STANDARD 6.0 SAFE USE OF MEDICINES

The pharmacy team ensure that safe medication practices are embedded in the organisation (included contracted or directly outsourced services and third part suppliers).

6.1 SAFE SYSTEMS

The chief pharmacist (or equivalent) leads on ensuring that all aspects of medicines use within the organisation are safe.

Examples of evidence
• Involvement. Groups and committees looking at the design and updating of prescription and administration systems include members of the pharmacy team.
• Designated post. Named individual has responsibility for electronic prescribing.
• Audit. Charts, medicines reconciliation forms, medication histories are audited to ensure that an identifiable pharmacist has screened them.
• National standards. National alerts are incorporated into Trust policies, procedures and guidelines.
• Recording in patients notes. Standards are in place for pharmacists documenting actions in patient notes.
• Omitted and delayed doses. Policy documents and SOPs are in place.

Example of Practice (See Appendix 2 for more examples)

The on-call pharmacist is supplied with a Blackberry linked to MHRA email alerts. This enables any product recalls to be made on a 24 hour basis and helps ensure patient safety. The RPS Hospital Standards were used to help highlight this issue and implement change. Wrexham Maelor Hospital , Betsi Cadwaladr , University Health Board

6.2 SAFETY CULTURE

The chief pharmacist (or equivalent) leads on promoting a "just" culture in which medication safety has a high profile both within the organisation and its partners.

Examples of evidence/measures
• Incident reporting. Systems are used to report and analyse medication incidents e.g. DATIX, SBAR. Reporting is actively encouraged.
• Shared learning. Newsletters, updates and safety reports published and promoted, medicines incident away day, reporting to relevant committees, learning from incident sessions, incorporating learning into training.
• Action. Root cause analysis of serious incidents involving medicines must involve a pharmacist.

Example of Practice (See Appendix 2 for more examples)

A Trust wide reporting system includes medication errors. Once a month, all medication errors that are scored as category 4 or 5 (i.e. serious) are highlighted on the dashboard, with the aim of raising awareness, improving learning and preventing re-occurrence. Central Manchester University Hospitals NHS Foundation Trust

Examples of how some sites are achieving delivery of standard 6.0 safe use of medicine:

- National safety alerts are audited on a regular basis to demonstrate compliance e.g. NPSA guidance on delayed and omitted doses.
- Serious incidents and never events involving medicines are investigated.
- Medication incident reports are audited and trends investigated. Action plans developed to avoid recurrence.
- Reports on DATIX are regularly reviewed alongside contributions data. Issues identified are investigated and steps put in place to avoid recurrence.
- Quality of pharmacist recording of recommendations in patients' notes is audited.

Examples of areas for development identified for standard 6 safe use of medicines:

- Not all prescriptions are screened by a pharmacist, some are not seen and others have a minimal clinical check.
- Our monitoring of ongoing compliance with NPSA alerts is not as good as it could be.
- Communication and shared learning from events could be more targeted we currently produce a newsletter which may not get to all relevant groups.
- There is sometimes a limited review of Serious Incident action plans and little or no evidence of recommendations being acted upon.