Medication Error Incidents reporting survey

Consultation questions

The MHRA and NHS England have formed a strategic partnership to improve reporting and learning in the field of medication safety. This partnership includes joint working on several strategic initiatives to improve medication error incident reporting and learning.

There are 5 strategic initiatives:
- strengthening clinical governance
- identifying a medical medication safety officer
- a new integrated reporting route
- identify a local multidisciplinary group to review incidents and take action
- a national medication safety network

This questionnaire is designed to be completed alongside reading the draft alert (Questions 1 and 2 – organisation and job title)

3. To what extent do you agree with this statement: medication errors are an important patient safety topic

   Strongly agree ✔
   Agree
   Neither agree nor disagree
   Disagree
   Strongly disagree

   Comments

   Both our lay and clinical members strongly agree with this statement. Without the adoption of a rigorous approach to improvement of safety, the continued impact on patients is likely to result in more serious errors.

4. To what extent do you agree with this statement: The draft Patient Safety Alert: improving medication error incident reporting and learning is clear

   Strongly agree
   Agree
   Neither agree nor disagree
   Disagree ✔
   Strongly disagree

   Comments
Our clinical members felt that the document is not clearly written in some parts, in particular they thought that the sentence “continual learning and improvement of patient care, top-to-bottom and end-to-end” is badly worded and unclear.

5. To what extent do you agree with this statement: the oversight role of the Medical/Nursing Director (section 7.1) is clear

Strongly agree
 Agree ✔
 Neither agree nor disagree
 Disagree
 Strongly disagree

Comments

Our members felt that in principle this is a good idea, but they also felt section 7.1 is somewhat vague and more flesh around the details and agreed processes are necessary for the oversight role to work; some suggest that the oversight role needs to be added officially to job descriptions and work plans/objectives of Medical and Nursing Directors.

6. Do you support the proposal of identifying a medication safety officer as outlined in section 7.2?

Yes ✔
 No

Comments

Our members largely support this proposal, but again they would like to see more detail on how this role will be integrated in current personnel structures. For example will each Trust have a MSO or will he/she cover Trusts and hospitals in a region. Who will the MSO report to? For this role to be effective it would be advisable that the MSO reports to senior management.

7. Do you support the proposed role responsibilities for the medication safety officer?

Yes ✔
 No

Are there any other responsibilities you would include?
Overall our members support the proposed role responsibilities for MSOs, but warn that attention needs to be given to how this role will sit in existing structures for Incident Reporting in Trusts and must not add another layer of reporting, which would lead to confusion.

8. Do you support the identification of a Medication Safety Committee (section 7.3)?

Yes ✔  No

Comments

Our members support this proposal. Clinical members have pointed out that most Trusts already have such committees in place. Our lay members would like to see more details around the authority, transparency and duties of these committees.

9. Do you support the proposed Medical Safety Committee responsibilities?

Yes ✔  No

Comments

Our members support the responsibilities of the proposed Medial Safety Committees. However our clinical members are aware that Standard Operating Procedures are to be introduced for medication and wonder how the two will be integrated.

10. Do you support the proposed development of the national medication safety network?

Yes ✔  No

Comments

Our members supposed this proposal, but warn that there should not be confusion with existing networks and it needs to be clear whether these networks will replace others.

11. Do you support the proposed aims of the national medication safety network?

Yes ✔
12. Is the route for reporting medication error incidents clear (section 5)?

Yes ✔
No

Comments

Over all our members think that the route is clear, but feel that the route for reporting should also include an internal process where the incident goes back to the Trust and local staff, so that they can review their own incidents.

13. Is it clear when you should complete a Yellow Card report?

Yes ✔
No

Comments

Training in recognising ADRs and the subsequent reporting process should continue to be stressed as an important part of medical training.

14. Is the draft supporting information clear?

Yes ✔
No

Comments

15. Are there any barriers to implementing the recommendations in this guidance?

Yes ✔
No

If you have answered yes, please tell us what these barriers are and how you think they can be minimised
Our clinical members are concerned that these changes, although very useful potentially, they will be seen as a new layer of bureaucracy if they are not properly integrated into the current systems. Education is key.

Our lay members have suggested that the following could be barriers:

- The reluctance to report incidents and near misses where things go wrong.
- Lack of clear processes to implement the proposals, especially around funding, recruitment and training.

16. Do you have any further comments on draft Patient Safety Alert or the draft supporting information?

Yes, see below:

- Some members commented that the questions in the survey appear to be somewhat leading at times, for instance the surveys ask if things need to be 'improved' rather than whether the proposed changes would be an improvement. They would also like to know that the ensuing 'benefits’ from these changes are actually proven, before changing current systems.
- Concern over amount of cases to be reported and how well the system will cope.
- Our Patient Liaison Group members feel that patients should be aware of the new systems, not just the medical profession.
- The Faculty of Intensive Care Medicine is pleased that this important topic is being highlighted. They commented that the attachments, and in particular the supporting information, are clear and well formulated.
- Page 2 of the supporting document: ‘Target audience’ – only Foundation Trusts are mentioned, what about non Foundation Trusts?
- There seems to be inconsistency between the safety alert (which states the requirement to report patient incidents THAT CAUSE HARM) and the supporting document, where the request is to report all (THAT DO OR COULD HAVE CAUSED HARM). There is an argument that the latter is a monumental challenge, due to the high rates of medication errors, which are reported by medical literature. We could expect about 7000 drug errors from anaesthesia alone (1 in 600 anaesthetics) and from ICU perhaps one error for every five ICU beds every day (or >70 reports per ICU bed pa).
- A major problem with learning and feedback is that it needs to be specific and focused. Doctors will only be interested and have the time to read about drug issues for their areas of practice. It will be a major challenge to strike the right balance between getting the information out and hitting the right targets, so that clinicians are not inundated with and put off by information irrelevant to their specialty.