University College London Hospitals NHS
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Capturing Near Miss Dispensing Errors- NAB

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Initiative Summary

Medication errors are defined as "any preventable event that may cause or lead to inappropriate medication use or patient harm". Such events may be related to procedures and systems including prescribing, product labelling, packaging, dispensing, drug selection, distribution and administration.

Over 570,000 items are dispensed at UCLH pharmacies annually. Datix reports highlighted that the number of dispensing incidents from pharmacy were increasing.

To reduce the incidence rates, we introduced a new process called NAB (Nearly A Blunder) to identify in-process errors picked up at the final accuracy check prior to the medication leaving pharmacy and also help identify other contributing factors to errors e.g. training issues.

Aims & Objectives

· To reduce the number of dispensing errors picked up at the final accuracy check.

· To have a constant competency monitoring system of staff and pharmacy sites.

· To devise a Key Performance Indicator (KPI) to measure patient safety on an ongoing basis.

Method

An electronic near miss recording system (NAB) was developed to allow for constant monitoring.
This was implemented and communicated through the UCLH pharmacy dispensaries.
Awareness of self check for dispensers was raised through team meetings and a self check study guide was developed.
Data from NAB was analysed for individual and site specific error rates.
A system to re-assess competency was developed. Further training was provided where individual error rates greater than 1% were identified.

NAB process

All dispensing errors picked up at the final check are recorded electronically via the NAB system

Staff are made aware of dispensing errors they have made

Monthly dispensing error report indicates individual error rates

Individuals with Dispensing error rates > 1% are give 200 item dispensing logs to complete

Dispensing error logs must be completed without any major error.

3 minor errors are allowed (minor error classification list decided by dispensary managers group)

Completion

Logs completed without error- no further action required

Failed attempts

3 attempts are allowed. If after the 2nd attempt the dispenser does not complete their dispensing logs they are given a self check study guide to complete

Further Initiatives

We are in the process of developing a similar system to identify clinical pharmacist screening incidents or prescription queries. This will lead to a higher quality of ordering and transcribing of medications.

Results

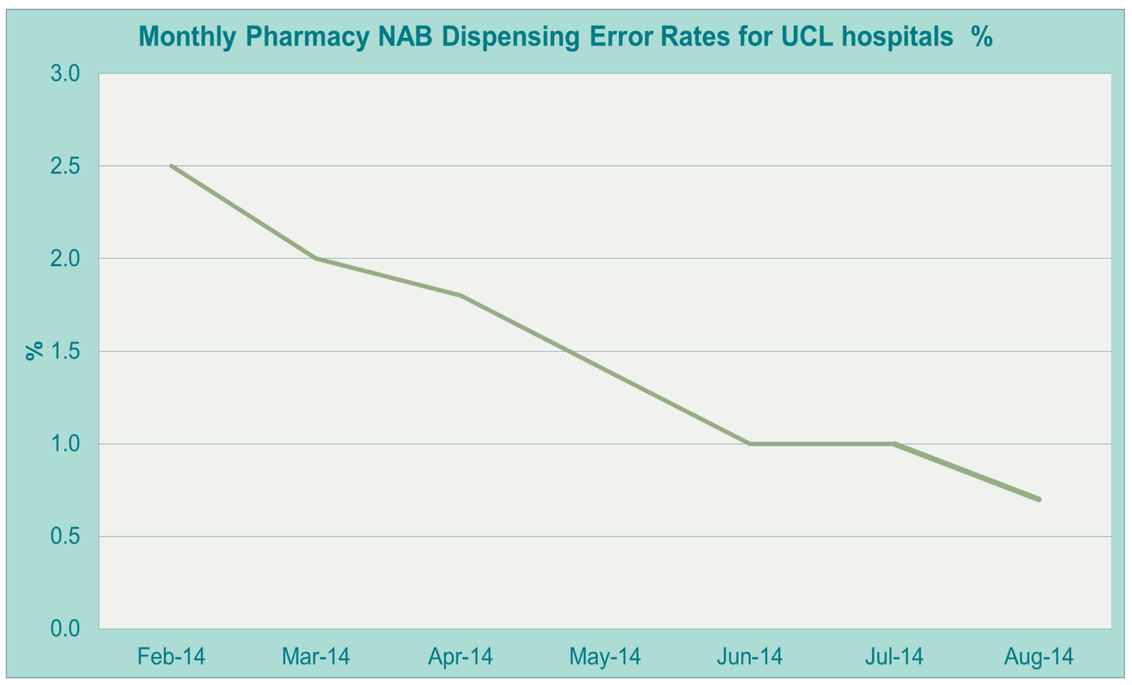
Table 1 - February 2014

Location	No of issues	No of NAB	% NAB
Cancer Centre	2240	112	5.0%
Heart Hospital	627	4	0.6%
Queen's Square	2009	40	2.0%
UCH Inpatients	5010	114	2.3%
UCH Outpatients	4218	94	2.2%

Table 2 - August 2014

Location	No of issues	No of NAB	% NAB
Cancer Centre	2773	18	0.6%
Heart Hospital	715	1	0.1%
Queen's Square	2358	5	0.2%
UCH Inpatients	5866	51	0.9%
UCH Outpatients	4922	41	0.8%

Figure 1 – NAB dispensing error rates



Conclusions

This process has enabled a constant system of monitoring competency and patient safety. This has led to a visible reduction in the number of Near Miss incidents across all pharmacy sites in the Trust.
A consistent training and learning package has been developed.
By getting it right the first time our process is more efficient which leads to a better patient experience.

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