Role of Medication Safety Officer (MSO)/Medical Devices Safety Officer (MDSO) in CCGs

NHS England and The Medicines and Healthcare products Regulatory Agency (MHRA) are working together to simplify and increase reporting, improve report quality, maximise learning and minimise harm from medication errors and medical device incidents.[1]

Recommendations from NHS England and MHRA patient safety alerts

- Large healthcare providers (NHS Trusts, community pharmacy multiples, home healthcare companies and those in the independent sector – including some who provide care homes, e.g. Care UK) should:
  - » Identify a board level director to have the responsibility to oversee medication error/medical device incident reporting and learning.
  - » Identify a Medication Safety Officer (MSO)/Medical Devices Safety Officer (MDSO) and email their contact details to the Central Alerting System (CAS) team.
  - » Identify an existing or new multi-professional group to regularly review medication error/medical device incident reports, improve reporting and learning and take local action to improve safety.[2,3]
- Small healthcare providers (general practices, dental practices, community pharmacies and those in the independent sector) should:
  - » Continue to report medication error/medical device incidents to the National Reporting and Learning Systems (NRLS) using the e-form on the NRLS website, or other methods and the MHRA's online reporting system for medical devices. Take action to improve reporting, learning and safety locally.[2,3]
- Healthcare commissioners (Area Teams and Clinical Commissioning Groups) are invited to:
  - » Identify a MSO/MDSO and email their contact details to the CAS team; and,
  - » Regularly review information from the NRLS and the MHRA to support improvements in reporting and learning and to take local action to improve safety.[2,3]

Local implementation for healthcare commissioners

The recommendations should be implemented by large healthcare providers, but commissioners are only invited to implement the actions. However, it is good practice and strongly advised they do as they are responsible for improving quality and safety in primary and secondary care.[4,5]

A board level Director should be identified to have the responsibility to oversee medication error/medical device incident reporting and learning.[2,3] This is not required of healthcare commissioners, but could be considered to be appropriate.

A MSO/MDSO should be identified and consider cover for absence. Set up a generic e-mail/group email that can be accessed by the covering person[6] and notify CAS team of the contact details.[2,3] CCGs should register with the CAS to ensure they receive CAS alerts directly.[4,5]

The MSO/MDSO will be a member of the National Medication/ Medical Device Safety Networks,[2,3] work with regional/ area networks, attend webinars from NHS England, attend conferences and keep up to date with the information on http://www.patientsafetyfirst.nhs.uk[6]

They will support reporting and learning and take local actions to improve medication/medical devices safety.[2,3] A baseline assessment of the quality of reporting should be made to measure future improvements.[6]

They should use learning to influence policy, planning and commissioning as part of clinical governance in the commissioning organisation.[2,3] Ensure reporting systems are operating effectively, the quality of reports supports learning, important patient safety issues locally identified are adequately addressed and incident reports are submitted in a timely fashion.[4,5]

They should regularly review information from the NRLS and the MHRA to support improvements in reporting, learning and take local action to improve safety.[2,3] Procedures should be in place to allow effective feedback and learning. They should build relationships with existing organisation risk management/clinical governance teams, obtain permission to access NRLS 'live', and regularly review and amend the quality of the reports for all serious and moderate incidents.[6]

They should work with medication/medical devices safety champions in local professional committees and networks, and with new or existing multi-professional groups.[2,3] The group's representation should be checked, Terms of Reference agreed, roles clarified and mechanisms to feedback data to reporters agreed.[6]

Summary

Role responsibilities should include the following:

- Active membership of the National Medication/Medical Devices Safety Network;
- Improving reporting and learning from medication error/ medical device incidents;
- Receiving periodic summaries of medication error/medical device incidents reported from the NRLS to support learning;
- Analysing trends and issues and taking supportive action as appropriate;
- Working with the medication/medical devices safety committee to deliver responsibilities listed below;
- Using learning to influence policy, planning and commissioning;
- Working with medication/medical devices safety champions on local professional committees/networks;
- Supporting the dissemination of communications from NHS England and the MHRA;
- For MDSO's only act as a point of contact for manufacturers supporting local actions on Field Safety Notices.[4,5]

Responsibilities of the medication/medical devices safety committee

- Improving reporting and learning of medication/medical device error incidents;
- Receiving summaries of NRLS incident data, audit and other data to identify, prioritise and address medication/medical devices risks to minimise harm to patients;
- Identifying, developing and promoting best practice for medication/medical device safety guidance from NHS England, MHRA, NICE and other organisations - implementation will require coordination and support for process and system changes to reduce the likelihood of serious medication/medical device errors occurring and reoccurring;
- Providing regular feedback and planning action to minimise these risks to healthcare providers;
- Using learning to influence policy planning and commissioning;
- Co-ordinating education and training support to improve the quality of medication/medical device error incident reports and safe medication practices; and,
- Assisting in development and review of medication/medical devices use policies and procedures.[4,5]

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