Belfast Health and Social Care Trust
caring supporting improving together

# FOI/25942

**14 December 2021**

# Medicines-related patient safety incidents

1. **Does BHSCT ensure that robust and transparent processes are in place to identify, report, prioritise, investigate and learn from medicines-related patient safety incidents, in line with national patient safety reporting systems – for example, the National Reporting and Learning System.**

   **Can they detail the path followed?**

   National Reporting and Learning system (NRLS) is a system for England and Wales therefore Belfast Health & Social Care Trust (BHSCT) cannot contribute to it. Within BHSCT, an Incident Trigger list helps staff identify medication incidents to report. BHSCT Adverse Incident Reporting and Management policy provides a framework to support staff in reporting, prioritising, investigating and learning from incidents (including medication incidents).

2. **How do BHSCT practitioners explain to patients, and their family members or carers where appropriate, how to identify and report medicines-related patient safety incidents.**

   To our knowledge there are no mechanisms for patients, their family members or carers to report e.g. wrong dose, omitted dose etc. incidents. NRLS in England and Wales permits only health care professionals to report incidents.

   **UK Yellow Card Scheme:** The MHRA runs the Yellow Card Scheme which collects and monitors information on suspected safety concerns on medicines and vaccines. This scheme relies on voluntary reporting of suspected safety concerns by Healthcare Professionals or Members of Public. There is no robust guidance to communicate this within the BHSCT.

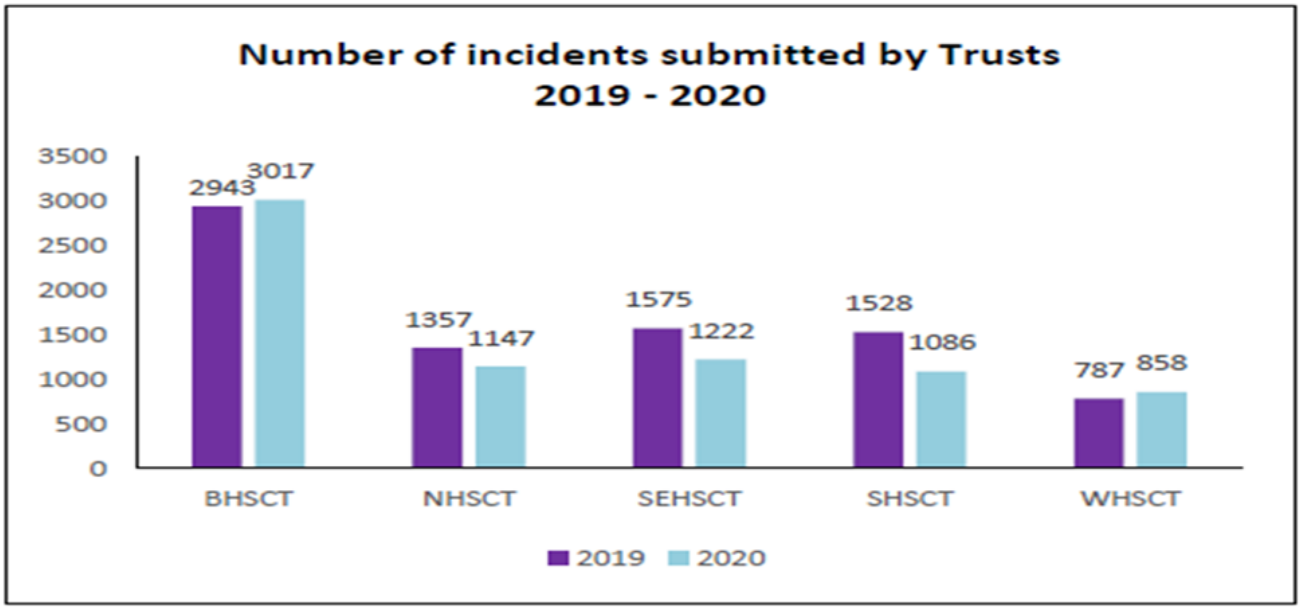
   Website link
   **https://yellowcard.mhra.gov.uk/**
   Yellow Card reports can also be made:
   - via the mobile app from the AppleApp Store Apple App Store, or Google Play Store Google Play Store.
   - MHRA freephone (0800 731 6789) 9am to 5pm Monday to Friday
   - Belfast Health & Social Care Trust Regional Medicines and Poisons Information Service can report on behalf of Healthcare Professionals (via MiDatabank) (028 950 40558) 9am to 5pm Monday to Friday.
   - in clinical IT systems for healthcare professionals (EMIS, SystmOne, Vision, MiDatabank and Ulysses)

   Specific Information requests should be directed to E-mail: yellowcard@mhra.gov.uk

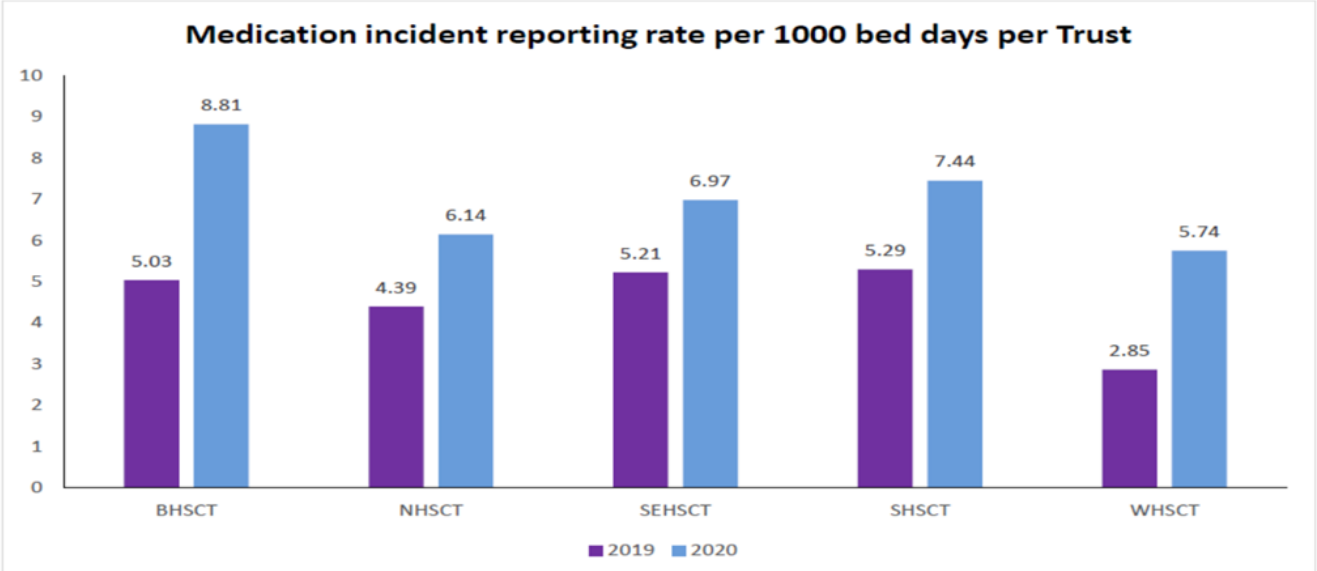
**Accidental poisoning**: this may also be presented as therapeutic excess- whilst there may be some incidents on Datix or RMPIS system MiDatabank/RMPIS Poisons forms this is not actively collated and would not be comprehensive or representative of the entire Trust.
It would take time to pull reports and review for this specific information from across a variety of routes. EDs and other clinical areas would also have to be involved and I'd estimate this would take in excess of 18 hours time to attempt this.

3. **How do BHSCT support a person-centred, 'fair blame' culture that encourages reporting and learning from medicines-related patient safety incidents.**

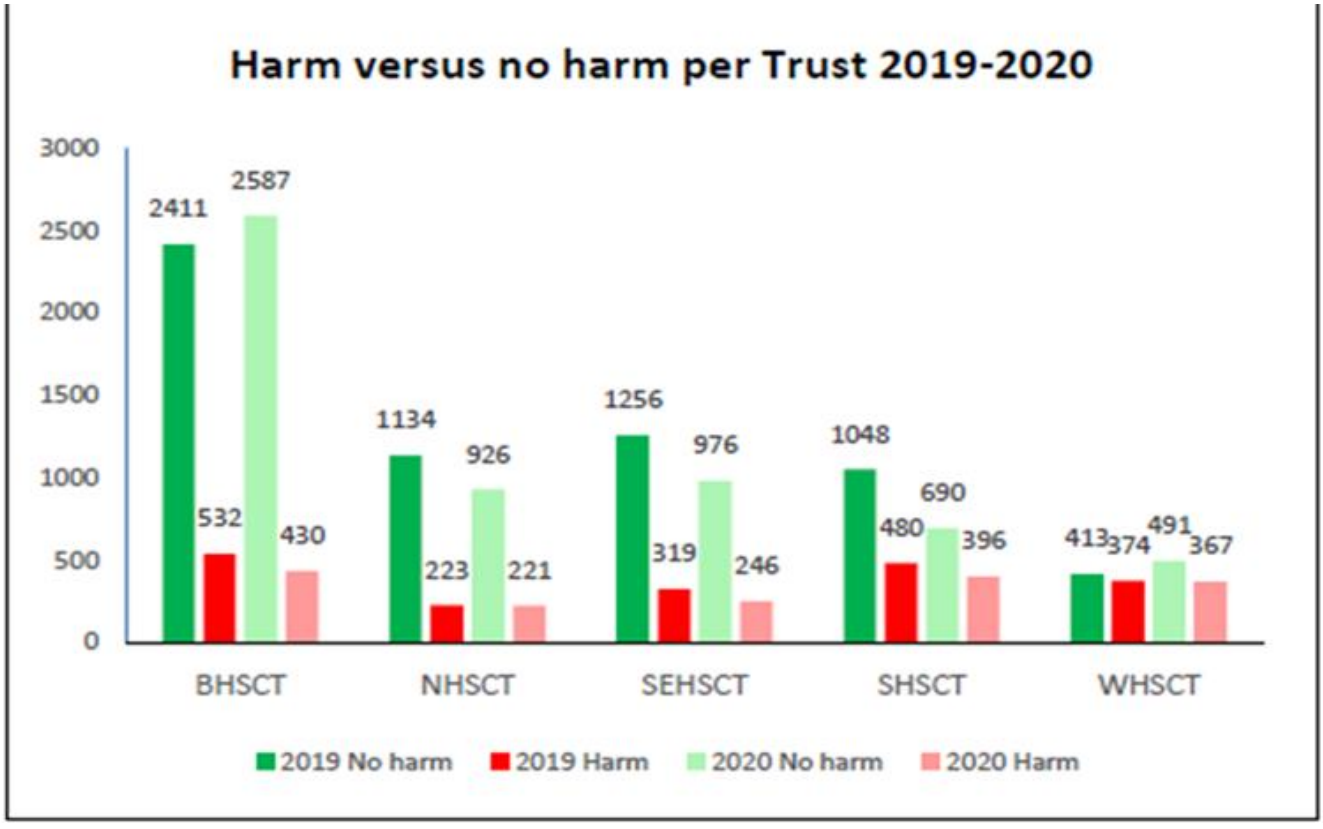
BHSCT has an open reporting datix system. The review of Northern Ireland Medicine Incidents 2019-2020, has shown the following results demonstrating the reporting figures of medicine related incidents.



Obviously BHSCT has more beds and the following graph shows the data in a manner to address this




Our Trust also encourages reporting all incidents not just those causing harm. It is well recognised that learning is achieved from these non-harm incidents to actually prevent incidents causing harm. We also encourage reporting as shown in the graph these incidents that unfortunately are linked to harm.



The data can be deeper mined to reveal the categories contributing to these incidents within our Trust.

| | BHSCT | |
|---|---|---|
| **Medication incident types** | **2019** | **2020** |
| Administration to Patient | 1830 | 1796 |
| Delivery Processes | 69 | 222 |
| Dispensing Processes | 140 | 200 |
| Medication advice | 15 | 16 |
| Other Medication/Biologics/Fluids Incident | 277 | 141 |
| Post-administration Patient Monitoring | 31 | 26 |
| Preparation/Formulation Processes | 30 | 30 |
| Prescribing Processes | 474 | 386 |
| Procurement/Supplier Processes | 10 | 19 |
| Storage Processes (in pharmacy or on unit) | 67 | 181 |
| **Totals** | 2943 | 3017 |

**4. On which system are these incidents recorded for trust wide learnings and potentially regional learnings.**

Incidents are reported using Datix system. This Datix system is reviewed on a weekly Charles Vincent model by the medicine safety pharmacist group who contribute to the monthly Medicine Risk and Safety Assurance Group. During the monthly meeting, assurance is achieved by reviewing the incidents, incidents of concern, Serious Adverse Incident, Patient Complaints, and the Medicine Safety Thermometer data from the directorates. This generates shared learning discussion and also supports quality improvement.