have reduced missed doses, changed the way we order medicines and have seen an 80% reduction in missed doses. As the medicines chart has an electronic ordering function, we have piloted the use of this, and staff have implemented this change and it's worked. [This] has also meant we have reviewed stock levels on the ward and overall it has made a big change – this was led by the medicines safety team but all the work was [undertaken by] front line [ward staff]."

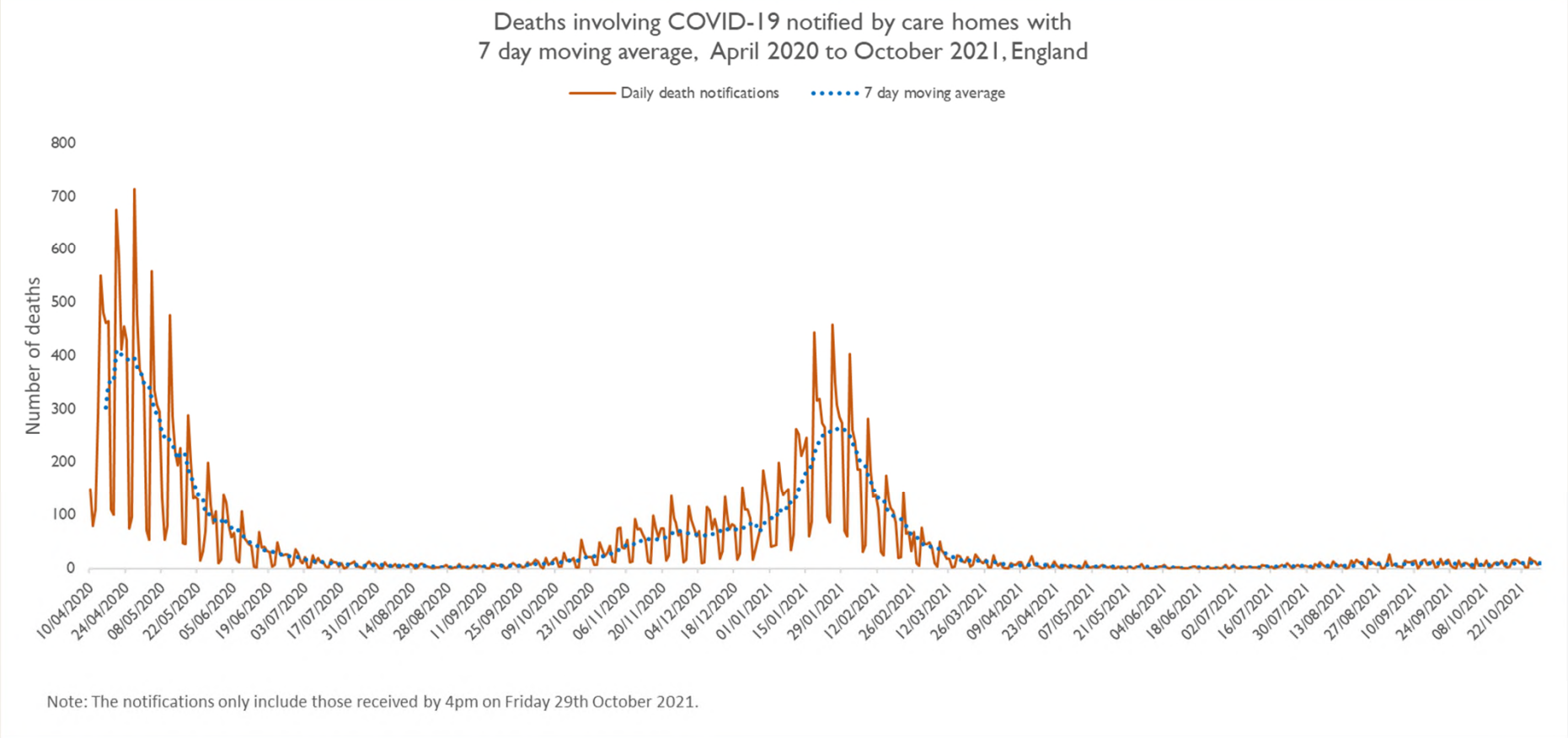
Some trusts told us they had embraced human factors training to aid learning and improvement from medicines safety incidents.

> "Using a human factors approach to medicines incident investigation means we have engaged more widely with staff to understand the systems in which they work. We consider how staff adapt and interact to keep people safe and the effect of changes in practice to support trust-wide change and improvement."

COVID INSIGHT

DATA APPENDIX

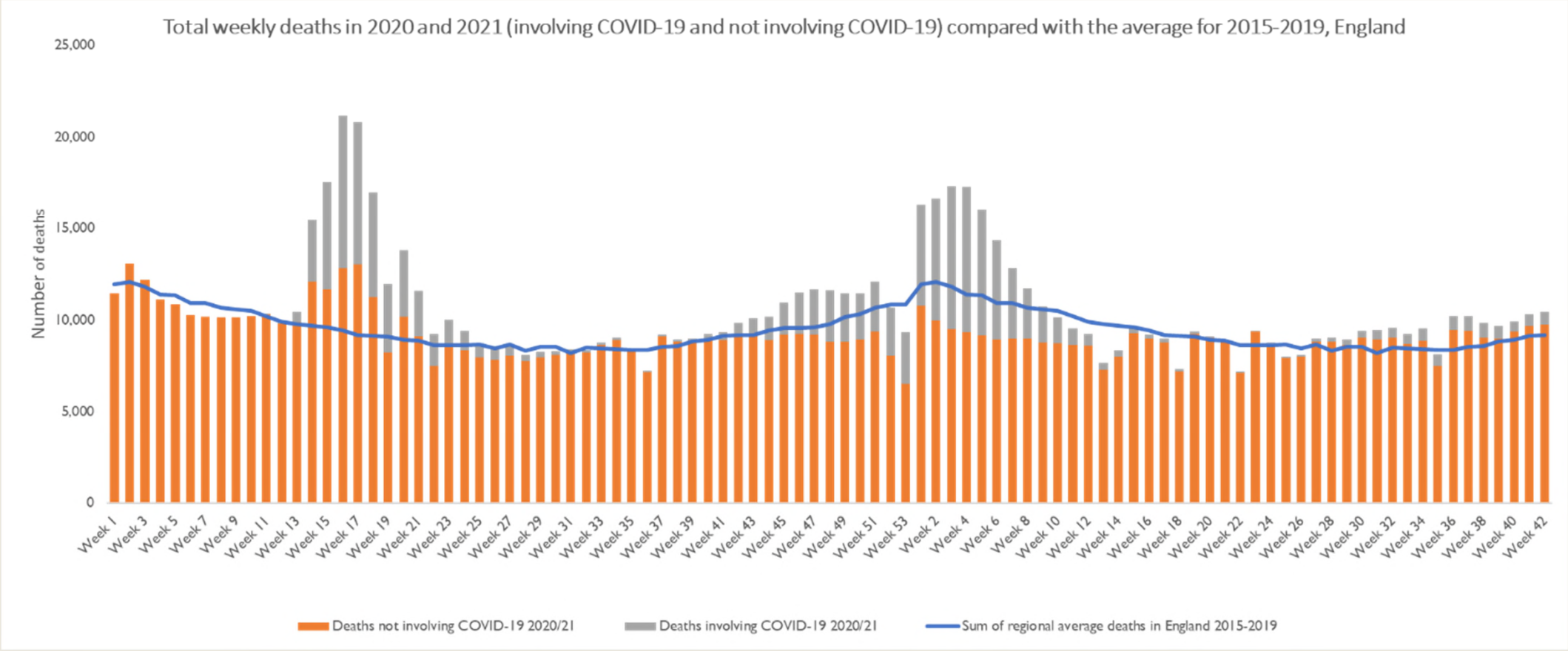
Deaths notified by care homes in England



Source: CQC death notifications submitted 10/04/2020 to 29/10/2021

The chart shows the number of death notifications of people in care homes flagged as involving COVID-19 submitted each day up to 29 October 2021, with a seven-day moving average line showing the smoothed trend. The numbers of notifications of deaths peaked for the second time by late January 2021 and fell steadily until late April 2021. Numbers have remained relatively low since then, although there has been a small increase since the middle of August.

Office for National Statistics weekly death registrations and occurrences



Source: ONS COVID/non-COVID 2020 and 2021 death data:
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard
and 2015-2019 death data from:
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/11674fiveyearaverageweeklydeathsforenglishregionsandwalesdeathsthatoccurredbetween2015and2019
Week 42, 2021: week ending 22 October 2021