

Patient Safety Memo

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MEDICINES MANAGEMENT

Administering medicines is the most frequent intervention to patients in the NHS, and making sure we follow best practice in the way we manage medicines is vital to keep our patients safe. It is also important that we report any medication errors or near misses, as this helps us to learn lessons and reduce the frequency of these incidents.

Dr Nadeem Moghal, Medical Director



"PATIENT SAFETY IS EVERYONE'S RESPONSIBILITY"

We need to hear from you so we can improve the way we manage medicines to keep our patients safe. Please take two minutes to complete the quick survey at the end of this Patient Safety Memo, and tell us how you play your part.



Matthew Hopkins
Chief Executive



BALJIT SAHOTA

**PRINCIPAL PHARMACIST, QUALITY AND SAFETY
KING GEORGE HOSPITAL**

To ensure medicines are safe to be administered, they must be stored at the right temperature. If they are stored incorrectly they may not work in the way they were intended which could pose a potential risk to the health and wellbeing of our patients. Nursing staff and departmental leads should be monitoring the fridges daily to ensure that they are working properly, and I regularly audit the temperature logs in my clinical areas to check that medicines are being kept properly.

Controlled drugs are bound by legislation to make sure that they are securely stored, stock levels are correct, and each administration is accurately and clearly recorded. Pharmacists monitor controlled drugs every three months to check stock balances and check that all entries in the controlled drug record book are legally correct and legible.

All medicines on our wards and in our departments need to be stored safely and securely and we all have a role to play in that.



WAYNE HURST

**MATRON, EMERGENCY DEPARTMENT
QUEEN'S HOSPITAL**

Patient safety is at the core of everything I do. One of the ways I can achieve this is by ensuring doctors and nurses are undisturbed while preparing medicines behind a closed door, in the designated utility area. I have had extensive training in eliminating errors caused by the human factor.

The Emergency Department is a busy place; it is vital for us to learn how errors are made and to learn from those mistakes so we avoid them in the future. When errors do occur I promptly investigate, take on learning points and make urgent changes to protocol. It's about encouraging and adopting a learning culture.



ANGELA BELL

**PRINCIPAL PHARMACIST, CLINICAL SERVICES
QUEEN'S HOSPITAL**

When a patient is first admitted, I confirm which medicines they are taking by speaking with the patient, checking any medicines they have brought with them to the hospital, checking any previous discharge summaries and, where necessary, contacting their GP or accessing their Summary Care Record.

I also make sure that any medicines a patient has taken before they were admitted are reconciled against the medicines prescribed on their prescription chart and discuss any discrepancies with their doctor. When I am on the ward I make sure that any medication the patient needs is obtained from the pharmacy. When I am not on the ward I need the help of the doctors and nurses to let me know what changes have been made to a patient's prescription so that I can help to make sure the medicine is available.

If the pharmacy is closed, we have an extensively stocked emergency drug cupboard where medicines can be obtained and there is a pharmacy on-call service which can provide advice and information on medicines. Administering medication at the correct time is essential to keep patients safe from avoidable harm.

WE ARE ALL RESPONSIBLE FOR KEEPING OUR PATIENTS SAFE. PLEASE SHARE YOUR VIEWS ON HOW YOU MANAGE MEDICINES BY ANSWERING THE QUESTION BELOW.

How do you help to ensure safe medicine management for patients?

Write response here

Which hospital do you work in?

BARKING
HOSPITAL

KING GEORGE
HOSPITAL

LOXFORD
POLYCLINIC

QUEEN'S
HOSPITAL

I work in...

Management

Nursing

Midwifery

Medical

Pharmacy

Admin/
Clerical

Porter/
Estates

Other

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SPEAKING UP

A key part of keeping our patients safe is for staff to speak up when they are concerned about an issue, as well as to underline the organisation's commitment to quality care. We have a Guardian Service just as Sir Robert Francis recommended following his review into the failings at Mid-Staffordshire. Speaking up is everyone's job. When a colleague voices a concern we should listen and decide what action needs to be taken. In a busy hospital speaking up and reinforcing the safer care culture isn't always easy, and it's important we all feel able to raise concerns and worries and suggest ideas for improvement.

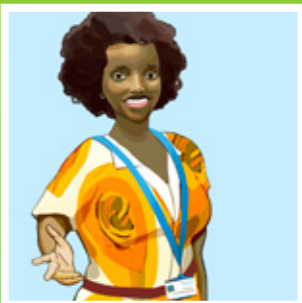


"PATIENT SAFETY IS EVERYONE'S RESPONSIBILITY"

We need to hear from you so we can improve the opportunities you have for your voice to be heard. Speaking up helps to keep our colleagues and patients safe. Please take two minutes to complete the quick survey at the end of this Patient Safety Memo, and tell us how you play your part.



Matthew Hopkins
Chief Executive



JENI MWEBAZE

GOVERNANCE MANAGER, SPECIALIST MEDICINE DIVISION

I am responsible for two staff, a Complaints Co-ordinator and a Quality and Safety Facilitator in our division. They know that they can come to me and raise concerns, or talk to my line manager or the divisional senior management team.

I encourage my staff to feel safe and to know that they are listened to when they speak up by being positive about any concerns raised, and to focus on solutions and learning rather than difficulties and problems.

Staff do not have to raise concerns to their line manager if they feel uncomfortable doing that. They can talk to their manager's manager or use the independent Guardian Service and their concerns will be dealt with appropriately and in confidence. The Guardian Service is available for all staff and details are on the intranet under HR.



RACHEL ROYALL

DIRECTOR OF COMMUNICATIONS AND MARKETING

Helping people to speak up is a core part of my job as Director of Communications and Marketing. I'm really passionate about people having honest conversations that help solve problems. Sometimes this means you need to be brave and take responsibility.

Speaking up, for me, means letting your manager know if there are things that you're unhappy or worried about. If you're still concerned then you need to raise it at the next level. To ignore things means that things won't get fixed and won't get better for colleagues or patients.

There are lots of forums to get your voice heard and to get involved, like coming along to a Meet the Chief session or if its more serious or confidential contacting our Guardian Service. We also have a responsibility to speak up about the good stuff too, work can be tough, so let's be proud of what we've achieved.

WE ARE ALL RESPONSIBLE FOR SPEAKING UP AND KEEPING OUR PATIENTS SAFE. PLEASE SHARE YOUR VIEWS BY ANSWERING THE QUESTION BELOW.

Give us the benefit of your experience. How can we improve patient safety in our hospitals?

Write response here

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LOXFORD POLYCLINIC

QUEEN'S HOSPITAL

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BETTER PATIENT RECORDS

We work hard to ensure the safety of our patients at all stages of their journey through our hospitals, and that includes making sure they have up to date, high quality patient records. As part of our continual improvement we need to keep asking ourselves if we are working in the best way that we can, because without excellent record keeping and a good flow of information, the quality of our patient care is affected. When we are all aware of each step in our patients' journeys, we can improve our communication with them and work better with each other across departments and across sites.



"PATIENT SAFETY IS EVERYONE'S RESPONSIBILITY"

High quality information helps to keep patients and each other safe. We want to hear from you so we can improve our systems and our patient records. Please take two minutes to complete the quick survey at the end of this Patient Safety Memo, and tell us how you play your part.



Matthew Hopkins
Chief Executive



RUSSEL EVANS

BUSINESS INFORMATION MANAGER, INFORMATION SERVICES
QUEEN'S HOSPITAL

Within the Information Team we provide a set of standard and custom-made reports to suit the needs of our staff and patients. With these reports, our aim is to provide information into the patient's journey, from their arrival in our Emergency Departments to their discharge from Outpatients. One of my responsibilities is to ensure that the information we provide is clear, easy to understand and straightforward to use, so that we can look at things that are common across the hospitals, areas of concern, and to reassure ourselves that we are delivering high quality care. When things go wrong, we are able to provide information from the system to enable staff responsible to review the situation, understand, and learn what needs to change to avoid future events.



DR MAX CHAUHAN

ASSOCIATE MEDICAL DIRECTOR
KING GEORGE HOSPITAL

As a Consultant in Oral Surgery I need high quality information about each patient so that I can ensure that the best quality care, treatment and support is provided to them. Good quality, accurate records means that they include information for the clinical team about all test results, have a record of patient appointments, are clear, filed correctly and are available without delay.

Patient records are our most important source of clinical information. If the information or records are wrong, there can be very serious consequences. I know that for us as a healthcare team, as part of providing high quality care it is important to follow good practice guidelines to make sure that appointments are made within minimum time periods, and to keep notes secure, up to date and accurate. This will help us to ensure that we remove the potential for any avoidable harm to patients.

WE ARE ALL RESPONSIBLE FOR ENSURING THAT OUR PATIENT RECORDS ARE OF THE HIGHEST QUALITY AND KEPT SAFE. PLEASE SHARE YOUR VIEWS BY ANSWERING THE QUESTION BELOW.

Give us the benefit of your experience to help improve our patient safety.

Write response here

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