

# Advanced Medicines Management Medication Errors & the Role of Bar-Code Scanning

## **GS1 Global Healthcare Conference 2019**

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Royal Cornwall Hospitals NHS Trust

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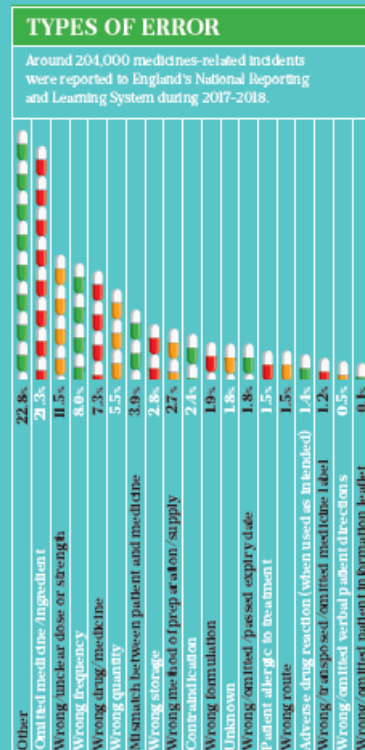
Royal Cornwall Hospitals  
NHS Trust



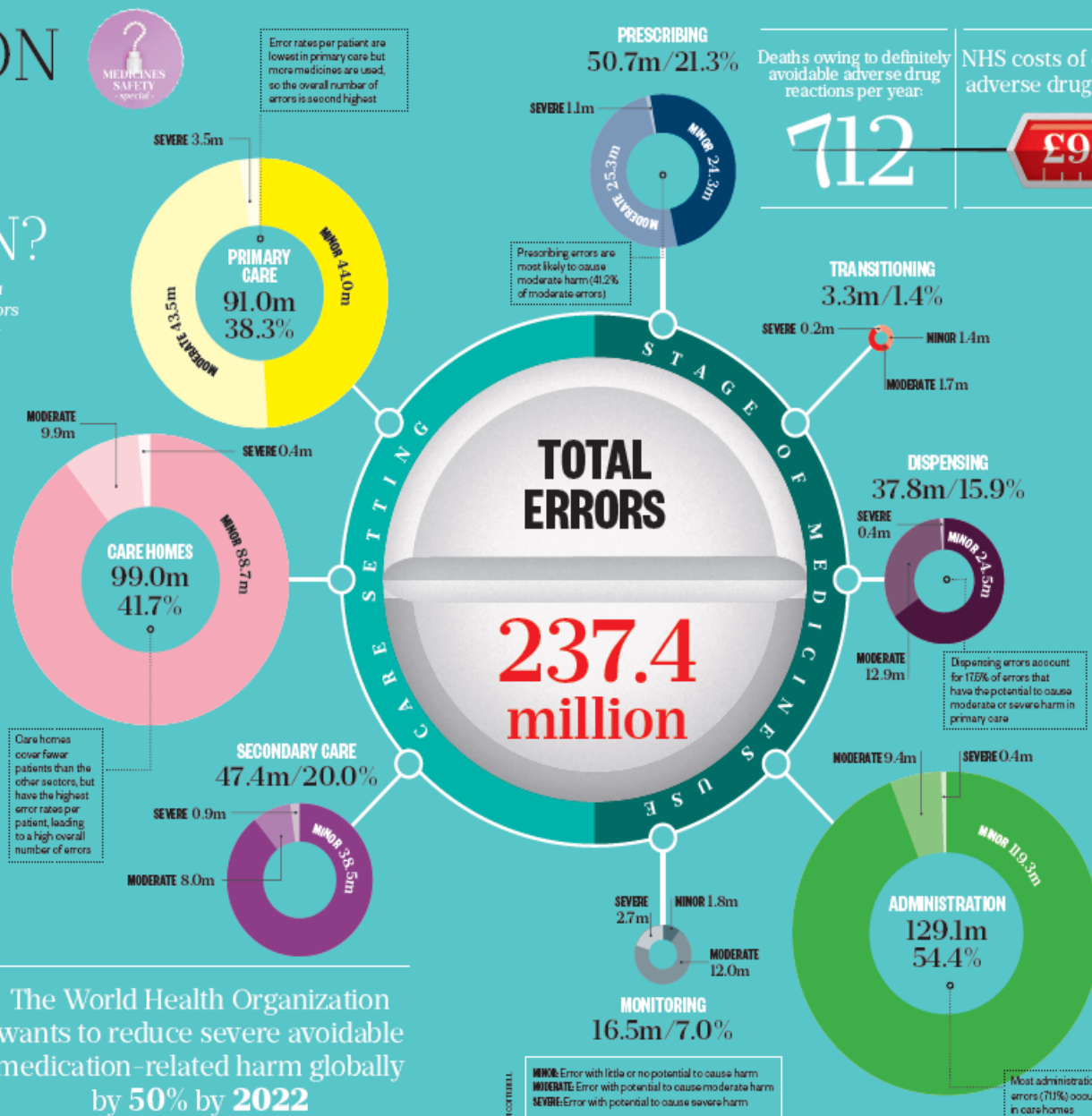
# MEDICATION ERRORS: WHERE DO THEY HAPPEN?

Reducing medicines-related harm requires a clear understanding of where and when errors occur. This visual summary shows the latest estimates in England per year.

DAWN CONNELLY & MARTIN COTTERELL



Source: Data obtained via a Freedom of Information request submitted by The Pharmaceutical Journal to NHS Improvement. Incidents reported to the NPLS as occurring between 1 April 2017 and 31 March 2018.



The World Health Organization wants to reduce severe avoidable medication-related harm globally by 50% by 2022

Deaths owing to definitely avoidable adverse drug reactions per year:

# 712

NHS costs of definitely avoidable adverse drug reactions per year:

# £98.5m



## POTENTIAL SOLUTIONS

Several strategies can be employed to reduce medicines-related harm.

- Roll out and optimise electronic prescribing and medicines administration systems
- Roll out proven interventions, such as Pincer, where pharmacists identify patients who are at risk from hazardous prescribing (see page 95)
- Improve the information available to patients to promote joint decision-making
- Use patient-friendly packaging and labelling
- Improve shared care across different settings
- Embed adequate training in safe and effective medicines use in undergraduate training and continuing professional development
- Encourage reporting of medication errors (see page 120)
- Reduce inappropriate polypharmacy

Source: Department of Health and Social Care. The report of the short life working group on reducing medicines-related harm, February 2018.

Source: Policy Research Unit in Economic Evaluation of Health & Care Interventions. Prevalence and economic burden of medication errors in the NHS in England, February 2016.



# Overworked pharmacist's error led to death of grandmother who died from the 'wrong pills'



Mr White said the two boxes were “side by side on the shelf and have similar branding”.

Mr White claimed to have carried out the required checks under the pharmacy standard operation procedures.

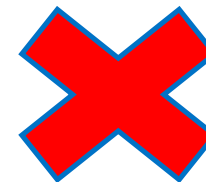


# **RESEARCH & EVALUATION**

## **The Adoption of Barcode Scanning Technology in an Acute NHS Hospital Pharmacy**

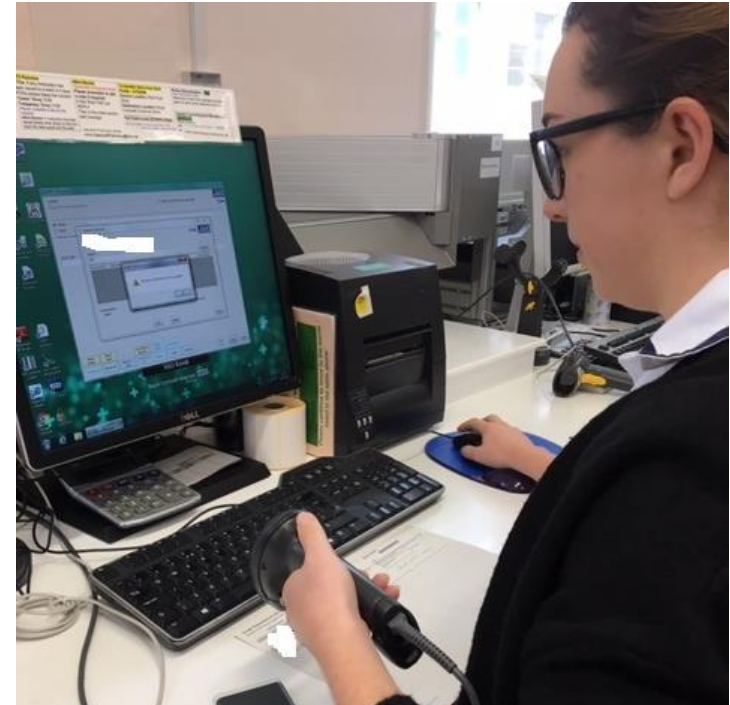
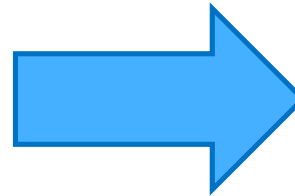
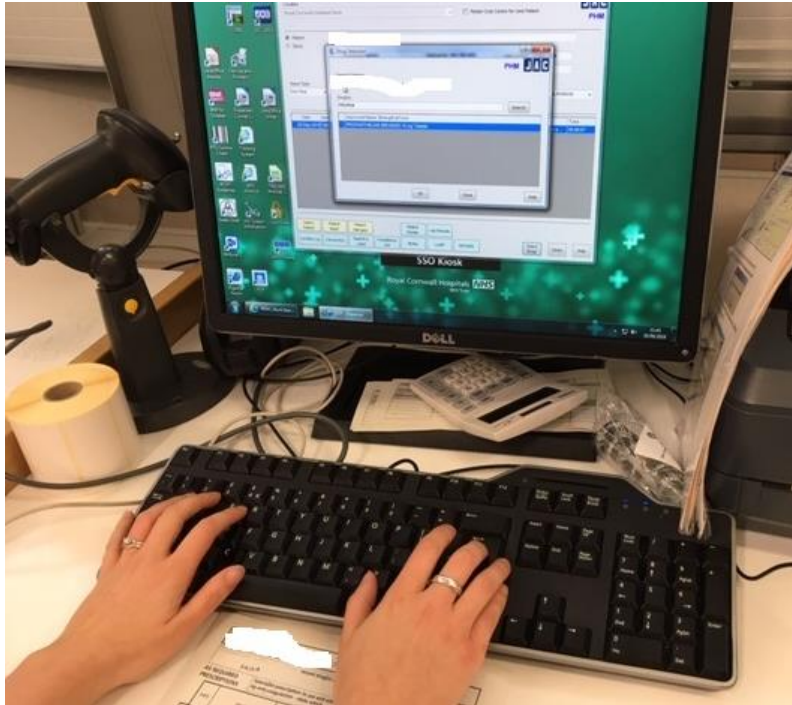
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# Barcode Enabled Dispensing

ALREADY VERIFIED

'GLN'

+

Royal Cornwall Hospitals

NHS

NHS Trust

Drugs Requested on JAC by Notes 27/02/2014 08:30 to 27/02/2014 09:00

Please suppress note on JAC after drug is supplied to ward

BOTOX WARD

| Hospital No | Patient name              | Verified | Note  |
|-------------|---------------------------|----------|---|
| C804047     | EDISCHARGE, MAXIMS NINETY | ✓        | <div>Stock at RCCS: 11 containers 0 du at ROBOT</div> <div>Stock at RCCS: 0 containers 0 du at ROBOT</div> <div>DOXYCYCLINE 100 mg Capsules STAT dose</div> <div>100 mg oral</div> <div><div><div></div></div></div> <div><div>Ordered by:MRS ESTHER DRYDEN</div><div>Clinically checked by: MR IAN NICHOLLS</div><div>Dispensed by:</div><div>Checked by:</div></div>  |
| C804047     | EDISCHARGE, MAXIMS NINETY | ✓        | <div>Stock at RCCS: 44 containers 0 du at ROBOT</div> <div>AMOXICILLIN 500 mg Capsules</div> <div>500 mg oral THREE times a DAY (Morning, Lunchtime + Night)</div> <div><div><div></div></div></div> <div><div>Ordered by:MRS ESTHER DRYDEN</div><div>Clinically checked by: MR IAN NICHOLLS</div><div>27/02/2014 08:42 urgently required ASAP ASAP</div><div>Dispensed by:</div><div>Checked by:</div></div> |

CRITICAL MEDICINE

'GSRN'

'GTIN'



# RESULTS

# Safer Dispensing (P<0.001)

## Prevented Error Rates Reduction

|                                     | Error type       | Dispensing Error Monitoring<br>Period 1<br>(barcode non mandatory) |          | Dispensing Error<br>Monitoring<br>Period 2<br>(barcode mandatory) |          |
|-------------------------------------|------------------|--|----------|---|----------|
|                                     |                  | Prevented<br>Incidents   | Rate (%) | Prevented<br>Incidents  | Rate (%) |
| Bar-code<br>Insensitive Errors      | Administrative   | 4  | 0.11     | 2   | 0.04     |
|                                     | Label directions | 13   | 0.35     | 7   | 0.15     |
| Total Bar-code Inensitive Errors    |                  | 17   | 0.46     | 9   | 0.19     |
| Barcode Sensitive<br>Errors         | Wrong patient    | 1  | 0.03     | 0   |          |
|                                     | Drug strength    | 5  | 0.13     | 0   |          |
|                                     | Drug form        | 3  | 0.08     | 0   |          |
|                                     | Drug name        | 2  | 0.05     | 0   |          |
|                                     | Cost centre      | 1  | 0.03     | 0   |          |
| Total Bar-code Sensitive Errors     |                  | 12   | 0.32     | 0   |          |
| Total Number of prevented Errors    |                  | 29   |          | 9   |          |
| Number of non-stock items dispensed |                  | 3730   |          | 4667  |          |
| Prevented Error Rate (%)            |                  | 0.78   |          | 0.19 (P <0.001)   |          |

# Results

**76%**

**Reduction in  
Prevented  
Error Rates**  
( $p < 0.001$ )



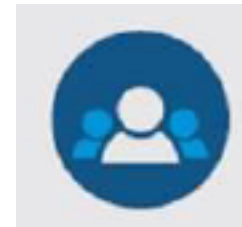
**7%**

**Faster than  
Manual  
Process**  
( $p = 0.015$ )



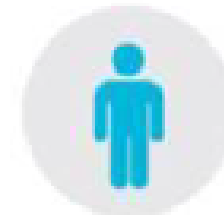
**97%**

**Users agree it  
reduces the  
likelihood of  
medication**



**67%**

**Want to use  
the bar-code  
enabled  
system**



## **Next Steps**

**Integration of GS1 into other Steps in  
the Dispensing Process  
&  
Barcode Medicines Administration**





MEDICINES MANAGEMENT

Cornwall LIVE

Mr Daniel O'Toole

My Account

Help

Logout

DB-JAC2019:LIVE



Technical Check



Patient Record



Outpatient Diary



Help



Dispensary Manager



Dispensing



Fast Return



Admit Discharge  
Transfer



Clinical Drug  
Information



Patient



Configuration



Reporting



User Management



System Info

1

## Co-Codamol Tablets

60 tablets

ONE tablet to be taken FOUR times a day, when required for pain



Mr. Alex Krasnov

16-FEB-2018

Lviv Hospital Pharmacy, Lviv Hospital, LVIV, LV  
Oblast

**KEEP OUT OF REACH OF CHILDREN**



2





[Home](#)
[Patient Finder](#)

Name of Pharmacy is Displayed Here

Name of User
[My Account](#)
[Logout](#)

**POJAR, Cosmin (Mr)**
Born **14-Jul-1991 (23y)**
Gender **Male**
National No. **123 456 7890**

Address **Strada Cometi Nr. 340, 70123, Cluj-Napoca, CJ, Romania**
Hospital No. **567898E**
Allergy Status **Recorded Allergies**

Consultant **Chandrasekhar**
Ward **Admissions**
Body Surface Area **2.1 sqm (e)**
Weight **81 kg (e)**
Height **188 cm**

Communication Zone

[Clinical Drug Information](#)
[Help](#)

**Technical Check**
**Patient Medication Record**

DISPENSING EPISODE: 23-JUNE-2017 @ HH:MM (Number of Items = 5)
STATUS: PENDING

Amoxicillin 500 mg Capsules x 28
Bendroflumethazide 5 mg Tablets x 28
Aspirin EC 75 mg Tablets x 28
Enalapril 5mg Tablets x 28
Simvastatin 20mg Tablets x 28

Product: Enalapril 5 mg Tablets
Directions:

☒ Expiry Date
☒ Batch Number
☒ Decommission

| Action         | User             |
|----------------|------------------|
| H:MM Dispensed | Ethan Richardson |
| H:MM Checked   | Paula Oughton    |
| H:MM Dispensed | Ethan Richardson |
| H:MM Checked   | Paula Oughton    |

☐ Provide Steroid Card
☐ Provide Warfarin Booklet

End Technical Check
Send for Re-Dispensing

Error
Confirm & Next

**Technical Check Alert**

**WARNING**

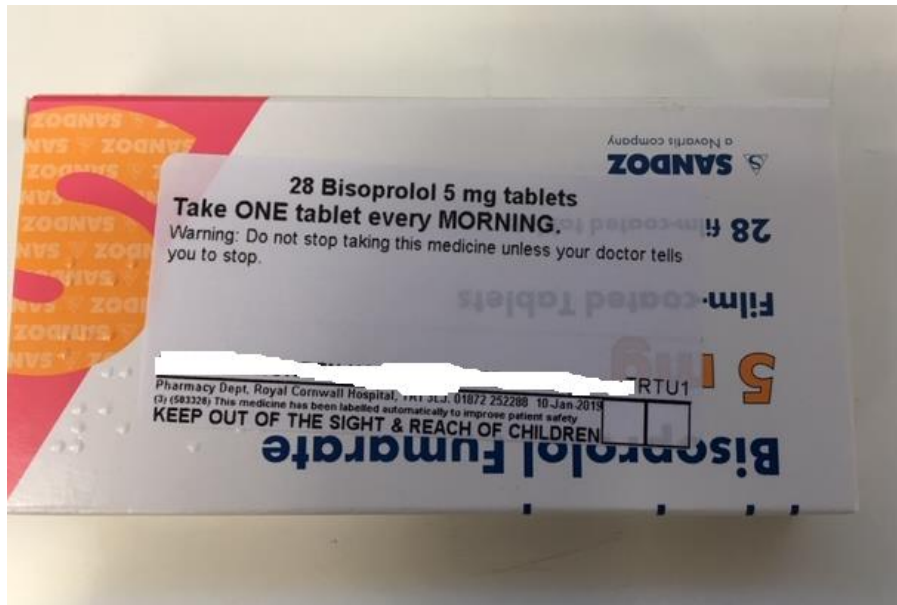
The dispensed product does not match the issued product

Override
Acknowledge

JAC Medicines Management
Powered by TECKNOWORKS



# Closed Loop Supply





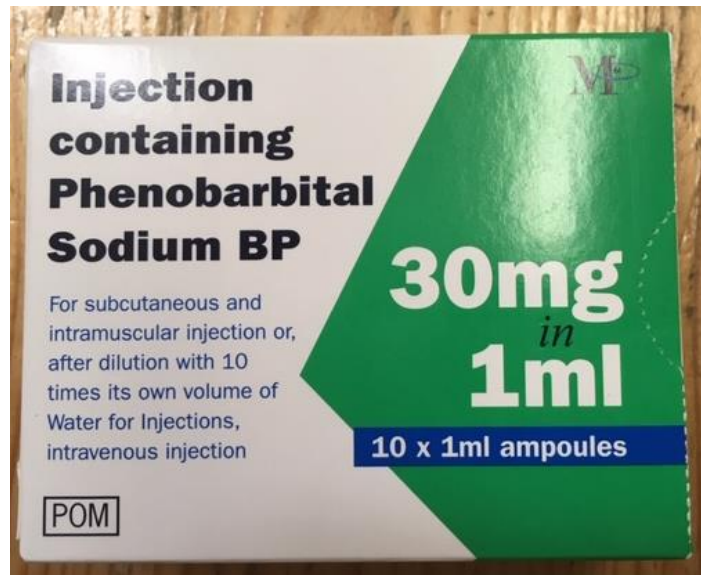
# Broader Application



# Barcode Medicines Administration



# Manufacturers Take Note!







## Right Patient

Setting standards to make sure we always have the right patient and know **what** product was used with **which** patient, **when**.



## Right Product

Setting standards to make sure our staff have **what** they need, **when** they need it.



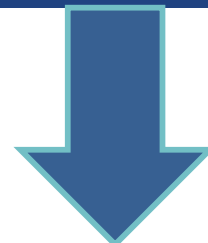
## Right Place

Setting standards to make sure that patients and products are in the right place.



## Right Process

Setting standards and implementing common ways of working to deliver better and more easily repeatable patient care.



Improve Efficiency

Improve Patient Safety

Release Time to  
Care



