NHS
National Patient Safety Agency

Rapid Response Report

NPSA/2010/RRR009

From reporting to learning

24 February 2010

Reducing harm from omitted and delayed medicines in hospital

Issue

Medicine doses are often omitted or delayed in hospital for a variety of reasons. Whilst these events may not seem serious, for some critical medicines or conditions, such as patients with sepsis or those with pulmonary embolisms, delays or omissions can cause serious harm or death. Patients going into hospital with chronic conditions are particularly at risk. For example, patients with Parkinson's disease who do not receive their medicines on time may recover slowly or lose function, such as ability to walk. This has been highlighted by the Parkinson's Disease Society's 'Get it on time' campaign, which has produced resources for both patients and staff to help raise awareness and enable patients to get their medication on time.

The Productive Ward initiative from the National Health Service Institute for Innovation and Improvement (NHS III) provides information on minimising interruptions and streamlining the medicines ward round and National Patient Safety Agency (NPSA)/National Institue for Health and Clinical Excellence (NICE) guidance on medicines reconciliation supports the reduction in omitted doses. These are useful resources, but further work is needed in the NHS to address this as an important patient safety issue.

Patient safety incidents

Between September 2006 and June 2009, the NPSA received reports of 27 deaths, 68 severe harms and 21,383 other patient safety incidents relating to omitted or delayed medicines. Of the 95 most serious incidents, 31 involved anti-infectives (antibiotic and antifungals), and 23 involved anticoagulants. Wider evidence suggests that the true rate of harm may be much higher, as events such as these are often not reported.

Work on reducing risks with omitted and delayed critical medicines is needed over a long period. The NPSA is recommending a staged approach, with initial actions now focused on specific critical medicines and longer term work with stakeholders over the next two years to sustain improvements over time.

For IMMEDIATE ACTION by all organisations in the NHS and independent sector who admit patients for in-patient treatment. Deadline for ACTION COMPLETE is 24 February 2011.

An executive director, nominated by the chief executive, working with the chief pharmacist and relevant medical/nursing staff should:

1. identify a list of critical medicines where timeliness of administration is crucial. This list should include anti-infectives, anticoagulants, insulin, resuscitation medicines and medicines for Parkinson's disease, and other medicines identified locally;
2. ensure medicine management procedures include guidance on the importance of prescribing, supplying and administering critical medicines, timeliness issues and what to do when a medicine has been omitted or delayed;
3. review and, where necessary, make changes to systems for the supply of critical medicines within and out-of-hours to minimise risks;
4. review incident reports regularly and carry out an annual audit of omitted and delayed critical medicines. Ensure that system improvements to reduce harm from omitted and delayed medicines are made. This information should be included in the organisation's annual medication safety report;
5. make all staff aware (by wide distribution of this RRR) that omission or delay of critical medicines, for inpatients or on discharge from hospital, are patient safety incidents and should be reported.

Further information

Supporting information including detailed evidence of harm and compliance checklists are available at www.nrls.npsa.nhs.uk/alerts. Further queries should be directed to the NPSA medication safety team at rrr@npsa.nhs.uk; telephone 020 7927 9890.

The NPSA has informed: NHS organisations, independent sector, commissioners, regulators and relevant professional bodies in England and Wales.

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