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HEALTHCARE SAFETY INVESTIGATION BRANCH

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# INTERIM BULLETIN

# MEDICINE OMISSIONS IN LEARNING DISABILITY SECURE UNITS

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## NOTIFICATION OF EVENT AND DECISION TO INVESTIGATE

The parent of an adult service user with learning disabilities notified HSIB that her son was regularly not being offered prescribed medication. He was an inpatient in a secure unit for people with learning disabilities in a mental health hospital. She believed the staff prioritised medication for mental health conditions and were less concerned about him taking medication for his physical health.

## HEALTHCARE DELIVERY GOALS

To improve the administration of prescribed medication to patients in mental health hospitals.

## WHAT HAPPENED

The service user, a 31-year-old man with a learning disability was a *'long stay'* service user on a secure unit in a mental health hospital. He was diagnosed with a personality disorder and other causes of mental health distress, type 2 diabetes and hypercholesterolaemia (raised cholesterol). Prior to the case being referred to the HSIB he had spent 32 months in a mental health hospital 113 miles from his home. He was then transfered to a smaller specialist psychiatric rehabilitation hospital (60 miles from his home). He was there for a further 14 months before being transfered to another setting in his home area.

The service user reported that on multiple occasions, whilst in the large mental health hospital, he had not been offered his medication. He thought the reasons included:

- being asleep at the time of the medication round
- being in his room and not going to the medicine dispensing hatch at the right time
- being at an *'off-ward activity'*
- attending an appointment
- doing work experience.

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He gained significant weight and developed diabetes and hypercholesterolaemia as an inpatient. Both are recognised side effects of the mental health medication he was taking. They were difficult to counter in secure mental health care, where lifestyle choices are not easily conducive to improving physical, or in some cases, mental health. His mother was concerned that staff had not recognised the importance of him taking medication or actions to improve and protect his physical health.

The preliminary investigation revealed there may be additional contributory factors to consider around the specialist skills of staff in creating an environment where service users/patients are inclined to take their medication.

**Outcome Impact – What impact has a safety issue had, or is having, on people and services across the healthcare system?**

Medication omission can lead to avoidable harm (Keers et al., 2018), increased length of hospital stays and complications around treatment-based decisions making (Shandilya et al., 2015). There is also anecdotal evidence that it can negatively impact upon the behaviour of service users/patients, thereby threatening the safety of others. Omitted medications are usually categorised as errors (Ferner and Aronson, 2006) which as well as jeopardising patient safety can affect relationships and trust between patients, their families and professionals, and the wider reputation of healthcare.

Much of the documented evidence around the outcomes of omitted medication in mental health care focusses upon how people who experience mental health distress are more likely to have poorer physical health and die earlier (DoH and NHSE, 2014).

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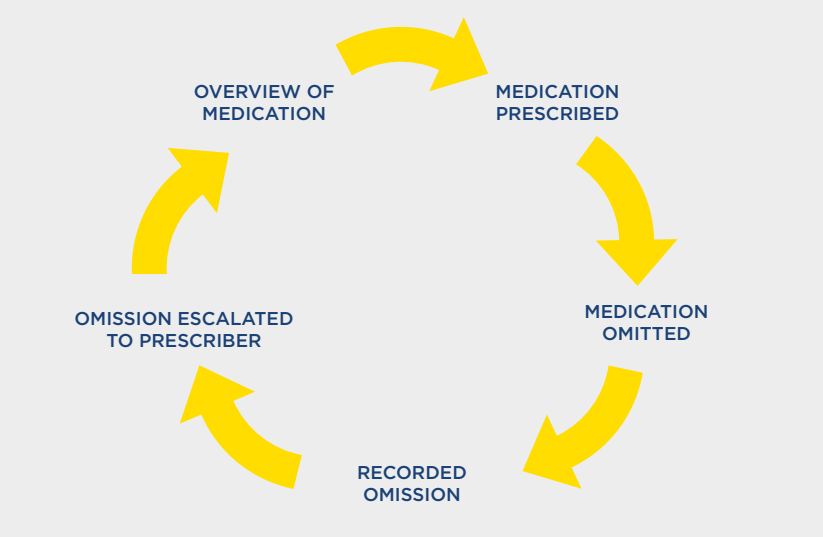
**Systemic Risk – How widespread and how common a safety issue is this across the healthcare system?**

Medication omission has long been recognised through research as one of the most common medication risks (Soerensen et al., 2013). During the pathway of the service user, who was referred to HSIB, there were errors in multiple areas of the management of his medicine prescribing and administration. In addition, the investigation has already identified errors occurring in other parts of the country in both private and NHS mental health settings.

**Learning Potential – What is the potential for an HSIB investigation to lead to positive changes and improvements to patient safety across the healthcare system?**

Initial observations and evidence gathered highlighted multiple opportunities for potential learning. In particular across what we identify as the *'medication omission loop'* (see figure 1). There is further learning opportunity in optimising both physical and mental health of service users/patients and specific staff skills which support the health of the *'whole person'*.

FIG 1



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## NATIONAL CONTEXT

During the initial stages of the investigation it was observed that medicines omissions were common across all healthcare settings. Additional research confirmed that mental health settings experience significant numbers of incidents relating to medicines omissions.

In 2009 the National Patient Safety Agency (NPSA) published a review of medication incidents in 2007. They highlighted that omitted medication was the second largest medication safety issue. It was followed in 2010 by their Rapid Response Report (NPSA) which concentrated on the need for identification of *'critical medicines'*. The outcome was guidance that focussed upon the likely outcome from delay or omission of a single dose.

The Care Quality Commission document *'Medicines in health and adult social care; Learning from risks and sharing good practice for better outcomes'* (CQC, 2019) identified 20,865 incidents reported to National Reporting & Learning System (NRLS) in 2016/17. During that period there were a total of 17,054 incidents reported for medicines omissions across the following mental health settings:

- forensic learning disabilities
- older adult mental health
- forensic mental health
- adult mental health.

The CQC analysed 600 NRLS reports that resulted in death or sever harm. Within these reports almost two thirds related to medication administration errors. Most errors referenced incorrect or omitted doses, or wrong medication. Some of the CQC findings were evidenced by the HSIB investigation during site visits to the independent and NHS funded mental health hospital.

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There is a slowly increasing quantity of literature and guidance to support safe prescribing and administration of medicines in mental health settings (Keers et al 2018), yet there appears to be very little specific guidance to improve or understand the factors which lead to medicine omission (Coleman et al., 2013). The NHS Medication Safety Thermometer (NHS, 2019) offers an opportunity for collecting data about omitted medicines but to date it has not been consistently applied across the sector.

## IDENTIFIED SAFETY ISSUES

The following safety issues were identified during the initial investigation and will form the basis of the wider national investigation:

- **The systems within the prescribing loop have potential areas of weakness:**

  - **Medicines optimisation** – Prescribing self-care[1] products has become prevalent in some mental health hospitals. It is particularly common for service users to refuse these products, which has had the effect of normalising medication refusal, this has directly impacted upon decisions and actions staff take around medicine omission.

  - **Self-administration (SA)** – Procedures and application of SA vary greatly from setting-to-setting; therefore, the investigation will look at circumstances when SA is achieved and any systemic barriers to achieving SA.

  - **Escalation procedures** – Differences in systems supporting or obstructing escalation, of omitted medication, between the administering staff and the prescriber.

[1] Examples of self care products are food supplements, shampoo and toothpaste.

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- **Whole person care requires a *'parity of esteem'* between physical and mental health medications.**
  - A priority is sometimes given to mental health medication, which is mandated by the Mental Health Act, over physical health medication, directly affecting the health of the service user.

## NEXT STEPS

The HSIB investigation will continue to explore the identified safety issues and welcomes further information that may be relevant, regardless of source. The HSIB will report any significant developments as the investigation progresses.

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