

Learning from Experience – Medicines Management – December 2009

Medicines Management in the NHS includes the ways in which medicines are selected, purchased, ordered, delivered, stored, prescribed, administered and reviewed. All the 'bubbles' in this newsletter come from the learning points identified from investigations into medications.

A FEW KEY MESSAGES

Remember if you are not familiar with a drug always check in the BNF and/or ask your clinical pharmacist before administering or prescribing a medicine.

Pabrinex Injection

Please remember Pabrinex is supplied in pairs. To give the correct dose of Pabrinex both ampoules have to be mixed together before administration.

Omissions

When an omission occurs in the drug administration record, the nurse who notices the omission, who may or may not be the nurse administering the next drug round, must follow this up. Local systems should be established by ward managers how this is done.

Security of Medicines

Check all medicines as soon as possible after delivery and lock them away. Contact the supplying pharmacy immediately to report any missing medicines and complete a trust incident form if any medicines remain unaccounted for.

Stop Causing Errors

Interruptions of any type increase errors in prescribing and administration of medicines. A recent trust report highlighted that an administration round could have as many as 12 interruptions. Please can all ward and medical staff make a point to not interrupt a nurse or MHP undertaking a ward round. Local procedures on handling this should be drawn up but a simple message book, which is checked at the end of a round, may be all that's needed.

Correct patient , Correct drug , Correct dose , Correct time , Correct route

This poster has been produced by the Medication Safety Working Group to highlight optimal practice.

If you have any suggestions or queries contact Ross Mitchell, Chief Pharmacist on 02380 874023