

The year of the injectable?

— an organisational approach

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The recent publication of the National Patient Safety Agency safe medication practice work programme (*Hospital Pharmacist* 2007;14:107) has effectively shaped the medicines safety campaign for health care organisations in England and Wales for the coming year. All five of the patient safety alerts are important and challenging. In particular, patient safety alert 20, "Promoting safer use of injectable medicines", is going to require much organisational commitment and multidisciplinary engagement. The first step of any implementation programme must be to focus local activity on achieving desired outcomes. The second, in this instance, must be to ensure that system change results in sustained improvement.

In accordance with advice from earlier medicines management reports, most health care organisations should have already developed local policies supporting the safe management of medicines, including injectable products. How far these have seeped into the organisational infrastructure and impacted on patient care appears to be variable.

Data from the National Reporting and Learning System for January 2005–June 2006 show that, although the majority of injectable medicines incident reports result in low or no harm to patients, there were still 25 deaths and 28 incidents of severe harm.

It is encouraging that the Department of Health and the Welsh Assembly Government

have recognised the importance of using chief pharmacists and pharmaceutical advisors to lead the response to the alerts. Those in these positions have been given a mandate to demonstrate clear and effective leadership in organisational medicines management issues, as called for by Keith Ridge, chief pharmaceutical officer for England at this year's *Hospital Pharmacist* conference (*Hospital Pharmacist* 2007;14:81).

Action

The NPSA alert provides six key recommendations for action and presents tools and supporting templates to help organisational engagement. For those who have policies and procedures in place, cross-checking the detail with that recommended by the NPSA should be relatively straightforward. For those starting from scratch, the tools and templates require minimal local review and adaptation to begin the process.

It is important that any work originating from the patient safety alerts builds on local successes and develops good practice models that can be shared across similar NHS organisations. All activity should be influenced by an understanding of local needs and priorities.

It is pivotal to undertake a risk assessment of injectable medicine procedures and products in use in all clinical areas. Some work has already been done independently^{1,2} through project sponsorship³ and as part of the NPSA safety alert development programme.

Although pharmacy teams can direct and co-ordinate this action, effective engagement of local nursing, medical and other

health care professionals (within management and clinical teams) will determine long term success.

Working together

Applying the proposed NPSA work competencies to all those working with injectable medicines will require links to existing multidisciplinary medicines management support structures. Where these do not already exist, the development of new links within the organisational framework is likely to be key to success.

We should aim to avoid any unnecessary duplication of work and, once risk assessments have been conducted, effective links to local manufacturing and production and procurement networks will be essential in responding to changes in local product and process needs.

A wider spread of procurement hubs promoting "purchasing for safety" policies will be important in working with the industry to encourage new injectable products and formulations to support patient safety.

One early outcome from the recent alert is the new partnership between the injectables guide, co-ordinated by the Hammersmith Hospitals NHS Trust, and the UK Medicines Information Services. This partnership aims to support the expansion and development of the resource for a wider audience. However, in the interim, organisations will need to consider local solutions to support access to relevant technical information at the point at which their health care staff need it.

Many may see financial pressures as a significant obstacle to implementing the alert.

Although ready-to-use injectable products can often be calculated as being cost neutral when replacing products requiring high risk manipulation in clinical areas, the reality of releasing budget from one allocated purpose to another is challenging. This highlights the importance of an organisational approach and strong leadership to ensure co-operation at all levels of management and clinical care.

Although more challenging in the short term, multidisciplinary implementation will differentiate those organisations which are serious about addressing risks in latent systems from those who are looking for a quick fix.

Although chief pharmacists, pharmaceutical advisors, clinical governance leads and risk managers have their work cut out for them in order to meet the March 2008 deadline for the NPSA actions to be complete, seizing the opportunity provided by this work programme can only enhance the clinical role of the pharmacist within the NHS.

References

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- 3 Hardy L, Mellor L. Risk Assessment of parenteral product preparation across secondary care acute trusts in the North of England. *Hospital Pharmacist* 2007;14:58–64.

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