Hywel Dda University Health Board

Nursing Medication Administration & Errors

Final Internal Audit Report

May 2020

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

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1. Introduction and Background

The review of nursing medication administration and errors within Hywel Dda University Health Board was completed in line with the approved 2019/20 Internal Audit Plan.

The relevant lead Executive Director for the review was the Director of Nursing, Quality & Patient Experience.

The Health Board has a duty to effectively monitor and manage medication errors/near misses involved in prescribing, preparation, dispensing and administration. In doing so, preventative measures can be put in place to avoid any further risk of similar events re-occurring.

2. Scope and Objectives

The overall objective of this review was to provide assurance for the management and administration of drugs in wards/departments and the arrangements in place to address nursing medication errors, in order to provide assurance to the Health Board that risks material to the achievement of the system's objectives are managed appropriately.

The objectives of the review was to provide assurance that:

- Policies and procedures are clear in respect of the management of drugs with governance arrangements and accountability of drugs are clearly defined;
- Controlled stationery is managed and securely retained centrally and at ward/ department level;
- The ordering and delivery of drugs by authorised individuals only;
- Stock levels of drugs accurately reconcile to local registers;
- Drugs are securely retained at ward and departmental level;
- Wards and department identify and report all nursing medication errors; and
- Directorate management regularly review nursing medication errors, and where require, ensure actions to address risks have been implemented.

The following 13 wards across three acute sites (Glangwili, Prince Philip and Withybush General Hospitals) were visited during January 2020 as part of this review.

- Picton Ward GGH
- Teifi Ward GGH
- Preseli Ward GGH
- Antenatal Ward GGH
- Gwenllian Ward GGH
- Ward 1 PPH
- Ward 3 PPH
- Ward 9 PPH
- ITU PPH
- Ward 1 WGH
- Ward 7 WGH
- Ward 8 WGH
- PACU (Puffin Ward) WGH

3. Associated Risks

The risks considered in the review were as follows:

- Lack of policies and procedures detailing governance arrangements and accountabilities on how to comply with the management of drugs;
- Inadequate storage and recording of drugs centrally and at ward/ departmental level;
- Poor levels of medicines stock management resulting in excessive stock levels being held;
- Inappropriate ordering of drugs by unauthorised individuals on non-controlled stationery; and
- Risk resulting from nurse medication errors are not identified or addressed.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Nursing Medication Administration & Errors is **Reasonable** assurance.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

At a corporate level, the Health Board has in place approved policies and procedures for medicines management and medication errors that are available to all employees. Whilst at ward level, the management of controlled stationery and drugs (controlled and non-controlled) was securely retained, whilst the regular reviewing of medication errors and subsequent actions in place to address risks was evident.

However, two high priority findings were identified during this review including the lack of agreed stock lists for controlled drugs and instances of incomplete ward authorised signatories lists.

In addition, three medium priority finding relating to the incomplete and non-compliant requisition forms, full stock reconciliations by Pharmacy not being undertaken every six-months and the lack of compliance in ensuring recorded medication errors are responded within the 30-day deadline.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

		Assurance Summary*			
Audit Objective					
1	Policies and procedures are clear in respect of the management of controlled drugs with governance arrangements and accountability of controlled drugs are clearly defined				✓
2	Controlled stationery is managed and securely retained centrally and at ward/ department level				✓
3	The ordering and delivery of controlled drugs is by authorised individuals only		✓		
4	Stock levels of drugs accurately reconcile to local registers			✓	
5	Drugs are securely retained at ward and departmental level				✓
6	Wards and departments identify and report all nursing medication errors			✓	
7	Directorate management regularly review nursing medication errors and where required ensure actions to address risks have been implemented				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issue that are classified as weaknesses in the system control/design for Nursing Medication Administration & Errors.

Operation of System/Controls

The findings from the review have highlighted **four** issues that are classified as weakness in the operation of the designed system/control for Nursing Medication Administration & Errors. These are identified in the Management Action Plan as (O).

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan at Appendix A.

OBJECTIVE 1: Policies and procedures are clear in respect of the management of drugs with governance arrangements and accountability of drugs clearly defined

The Health Board has in place the following approved policies that are all available to employees on the organisation intranet site relating to the management of drugs:

- Controlled Drugs Governance Policy
- Medicines Policy (Acute, Mental Health, Learning Disabilities and Community Services)
- Management of Nursing and Midwifery Medication Errors/Near Misses Policy

No matters arising.

OBJECTIVE 2: Controlled stationery is managed and securely retained centrally and at ward/department level

Of the 13 wards visited to establish storage and retention arrangements for controlled stationery, we can confirm that the controlled drugs registers and requisition books were held securely in the controlled drugs cupboard or cabinet. In addition, used registers and books were securely held on the ward for the appropriate retention period.

No matters arising.

OBJECTIVE 3: The ordering and delivery of drugs is by authorised individuals only

The Medicines Policy requires that every ward and unit must have an agreed stock list of medicines, which are either used regularly on that ward or unit, or are required in case of an emergency.

Internal Audit observed a stock list of non-controlled drugs in use on each of the sampled wards. However, out of 13 wards only two, Wards 1 and 3 at PPH, maintained an agreed stock list of controlled drugs.

A total of 59 controlled drug requisitions was also tested to ensure they had been fully completed and authorised appropriately across the sampled wards. Concluding testing, the following was noted:

- 19 instances where the nurse ordering the drugs could not be traced to an authorised signatories list. However, we can confirm that the individuals ordering drugs were qualified nurses.
- 18 instances where the receiving officer had not signed the requisition sheet upon receipt of the controlled drugs.
- Only one instance where the signatory had also printed their name.
- One instance where the name of the ordering ward had not been noted on the requisition form.
- Six instances where the controlled drugs requisition form stated the number of boxes ordered rather than quantity of items required.

We also noted that the latest authorised signatories maintained by PACU (Puffin Ward) did not reconcile to the signatories list held by Pharmacy.

See Findings 1 & 2 at Appendix A.

OBJECTIVE 4: Stock levels of drugs accurately reconcile to local registers

We can confirm that the 13 wards sampled maintained a bound and sequentially numbered controlled drugs register in line with the Medicines Policy. A review of the 59 controlled drug requisition forms accurately reconciled to entries in the ward controlled drug registers.

The Pharmacy Department is responsible for undertaking a full stock reconciliation of controlled drugs on wards a minimum of every three to six months as per the Medicines Policy. A record of the full stock reconciliations is recorded on a monitoring spreadsheet. Concluding a review of the monitoring spreadsheet, the following was highlighted:

- The monitoring spreadsheet had not been updated following reconciliation of controlled drugs visits at the Antenatal Ward GGH and Ward 1 WGH.
- Two instances were found where reconciliations were overdue at Ward 7 and 8 WGH (by 18 and 10 months respectively) and one instance where there was a period of nine months between reconciliation visits at Ward 9 PPH.
- The Pharmacy Department at GGH had not produced a rota of controlled drug reconciliations on wards for the current calendar year.

At each ward visited, a daily count and check of controlled drugs is undertaken by nursing staff at least once a day, with two nurses signing and dating the register to evidence completion of the checks. Internal Audit reconciled a total

of 68 controlled drugs held by the ward to the controlled drugs register and found that all balances agreed between the stock held and entries in the register.

See Finding 3 at Appendix A.

OBJECTIVE 5: Drugs are securely retained at ward and departmental level

A review of the sampled wards confirmed that drugs (controlled and non-controlled) were securely retained in dedicated cabinets and fridges within locked rooms. We can confirm that the keys for the rooms and drugs cabinets were kept on a separate fob from other sets of keys and were retained by the nurse-in-charge.

No matters arising.

OBJECTIVE 6: Wards and departments identify and report all nursing medication errors

At each ward visited it we ascertained with the Ward Sister the procedure followed on discovery of a medication error. We can confirm that the nursing staff we spoke to were aware of the correct steps to take on discovery of an error as per the Management of Nursing and Midwifery Medication Errors/Near Misses Policy.

We selected a sample of 25 reported incidents in our sample of wards and analysed the action taken since the incident was reported on Datix. We noted that 19 of the 25 incidents sampled had not met the 30 day deadline for responding to (that is finally approving) incidents reported on Datix. However, we can confirm that appropriate remedial action had been taken for the 19 incidents.

See Finding 4 at Appendix A.

OBJECTIVE 7: Directorate management regularly review nursing medication errors and where required ensure actions to address risks have been implemented

Medication incident reports produced by the Assurance, Safety and Improvement team are submitted to the Medicines Event Review Group (MERG) for review on a regular basis. Quarterly assurance reports from MERG are submitted to the Medicines Management Sub Committee for discussion and updates ultimately feed into the Quality, Safety and Experience Assurance Committee.

Furthermore, exception reports from MERG are also presented to the Local Intelligence Network. A review of minutes and terms of reference for these committees were reviewed to confirm that lines of reporting and monitoring were appropriate and effective.

No matters arising.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**3**	**0**	**5**

Finding 1 – Controlled Drug Stock Lists (O)	Risk
Of the 13 wards visited during this review, 11 did not maintain a Pharmacy agreed stock list of controlled drugs.	Poor levels of medicines stock management resulting in excessive stock levels being held
Recommendation 1	**Priority level**
Management should ensure wards maintain a Pharmacy agreed stock list of controlled drugs that are either used regularly on that ward or are required in case of an emergency.	**HIGH**
Management Response	**Responsible Officer/ Deadline**
Historically controlled drugs have not been part of the stock list controls and therefore have not routinely been included. However, it is accepted that the policy does not differentiate between CDs and non-CDs and it is good practice to have an agreed stock list for CDs for reference. In response to this recommendation: • Pharmacy to review and agree stock lists to ensure standardisation in all ward areas across the four Acute Hospital Sites and community hospitals in accordance with the local needs of the specialist area. • CD stock lists agreed for all wards. Reconfiguration of wards due to COVID has delayed implementation.	Clinical Pharmacy Lead for Patient Services 30th April 2020 – Completed 30th September 2020 (Implementation of stock lists to be reviewed at each site as ward

	reconfiguration occurs – rolling monthly programme at each site)

Finding 2 – Controlled Drugs Requisitions (O)	**Risk**
A review of 59 controlled drug requisitions across the sampled wards identified instances of incomplete and non-compliant forms, whilst the signature of a number of nurses recorded as the ordering officer were not evident on the ward authorised signatories list. We also noted that the latest authorised signatories maintained by PACU (Puffin Ward) at Withybush General Hospital did not reconcile to the signatories list held by Pharmacy.	Inappropriate ordering of drugs by unauthorised individuals on non-controlled stationery
Recommendation 2a	**Priority level**
Ward managers should ensure all controlled drug requisition forms are accurately and fully completed in line with the requirements of the Medicines Policy.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
Controlled drug requisition forms are to be completed in line with requirements of the Medicines Policy through: • Senior Nurse Medicines Management to circulate e-mail on requirements detailed within the Policy to all ward sisters and feedback to MERG (completed).	Clinical Pharmacy Lead for Patient Services Heads of Nursing - GGH/WGH/PPH/BGH/Paediatrics and Maternity Services

• Ward sisters to ensure that requisition forms are correctly completed and receipted. • Quarterly schedule of spot check audits held in pharmacy department and undertaken by Pharmacy – spot checks on CD order books will be done as part of 3 monthly CD stock check. • Pharmacy to feedback any anomalies from spot check audits to nursing staff – feedback to ward/department manager via e-mail.	Senior Nurse medicines Management 1st June 2020
Recommendation 2b	**Priority level**
Ward managers should ensure that authorised signatories lists for drug requests are regularly reviewed and updated, and a copy submitted to the Pharmacy Department.	**HIGH**
Management Response	**Responsible Officer/ Deadline**
• Ward Sisters to provide up to date Signature lists and copies forwarded to the Pharmacy Department. Pharmacy department secretary to maintain a log of signature list received. • A programme of Medicines Management workshops to be developed to re-enforce the procedures within the Medicines Management Policy (to be included in the medication safety days). • Issues to be discussed with ward sisters at professional meetings and scrutiny reviews.	Clinical Pharmacy Lead for Patient Services Heads of Nursing - GGH/WGH/PPH/BGH Senior Nurse medicines Management. 30th September 2020

Finding 3 – Controlled Drugs Reconciliation Monitoring (O)	Risk
Concluding a review of the Pharmacy full stock reconciliation monitoring spreadsheet, the following was highlighted: • The monitoring spreadsheet had not been updated following reconciliation of controlled drugs visits at the Antenatal Ward GGH and Ward 1 WGH. • Two instances were found where reconciliations were overdue at Ward 7 and 8 WGH (by 18 and 10 months respectively) and one instance where there was a period of nine months between reconciliation visits at Ward 9 PPH. • The Pharmacy Department at GGH had not produced a rota of controlled drug reconciliations on wards for the current calendar year.	Inadequate storage and recording of drugs centrally and at ward level
Recommendation 3	**Priority level**
The Pharmacy Department should ensure that full stock controlled drug reconciliations are undertaken on all applicable wards a minimum of every three to six months, with a record of the wards visits accurately recorded and maintained on the monitoring spreadsheets.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
It is noted that this element of policy implementation has not been routinely implemented. Some of the challenge is availability of a pharmacist and senior	Clinical Pharmacy Lead for Patient Services

nurse to undertake the reconciliation. However, it is accepted that this area needs further work. • Effective Control Systems for controlled drug reconciliations to be implemented across the hospital sites/including Maternity units and Paediatric areas. • Rolling programme of CD reconciliation to be developed by each site for wards, clinical areas and community hospitals with confirmation feedback of completed audits in senior pharmacy team meeting.* **Each site has a rolling programme, however, undertaking of audit has been delayed due to COVID-19 outbreak*	30th September 2020

Finding 4 – Datix Medication Errors (O)	**Risk**
Of the 25 reported incidents in our sample, 19 incidents had not met the 30 day deadline for responding to (that is finally approving) incidents reported via Datix. However, we can confirm that appropriate remedial action had been taken for the 19 incidents.	Medication errors are not identified or addressed.
Recommendation 4	**Priority level**
Management should ensure that medication error incidents recorded on Datix are approved in a timely manner in line with Health Board policy and procedure.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**

• All DATIX Incidents Reports to be investigated and remedial action implemented to mitigate risk. • All DATIX Incident reports relating to Nursing Medication Error and breaches of 30 day non-compliance to be reviewed in local site/Directorate scrutiny meetings.	Heads of Nursing/ Head of Midwifery/ Head of Paediatrics 30th September 2020

Appendix B - Assurance Opinion and Action Plan Risk Rating

2019/20 Audit Assurance Ratings

 **Substantial Assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable Assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

 **Limited Assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** arrangements in place to secure governance, risk management and internal control, within those areas under review, which are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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