

# HARM FROM OMITTED

An NPSA Rapid Response Report outlines how to ensure that critical medicines are administered correctly and without delay to prevent death and serious harm

Administration of medication is a core role for every nurse. It requires skill as well as knowledge of the drug and its side effects.

The Nursing and Midwifery Council's *Standards for Medicine Management* ([tinyurl.com/NMC-medsmanag](http://tinyurl.com/NMC-medsmanag)) states that medicines administration "is not solely a mechanistic task to be performed in strict compliance with the written prescription...

it requires thought and... professional judgement".

An area of major concern is where a dose is omitted or delayed. This was the second largest category of medication incidents reported to the NPSA in 2007.

Omission or delay can have severe or fatal results, for example in pulmonary embolus. In chronic conditions, delays or omissions

can lead to serious harm – delay affects symptom control in Parkinson's disease.

The high volume of incidents (more than 21,000) received by the NPSA between September 2006 and June 2009 led to the issuing of a Rapid Response Report in February 2010 to change practice at individual and system levels. Of the incidents, 27 had resulted in death and 68 in severe harm.

## FIVE WAYS TO MAKE PRACTICE SAFER IN YOUR HOSPITAL

**1 On admission, check critical medication already being taken by the patient and ensure it will be provided**  
When admitting a patient, establish as quickly as possible the medicines they are taking. Identify those regarded as critical and take steps to see they are prescribed and administered without delay.

**2 Check medication has been taken, not just given**  
Every time you administer a medicine and sign that it has been given, ensure the patient has actually taken it.

**3 Act when drugs have been missed**  
Act when a prescription chart shows a prescribed medicine has not been administered for two or more doses and every occasion where a critical medicine has not been administered.

**4 Have systems that ensure drugs are given on time**  
Ensure robust processes are in place to ensure that "stat" doses of a drug are administered at the given time.

**5 Plan for drugs at discharge**  
Establish systems and processes to ensure that no patient is discharged without an adequate supply of critical medicines.



Make sure that medicines are actually taken once they've been given

## WHAT SHOULD MY TRUST BE DOING?

The NPSA Rapid Response Report identified key actions to make practice safer.

The NPSA has asked your organisation to:

- Identify locally determined critical medicines for acute and chronic conditions where timeliness of administration is crucial.
- Review medicines management to ensure guidance exists on all stages: prescribing; supply; and administration. This should detail actions to minimise risk when a drug is delayed or omitted.
- Review processes for critical medicines supply in and out of hours.
- Review all incident reports relating to omitted and delayed medicines and initiate an annual audit; any systems improvements identified as a result should be acted upon to reduce patient harm.
- Ensure the RRR is available across the trust and that staff are aware that omissions or delays of critical medicines must be reported as patient safety incidents.

# AND DELAYED DRUGS

The 95 most serious incidents occurred in the acute setting. The NPSA identified four drug types where two or more fatal incidents had been reported: anti-infectives; anticoagulants; resuscitation medicines; and insulin.

Medications are given late or omitted owing to the following reasons: the drug is not prescribed, is not available (particularly out of hours), the route of administration is not available or the patient is off the ward.

Most respondents to an NPSA consultation last year thought drugs could be given more than two hours from the time on the chart.

Some need to be given as soon as possible, including resuscitation drugs, first doses of injected anti-infectives, anticoagulants, thrombolytics, anticonvulsants and stat doses.

#### Examples of text from incident reports:

- *Transferred as an emergency from ward to the cath lab for coronary angiography with or without PCL. A large thrombus in the left main stem was noted; at the same time it was noted that intravenous or intra-arterial heparin had not been given. Cardiac arrest team was called, resuscitation not successful and patient died.*

- *Patient admitted with infected ulcer and cellulitis. At 15.00 hours the doctor instructed the nurse to give intravenous antibiotics immediately. The doctor returned at 16.30 hours – observations not done and antibiotics not given. Patient was drowsy.... Patient had to go to intensive care unit, where she died from severe sepsis.*

- *Diagnosed with pulmonary embolus. Stat dose of enoxaparin (Clexane) prescribed but does not appear to have been given. Patient arrested and died.*

**Michael Surkitt-Parr, clinical reviewer, NPSA**

## HOW TO USE THE RAPID RESPONSE REPORT TO CHANGE PRACTICE

**Matt Griffiths, senior nurse, medicines management, at University Hospitals of Leicester Trust, believes the Rapid Response Report highlights the issue of omitted medication – but will only be effective if it is properly communicated to all staff.**

“The issue of omitted medication was brought to our attention by various patient groups. Omitted medication affects many patients with a range of conditions, including diabetes and epilepsy: 10% of patients are admitted to hospital because of an issue with their medication, such as toxicity, omission or side effects. Patients with Parkinson’s disease spend an average of five extra days in hospital through delays in getting their medication.

“In 2008, we met with patient groups to find out their views and we highlighted admissions areas as a high risk area. We sent a reminder to all related areas asking staff to help patients to take their own medication before formal admission, if the timing is critical.

“We have until February 2011 to implement the RRR guidelines and effective dissemination is proving crucial. We have used our existing nurses’ and midwives’ medicines management forum to communicate the guidelines.

“The RRR’s supporting information highlights the fact that, often, omissions happen when staff are too busy. Organisations have a responsibility when asking staff to administer medication to

offer them appropriate training, staffing levels and skill mix.

“Another issue raised in the RRR is the importance of reporting omissions as patient safety incidents. It is estimated only 10% of medication errors are ever reported, so reported figures are only the tip of the iceberg.

“Often staff don’t consider an omission to be as serious as an overdose – but the results can be life threatening”

“Part of the problem is that often staff don’t consider an omission to be as serious as an overdose. But, if a patient misses a dose of epilepsy medication for example, and has a fit as a result, it can be life threatening.

“Simply disseminating the RRR may allow an organisation to tick a box – but that is not enough. Has everyone read it and understood it?

“This is particularly important in areas where the medication is not routinely given. We produce a monthly newsletter, just one side of A4, concentrating on the

RRRs to make staff in all areas aware of specific issues with certain medication.

“As the RRR emphasises, it is important to create a list of medications where timeliness is crucial and use a range of means to get the information out there, including the use of email alerts and forums.

“We also have a senior nurse for medicines who works part time and focuses on the preceptorship of newly qualified staff.

“All the RRRs are extremely helpful and welcome. However, they are only effective if they are communicated to everyone and if other aspects, such as staffing levels and safe environments for checking and preparing IV medication, are addressed.

“Medicines management – including the issue of omitting medication – needs to be given the same priority as issues such as dignity, nutrition, and infection control.”

### EVERY REPORTED INCIDENT COUNTS

Each serious incident you report is reviewed at the NPSA. We see if there is potential for national action (an RRR) by looking for further evidence of harm in our database of more than four million incidents reported by nurses, doctors and others. This RRR was a response to the significant number of incidents around this topic. Please carry on reporting to ensure safer care. [tinyurl.com/npsaguidance](http://tinyurl.com/npsaguidance)

Find the Rapid Response Report and supporting information on the NPSA website at [tinyurl.com/RRR-omittedmeds](http://tinyurl.com/RRR-omittedmeds)

## DID YOU KNOW?

- **Releasing Time to Care: the Productive Ward**, developed by the NHS Institute of Innovation and Improvement initiative, has a module on medicines and how to streamline medicines rounds. See [tinyurl.com/productive-ward](http://tinyurl.com/productive-ward).
- Sixty per cent of all the serious incidents reported to the NPSA, including those concerning delayed and omitted medicines, relate to injectable medicines.
- A Care Quality Commission report issued in 2009, *Managing Patients’ Medication After Discharge*, published a survey involving 12 primary care trusts, with 81% stating that details of prescribed medicines were incomplete or inaccurate on discharge summaries “most of the time”. See [tinyurl.com/medman-disch](http://tinyurl.com/medman-disch).