

Debate & Analysis

Going beyond blame:

reporting NHS medication errors in nursing home residents with diabetes

INTRODUCTION

It is widely accepted in literature on patient safety that an open culture — one that seeks to understand the multiple reasons for error — is required to promote incident reporting and maximise learning for system improvement.¹ In the attempt to deliver the research described here we encountered a culture of blame. Such a culture leads to low levels of medication error reporting with regard to NHS systems supplying the nursing home setting. This article explores the problem of this low level of reporting being detrimental to future learning on NHS medication errors.²

The study we undertook, 'Root causes of medication errors in nursing home residents with diabetes: enhancing safety in NHS medicines management', was funded by the Research for Patient Benefit (RfPB) programme. It focused on residents with diabetes in nursing homes, as defined by the Care Quality Commission (CQC),³ and involved consenting homes in Bedfordshire and Hertfordshire. Nursing homes were selected because medication delivery processes are slightly different from residential care home provision, although the incident reporting systems are similar. The aim of the study was to gather data on NHS errors, and report on and analyse them for learning purposes and solution development. The comments made here relate to the data collection process. The final research findings will be summarised in future publications.

PATIENT SAFETY AND MEDICATION ERRORS

Patient safety is defined by the World Health Organization as the absence of preventable harm to a patient during the process of health care and involves coordinated efforts to prevent such harms.⁴ In part, the positive progress seen in patient safety in the NHS has been attributable to the creation of the National Reporting and Learning System (NRLS) and the establishment of the 'Being Open' initiative as promoted by the now defunct National Patient Safety Agency.¹ Management of the NRLS at the time of writing sits within NHS England. The more open reporting culture now seen in the NHS is evidenced by the 125 000 patient safety incident reports made a month into the NRLS.⁵ However, it should be noted that only 0.33% of those reports come from the

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general practice setting.⁵

The concept of medication errors embraces a range of factors including prescribing, dispensing, administration, ongoing medication management and monitoring, and adverse drug reactions.⁶ The consistency of medication management across different healthcare providers is acknowledged as often being weak and sometimes unsafe.⁷ In a report on this matter, the CQC noted some good practice, but also cited evidence that GP practices and hospitals can fail to share accurate information in a timely manner,⁸ something we have also encountered in the study.

In a report for the General Medical Council on the prevalence of prescribing errors in general practice, Avery *et al*, found prescribing and monitoring errors in 1 in 8 patients, with around 1 in 20 of all the prescriptions analysed containing an error.⁹ The CHUMS Report, on the prevalence and causes of medication errors in care homes, including those with nursing, concluded that around two-thirds of residents were subject to one or more medication errors.¹⁰ Residents were receiving an average of 7.2 medication items and 69.5% of residents had at least one error detected in their medication process. Guidance from the National Institute for Health and Care Excellence (NICE) requires care homes to find the root causes of medicine-related errors, although the guidance focuses on the concept of safeguarding and does not mention the concept of patient safety incident reporting.¹¹

THE REPORTING OF MEDICATION ERRORS

The study described here has not received the levels of medication error reporting that the literature, including that cited above, would suggest. It has been evident in the recruitment of homes and data-gathering that nursing home staff feel under significant pressure when it comes to the disclosure of medication errors. These reporting pressures relate to both internal and external factors. Nursing home staff can feel pressurised by managers in that errors are seen to be a problem related to the individual, rather than the system they work within. In addition to this, resolving and investigating the error is frequently perceived to be time consuming. Externally those pressures in relation to reporting come from agencies such as the CQC and NHS commissioners. Put simply, being associated with errors, even if they originate in NHS medicines management processes, are perceived to be negative in terms of external perceptions of the quality of care being delivered by the home.

Even though the study focused on errors in NHS processes, the culture of blame in which nursing homes operate hindered reporting to the study. This is a problem for a number of reasons. Enhanced reporting to the NHS of medication errors from the care home setting as a whole would be consistent with the goals of the NHS Outcomes Framework.² The Framework asks for further aligning of measures across health and social care to raise

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the quality of provision. Improvements in medicines reconciliation, and enhanced reporting of errors between the NHS and care home settings, would constitute a move towards that goal. General practice reporting will have to improve significantly if this is to be achieved.

SAFEGUARDING OR PATIENT SAFETY?

Error and patient safety incident reporting in the care home sector has a shorter history and is not as mature as that found in NHS systems. There are requirements that significant medication incidents affecting residents are reported as Safeguarding of Vulnerable Adults (SOVA) issues. Such incidents are required to be referred using local safeguarding processes, although it is unclear in the NICE guidance how to differentiate between a medication error being a safeguarding or a patient safety incident.¹¹ The reporting processes for safeguarding and patient safety incidents currently have no clear links, and the care home sector has no recognised access to the NRLS.

A key question that has arisen from this study is why, if a medication error is made in the NHS, it is considered to be a patient safety incident, but in the nursing home setting it is usually categorised as a safeguarding matter? Patient safety is concerned with avoidable harm,⁴ but does not carry the same negative connotations as safeguarding, which is associated with concepts such as abuse and neglect. The linkage of medication errors in the nursing home setting to safeguarding is perpetuating a blame culture that has been detrimental to the reporting of errors.¹¹ This culture of blame will inhibit subsequent learning from those errors. Ironically, the new guidance from NICE requires care homes to find the root cause(s) of medicine-related errors without acknowledging the concept of patient safety.¹¹ The use of root cause analysis has been central to the move away from blame in explaining and analysing patient safety incidents.

CONCLUSION

Although nursing homes are reliant on NHS medication management systems, the reporting of such errors from the homes and from staff in those NHS systems, GPs in particular, has been uncommon. Nursing home residents are NHS patients; they have a GP and are recipients of medication prescribed and delivered by NHS systems. It seems reasonable to suggest that NHS reporting systems, such as the NRLS, should be open to nursing home staff for

the reporting of medication errors. The current obligation on homes to categorise most medication errors as safeguarding events is perpetuating a culture of blame. That blame culture and the poor reporting by nursing home and NHS staff that we have encountered are placing residents in a more vulnerable position. Clarity needs to be gained with regard to the relationship between patient safety incidents, of which medication errors are a significant element, and safeguarding, with its connotations of blame. Only then can significant improvements in medicines reconciliation between the NHS and nursing home sector be achieved.

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For further details on the research study described here go to: <http://public.ukcrn.org.uk/Search/StudyDetail.aspx?StudyID=13610>

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