Openness and transparency following incidents

REPORT

- The Patient Safety Group discussed an incident related to a patient who was admitted to hospital after a fall.
- It was discovered that he'd been supplied Amitriptyline 25mg rather than Atenolol 25mg. Sadly the patient later died.
- The cause of death was Alzheimer's, aspiration pneumonia and Covid-19.

LEARN

- Learnings from this case were hampered by poor communication in the aftermath of the incident.
- A significant delay in communicating the incident to the community pharmacy was exacerbated by a lack details on what happened. Neither the packaging nor photos of the packaging were retained, making it difficult to ascertain exactly when the medication was dispensed and the generic brands involved. In addition details were not provided as to how many incorrect tablets were taken.
- This case highlights the importance of openness and transparency following an error. Without which it's difficult to investigate fully. This is extremely important if similar errors are to be prevented in the future.
- Having said this, the organisation involved conducted an incident reflection, undertook a review of SOPs, focusing on dispenser's check and implemented visual reminders. LASA guidance was also launched in new Patient Safety SOP.
- The investigation also pointed to the value of automation in reducing LASA errors due to the removal of the human factors element.

SHARE

- Details of the LASA error were shared with Medication Safety Officers (MSOs) at the Community Pharmacy Patient Safety Group meeting. MSOs will disseminate learnings via their networks. It will also be shared on the monthly MSO webex.
- Details were published on the Pharmacy Safety website, and shared with key stakeholders.
- The community pharmacy organisation emphasised the importance of open and timely communications between different organisations in their response to the coroner.

ACT

- Pharmacy teams should ensure all errors, incidents and near misses are reported so teams can learn from incidents and amend professional practice where appropriate. There's an opportunity for improved collaboration between secondary care and community pharmacy to ensure relevant information is obtained and retained.
- Members of the Patient Safety Group to continue to promote a culture of openness and transparency.

REVIEW

- Members to consider whether Amitriptyline / Atenolol errors are common place in their organisation and how could be addressed.
- A presentation at the Patient Safety Group conference provided examples of actions to reduce LASA errors.