

# Medication incidents reported by Irish hospitals in 2018

Mark McCullagh, Clinical Risk Adviser, presents a selection of National Incident Management System (NIMS) data on medication incidents reported by Irish hospitals in 2018.

## What is a medication incident?

A medication incident is defined as any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer.<sup>1</sup> The terms 'medication incident' and 'medication error' are similar.

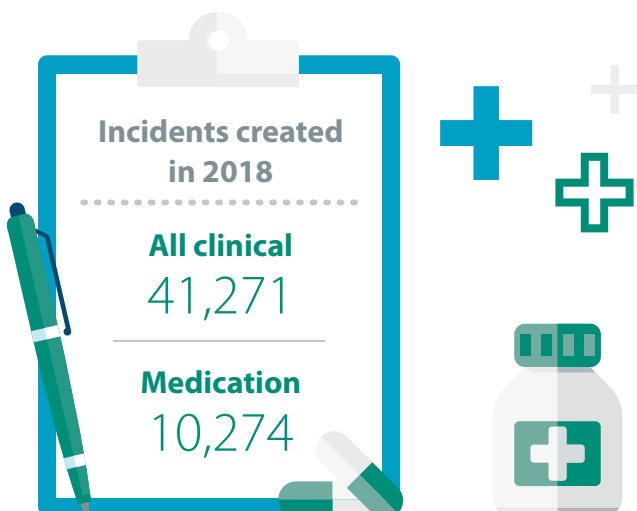
## What is the medication use process?

The medication use process describes the sequence of stages of medication utilisation from prescribing, transcribing, dispensing, administration through to monitoring.<sup>2</sup>

## What is medication reconciliation?

Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points.<sup>3</sup>

## Medication incidents in acute hospitals



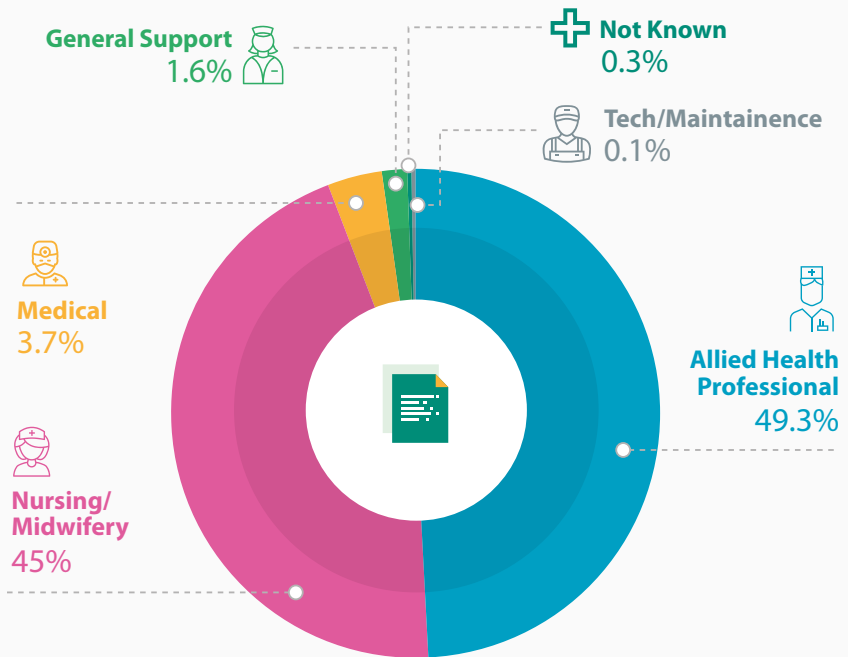
## Did you know?



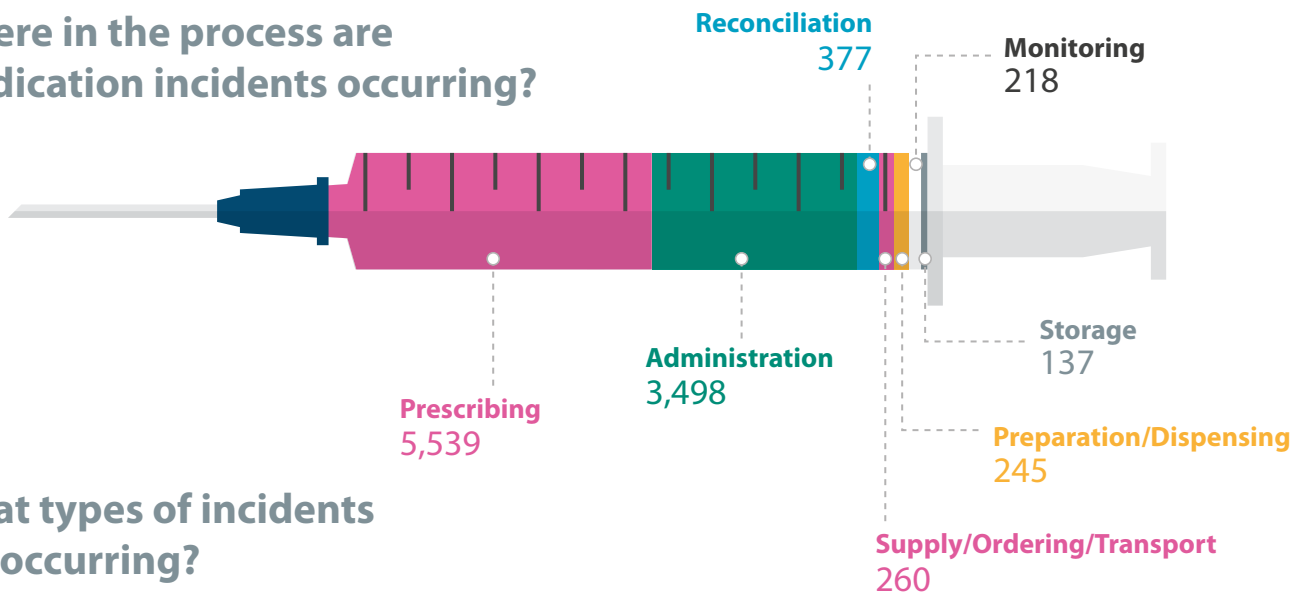
- + A recent study across primary and secondary care estimated that **237 million medication errors** occur at the various stages of the medication use process each year in England, of which **25.8% and 2%** have the potential to cause moderate and severe harm respectively.<sup>2</sup>
- + This same study estimated the cost to the NHS of definitely avoidable adverse drug reactions (ADRs) to be **£98.5 million (€115.3 million)** annually.
- + The World Health Organisation launched its third Global Patient Safety Challenge in 2017. Entitled Medication without Harm, the aim of this challenge is to **reduce severe avoidable harm related to medications by 50% over five years.**<sup>4</sup>

Higher incident reporting rates are considered nationally and internationally to be indicative of a stronger patient safety culture.<sup>5</sup>

## Who's reporting medication incidents?



## Where in the process are medication incidents occurring?



## What types of incidents are occurring?

Incomplete/Inadequate	2,428
Wrong Dose/Strength	2,127
Omitted/Delayed Dose	1,427
Wrong Drug	729
Wrong Frequency	726
Not Performed when Indicated/Delay	578
Contraindicated	535
Adverse Drug Reaction	504
Wrong Quantity/Duration	294
Wrong Formulation/Route	249
Failure/Malfunction of Equipment	195
Wrong Label/Instructions	180
Drug Interaction	156
Wrong Patient	146



'Incomplete/Inadequate' was the most common incident category reported on NIMS in 2018. This category is frequently selected in conjunction with 'prescribing' to report incidents in which the prescriber has omitted important information on the prescription such as dose, route or frequency.

## What can hospitals do to improve medication safety?



Provide **medication safety education and training** for health and social care professionals.



Ensure **medication reconciliation** at transfers between care settings.



Ensure **availability of a recognised reference** source(s) at the point of prescribing.



**Empower the patient or carer** through participation in programmes such as the HSE's 'Know, Check, Ask' safer medicines campaign.



Develop a **safe prescribing guide/app** to ensure non-consultant hospital doctors have access to evidence-based current prescribing guidelines.



**Encourage medication incident reporting** and timely uploading to NIMS to allow detection of trends and clusters at both local and national level.



Ensure clinical areas have **access to clinical pharmacy services**.

*A report on medication incidents reported by Irish hospitals in 2017 & 2018 is due to be published later in the year. References available on request.*

