NHS
Stockport
Clinical Commissioning Group

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Our ref:

6 August 2021

Ms Alison Mutch
H M Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Regulation 28 Report - Mr Ian Hall (deceased)

I refer to your letter dated 14 June 2021 in relation to the above and thank you for contacting NHS Stockport Clinical Commissioning Group (CCG) in this matter. I am sorry to learn of the circumstances of Mr Hall's death and offer my sincere condolences to his family.

Community Pharmacy Services are the responsibility of NHS England and I have therefore liaised with my colleagues at Greater Manchester Health & Social Care Partnership (GMHSCP) to address the issues raised.

I note the cause of death as detailed in the report and your concern that future deaths will occur unless action is taken. You have raised two areas of concern which I will address in order and will identify how learnings from this case can be shared across the wider system.

The events of concern relate to medication management within Well Pharmacy who have undertaken an investigation focussing on the following points:-

(1) How Amytriptyline rather than Atenolol had been dispensed in the community
(2) What checks the pharmacy in question had or any pharmacy has to avoid the inadvertent dispensing to a vulnerable adult where the carer's role is to administer whatever medications are collected from the pharmacy in the name of the individual

The investigation report by Well Pharmacy found the following:

Well Pharmacy standard procedure is for medicines to be dispensed from Central Fulfilment, a hub and spoke dispensing model which uses robots and barcode scanning technology, minimising the risk of errors. Prescriptions for Ian Hall had normally been dispensed in this way (confirmed to be the case for June and October 2020), and the Pharmacy is very confident that there was no selection error through this process. However their records show that in August 2020 his medication was dispensed within the community pharmacy and it is assumed that this is the point at which the error occurred.

Within the community pharmacy, Well have Standard Operating Procedures (SOPs) in place for the Dispensers Check and the Accuracy Check. In the event of a dispensing error, a near miss would be reported. In this instance, Well noted they were not alerted to the incident until January 2021, which has unfortunately impacted on their ability to carry out a more thorough investigation. Due to this, a near miss was also not reported.

Through the process of investigation, this incident has been highlighted, as well as additional guidance on reducing LASA (looks-alike, sounds-alike) errors, which has been incorporated into their SOPs.

The report states that Atenolol and Amitriptyline is not a common LASA error, and has not previously occurred within Well Pharmacy. Following this incident, the location of these medications on the shelves within the community pharmacy has been reviewed in order to minimise the risk of selection error.

Key outcomes from the Well Pharmacy investigation:

- Shared learning by Well at organisation-wide and individual pharmacy level
- Dispensers Check, Accuracy Check and Patient safety SOPs have all been reviewed and shared across all Well Pharmacies week commencing 12/7/21. Staff are required to complete an assessment and declaration by a defined deadline of all new SOPs that are circulated
- Location of medicines and visual alerts – the Atenolol and Amitriptyline have been moved onto separate shelves with clear stickers reminding staff to check selection
- Area Manager to ensure review of all near misses to ensure LASA trends are spotted

Actions taken or being taken to prevent reoccurrence across Greater Manchester.

1. Learning to be presented/shared with the Greater Manchester Quality Board. This meeting is attended by commissioners, including commissioners of specialist services, regulators, Healthwatch and NICE.

2. Shared learning from this and similar cases at Greater Manchester and locality level will be cascaded to professionals through relevant governance and learning forums

The Greater Manchester Health and Social Care Partnership (GMHSCP) is committed to improving outcomes for the population of Greater Manchester. In conclusion key learning points and recommendations will be monitored to ensure they are embedded within practice.

You refer to the role of a carer in the administering of medications to a vulnerable adult, making the point that as carer staff are not clinically qualified, their responsibility when giving a medication is to simply check that the medication is correctly labelled for the patient they are attending. Having carefully considered this point, I reach the conclusion that the key issue is the pharmacy process as the dispensing of an incorrect medication should not happen if all procedures are correctly followed. My focus has therefore been to address the issue of dispensing and I am satisfied that appropriate steps have been taken to reduce the likelihood of incorrect medications being labelled and dispensed for administering by a carer.

I hope this response provides the relevant assurances you require. Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely

Dr [redacted]
Medical Director