MSO role in secondary care
- an example from one organisation

Dr Yogini Jani
Medication Safety Officer
Supporting information

- Alert reference number: NHS/PSA/D/2014/005
- Alert stage: Three - Directive

7.1.3. The role of the medication safety officer

The establishment of a MSO is integral to improving medication error incident reporting and learning within healthcare provider organisations. One of the MSOs' key roles is to promote the safe use of medicines across their organisations and be the main experts in this area. In addition to improving the quality of reporting, the MSO will serve as the essential link between the identification and implementation of (local and national) medication safety initiatives and the daily operations to improve patient safety with the use of medicines.

Responsibilities should include the following:

i. active membership of the National Medication Safety Network;
ii. improving reporting and learning of medication error incidents in the organisation;
iii. managing medication incident reporting in the organisation. This may entail reviewing all medication incident reports to ensure data quality for local and national learning and where necessary to investigate and find additional information from reporters. Also, to authorise the release of medication error reports to the NRLS each week;
iv. receiving and responding to requests for more information about medication error incident reports from the Patient Safety Doman in NHS England and the MHRA;
v. work as a member of the medication safety committee to deliver the responsibilities listed in 7.1.4; and,
vi. supporting the dissemination of medication safety communications from NHS England and the MHRA throughout the organisation.
Medication Safety Officer

- Incidents and risks
- Education & training
- Safer Use of Medicines newsletter
- Medication Safety Committee strategy & work plan
- Medication Safety Indicators
SUM tips Issue 9 August 2014

Safer Use of Medicines – to Improve Patient Safety

Policy Refresher: Anticoagulation discharge policy

DO –
- Commence discharge planning before or upon admission
- Involve family/carers in the discharge process and in counselling
- Prescribe patient’s take home medicines (TTAs) at least 24 hours before the planned discharge date
- Clearly document and communicate any changes to prescribed medication to all members of the multidisciplinary team, both within the trust as well as relevant primary care practitioners

Specifically for anticoagulation:
- Ensure that a follow-up with the patient’s selected anticoagulation clinic has been arranged for within 5-7 days of discharge

Topics covered in this issue:
- Policy Refresher: Anticoagulation discharge policy
- MHRA Update: infusion related reactions
- Did you know? Animal derived medicines/ingredients
- Risk It! – Reports Incidents to Share Knowledge

Did you know?
A number of medicines may comprise or contain materials derived from animals. Examples include heparin and low molecular weight heparins such as dalteparin (porcine), older insulin products (bovine or porcine origin), some vaccines (e.g. MMR) and gelatin capsules (bovine or porcine).

Examples
1. Intravenous administration or infusion related
   “Patient was receiving IV fluids which had been started during the night shift. When checked against the prescription chart they were the wrong fluids. 0.45% saline and 2.5% dextrose was running although 0.9% and 5% dextrose was prescribed.”
   “While I was giving a medication to the patient, I noticed that the Phosphate infusion was running at 34.4 mL/hr instead of 7.5 mL/hr.”

Lessons learned
There continues to be a high rate of error at all stages of medicine administration. The “Spotlight on Infusion” highlighted this ongoing issue and policies currently in place at UCLH aim to reduce errors.

Risk It! – Reports Incidents to Share Knowledge

75 medication-related incidents were reported using the Trust online reporting system (DATIS) in July 2014.

Take home messages:
- Develop or provide evidence of your competence in IV drug administration
- Double check doses and infusion rates
- Refer to the UCLH Injectable Medicines Administration Guide
- Ensure your medicines management training is up to date
- Familiarize yourself with the different infusions routes e.g. IV, SC, epidural
- Only staff who are trained to administer infusions should do so

Why should you report?
This is the lowest number reported in a month since we moved to online reporting. A reminder that all incidents and near misses must be reported.

Evidence suggests that
- Higher reporting rates are associated with a more positive safety culture, and
- By creating a ‘reporting culture’ organisations can improve their ability to learn when things go wrong.
Medication Safety Committee
- areas of focus 2014-15

<table>
<thead>
<tr>
<th>Area</th>
<th>Focus Areas</th>
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<tbody>
<tr>
<td>Missed medication</td>
<td>• Dose omissions</td>
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<td></td>
<td>• Discharge medications</td>
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<td>Allergies</td>
<td>• Breaches</td>
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<td></td>
<td>• Documentation</td>
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<td>Injectable medicines</td>
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<td>Prescribing quality</td>
<td>• Take 5 project</td>
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<td>Safe &amp; secure storage</td>
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Monitoring performance
- medication safety indicators

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Jul 13</th>
<th>Aug 13</th>
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<tbody>
<tr>
<td>Preventable dose omissions</td>
<td>0.7%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Antibiotics - % Indications Documented</td>
<td>97.8%</td>
<td>97.8%</td>
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<tr>
<td>(Quarterly Audit)</td>
<td></td>
<td></td>
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<tr>
<td>Antibiotics - % Durations Documented (Quarterly Audit)</td>
<td>87.5%</td>
<td>87.5%</td>
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<tr>
<td>Percentage of Completed eVTE Risk Assessments</td>
<td>93.79%</td>
<td>93.42%</td>
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<tr>
<td>Allergy Status Documentation</td>
<td>100.0%</td>
<td>98.7%</td>
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<tr>
<td>Medication Security Compliance</td>
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<td></td>
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<tr>
<td>Allergy Breaches</td>
<td>0</td>
<td>0</td>
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Monitoring performance - does it make a difference for the patient?

**Insulin prescribing**
- Pre-printed section on inpatient prescription chart
- Insulin infusions stickers (adults and paediatrics)

**Bedside medication lockers**
- Minimise dose omissions
- Promote self-administration

**Innovative techniques: ‘teach-back’**
- Improve patient understanding and adherence
- Reduce errors at discharge
- Reduce re-admissions (as part of a wider initiative)
HOT CHOCOLATE

expectation

reality
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MSO network

- Define and drive priorities
- Influence
- Research