National Insights on Medication Safety & Non Medical Prescribing

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Learning Outcomes

- Definitions of medication error terminologies
- Nature of medication errors
- Incidence & frequency of medication errors
- Severity of harm associated with medication errors
- Causes of medication errors
- Reporting of medication errors

*Medication errors are any **patient safety incidents** (PSIs) where there has been an error in the **process** of **prescribing, preparing, dispensing, administering, monitoring** or providing advice on medicines. These PSIs can be divided into two categories; errors of commission or errors of omission.*

(NHS England, Patient Safety Alert March 2014)

CONCEPT

ERROR

Unintentional
Preventable

Process

- Prescribing
- Dispensing
- Administration
- Monitoring
- Advice

NHS

>£750 million/year costs:
Litigation
Hospitalisation
Resources

Human

Healthcare Professionals
Patients
Consumers

Medication safety in the NHS

At the heart of future NHS challenges

20% of people over 70 years old take five or more medicines. With an ageing population and multiple chronic medical conditions these numbers will just keep increasing

2.5 million **doses of medicines** are administered every year in the average acute hospital

! **215,000** errors

600,000 **non-elective hospital admissions** are due to medicines

70% of these are preventable

5 classes of medicine account for most admissions

- NSAIDs
- Antiplatelets
- Anticoagulants
- Diuretics
- Antihypertensives

1 billion **prescriptions** are issued every year in primary care

! **50 million** prescribing errors

! **400,000** **33 million** dispensing errors

½ million **inpatient prescriptions** every year in the average acute hospital

! **45,000** prescribing errors with **550** potentially fatal

! **40–100** dispensing errors

2500 **preventable deaths** across all acute hospitals are due to medicines

! **97,000** patients admitted to all acute hospitals suffer from harm due to medicines

97% of medication errors reported to the NHS result in no or low patient harm

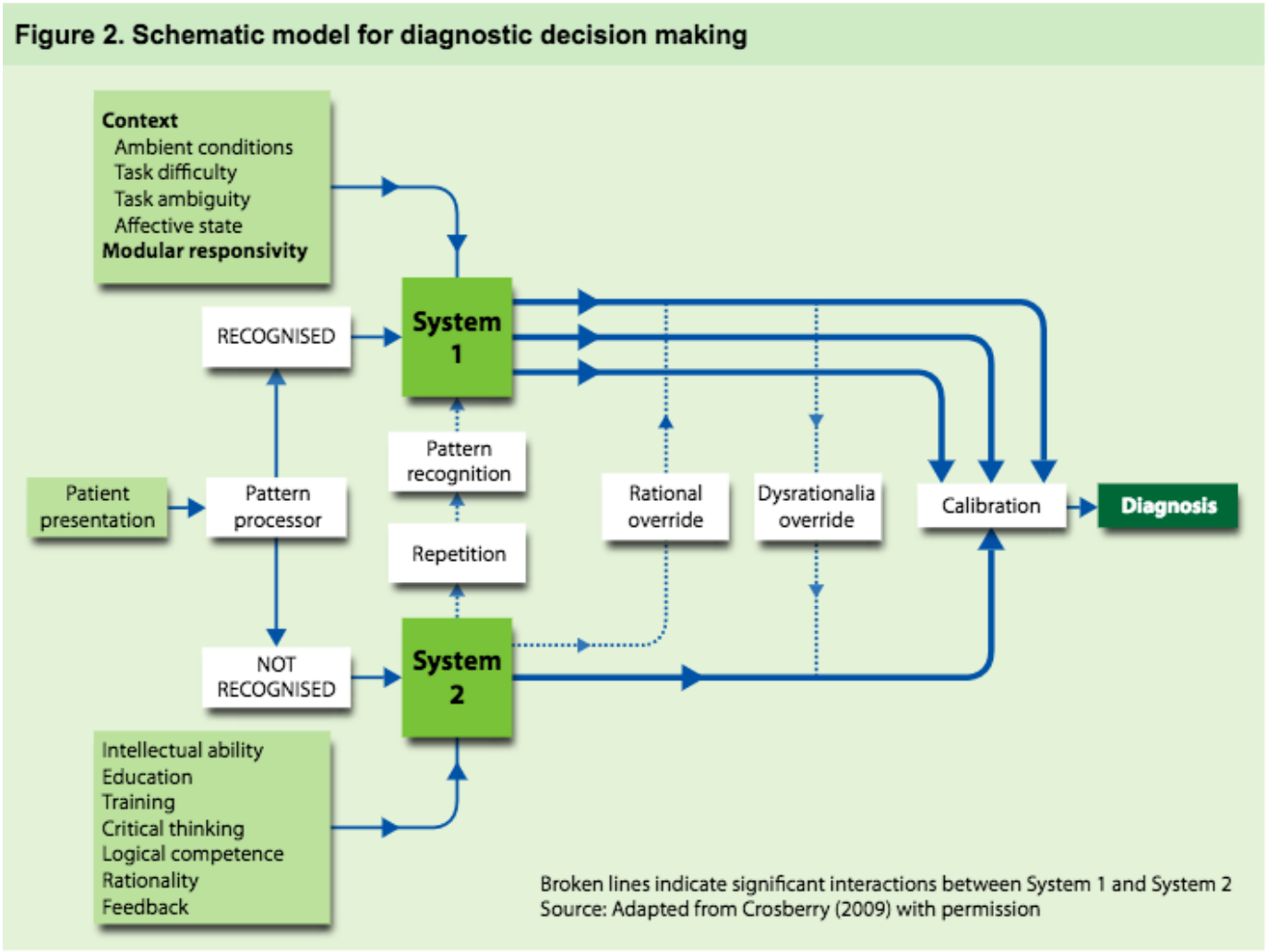
Prescribing Error

"A **clinically meaningful** prescribing error occurs when, as a result of a prescribing **decision** or prescription writing **process**, there is an **unintentional** significant (1) **reduction** in the probability of treatment being **timely and effective** or (2) increase in the **risk of harm** when compared with generally accepted practice." Dean, Barber & Schachter. Qual Health Care. 2000 Dec; 9(4): 232–237.

Any examples of an error/near miss you made in practice?

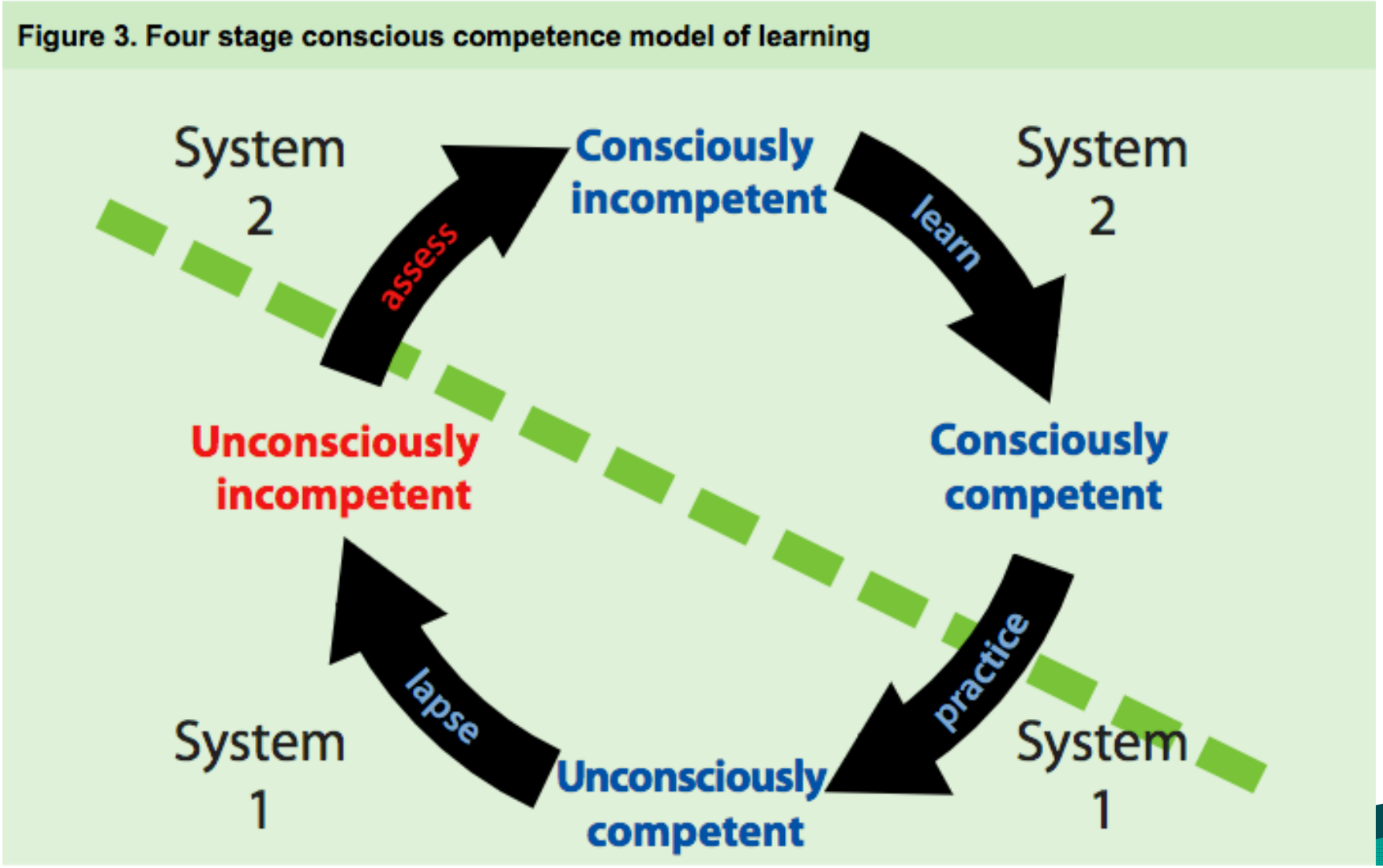
How did you deal with it? How did it effect your practice?

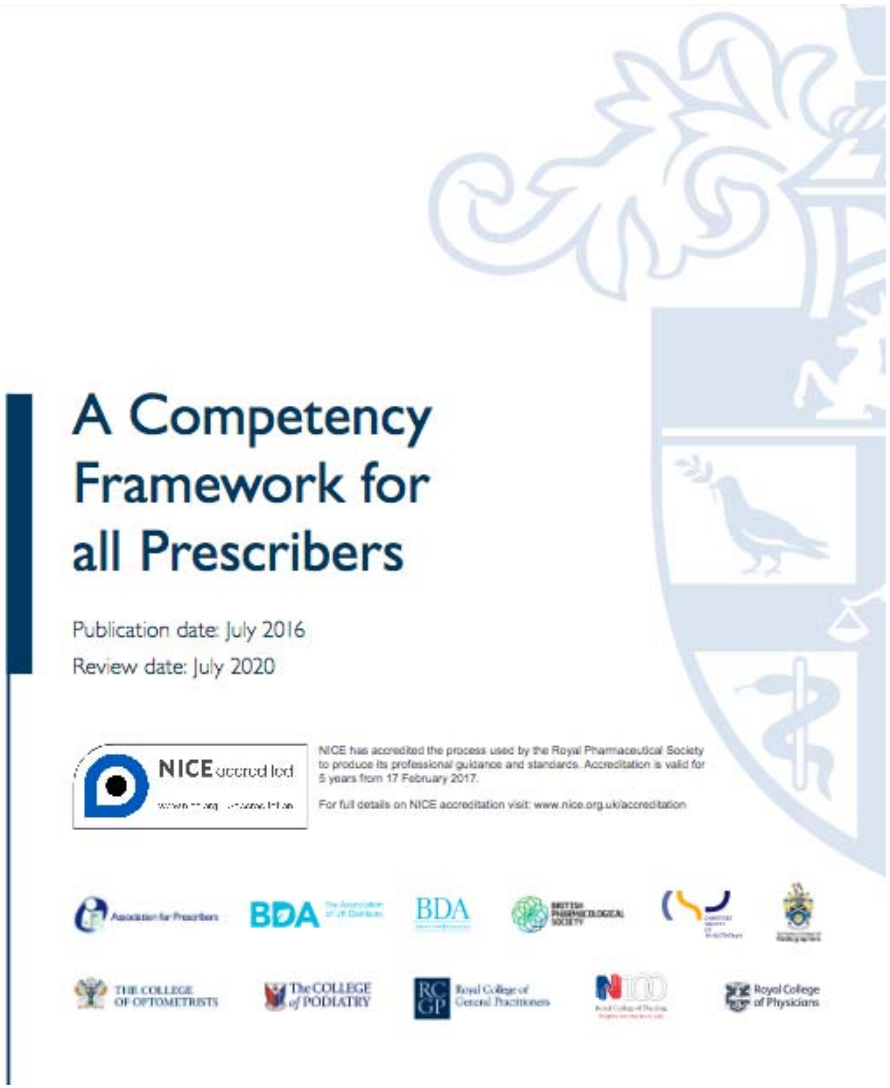
Figure 2. Schematic model for diagnostic decision making



Reprinted from Croskerry P. *Context is everything or how could I have been that stupid?* Healthc Q. 2009; 12:e171-6.

Figure 3. Four stage conscious competence model of learning




A Competency Framework for all Prescribers
Publication date: July 2016
Review date: July 2020
NICE accredited
NICE has accredited the process used by the Royal Pharmaceutical Society to produce its professional guidance and standards. Accreditation is valid for 5 years from 17 February 2017.
For full details on NICE accreditation visit: www.nice.org.uk/accreditation
BDA
BDA
THE COLLEGE OF OPTOMETRISTS
The COLLEGE of PODIATRY
RCGP
Royal College of General Practitioners
Royal College of Physicians

PRECRIBING GOVERNANCE (COMPETENCIES 7-10)

7: PRESCRIBE SAFELY

7.1 Prescribes within own scope of practice and recognises the limits of own knowledge and skill.

7.2 Knows about common types and causes of medication errors and how to prevent, avoid and detect them.

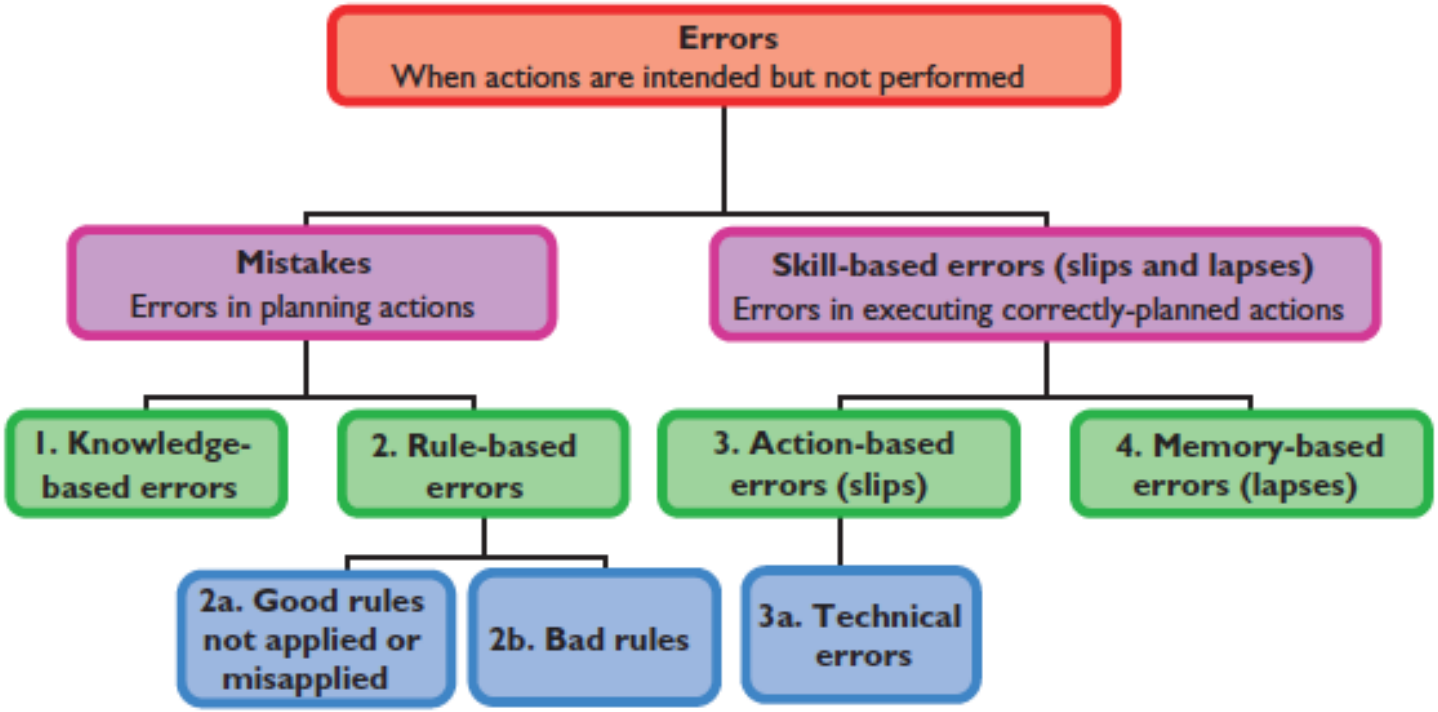
7.3 Identifies the potential risks associated with prescribing via remote media (telephone, email or through a third party) and takes steps to minimise them.

7.4 Minimises risks to patients by using or developing processes that support safe prescribing particularly in areas of high risk (e.g. transfer of information about medicines, prescribing of repeat medicines).

7.5 Keeps up to date with emerging safety concerns related to prescribing.

7.6 Reports prescribing errors, near misses and critical incidents, and reviews practice to prevent recurrence.

Psychological Approach to Medication Error Classification:



Violations are **not** errors:
Intended action
1.Routine Violations: regular short cuts
2.Reasoned Violations: Deliberate deviations from protocol
3.Reckless Violations: Deliberate deviation from protocol & ignoring potential harm
4.Malicious Violations: Out there to harm

What can go wrong when prescribing?

- Adverse drug reaction (when used as intended)
- Contra-indication to the use of the medicine in relation to drugs or conditions
- Mismatching between patient and medicine
- Omitted medicine / ingredient
- Patient allergic to treatment
- Wrong / omitted patient information leaflet
- Wrong / omitted verbal patient directions
- Wrong / unclear dose or strength
- Wrong drug / medicine
- Wrong formulation
- Wrong frequency
- Wrong quantity
- Wrong route

Causes of Medication Errors

- Communication Failures: poor handwriting, oral communication only, missing or misplaced zeroes, use of abbreviations, ambiguous or incomplete prescriptions
- Similar drug names or presentation (look alike sound alike)
- repeat prescribing and dispensing without monitoring
- Complex diseases or treatment plans
- Patients with chronic conditions
- Workplace problems: Stress, team, design, workload and satisfaction
- Level of staffing
- Level of experience
- Complex or poorly designed technology, devices or procedures
- Calculation errors
- Lack of information to prescribers, dispensers or patients
- Lack of patient's understanding of their therapy
- Frequent patient transition of care

Lessons from reported Patient Safety Incidents

- So far, PSIs indicate NMPs are not associated with serious harm, congratulations
- Clearly there are processes supporting NMPs that lead to errors and need addressing
- …. worrying issue of prescribing/administering POMs without authority

Need of National Medication Safety Network

- Increase of patient safety incident reporting to the National Reporting and Learning System (NRLS)
- Change of organisational structure. Transfer of patient safety function from National Patient Safety Agency to NHS England (commissioning body) in 2011
- Change of adverse drug reaction (ADR) definition to include medication error (EU Directive 2010/84/EU1)
- Low reporting from non-acute NHS providers
- Report quality Vs. National Learning

MHRA

NHS England

Patient Safety Alert

Stage Three: Directive

Improving medication error incident reporting and learning

20 March 2014

Alert reference number: NHS/PSA/D/2014/005 Alert stage: Three - Directive

NHS England and MHRA are working together to simplify and increase reporting, improve data report quality, maximise learning and guide practice to minimise harm from medication errors by:

- sharing incident data between MHRA and NHS England reducing the need for duplicate data entry by frontline staff;
- providing new types of feedback from the National Reporting and Learning System (NRLS) and MHRA to improve learning at local level;
- clarifying medication safety roles and identifying key safety contacts to allow better communication between local and national levels; and,
- setting up a National Medication Safety Network as a new forum for discussing potential and recognised safety issues, identifying trends and actions to improve the safe use of medicines. The network will also work with new Patient Safety Improvement Collaboratives that will be set up during 2014.

The Yellow Card Scheme for reporting suspected adverse drug reactions to the MHRA will continue to operate as normal.

Actions (Target date for completion 19 September 2014)

All *large healthcare providers including NHS Trusts, community pharmacy multiples, home healthcare companies and those in the independent sector should:**

1. identify a board level director (medical or nursing supported by the chief pharmacist) or in community pharmacy and home health care, the superintendent pharmacist, to have the responsibility to oversee medication error incident reporting and learning;
2. identify a Medication Safety Officer (MSO) and email their contact details to the Central Alerting System (CAS) team. This person will be a member of a new National Medication Safety Network, support local medication error reporting and learning and act as the main contact for NHS England and MHRA; and,
3. identify an existing or new multi-professional group to regularly review medication error incident reports, improve reporting and learning and take local action to improve medication safety.

Small* healthcare providers including general practices, dental practices, community pharmacies and those in the independent sector should:

4. continue to report medication error incidents to the NRLS using the e-form on the NRLS website, or other methods and take action to improve reporting and medication safety locally, supported by medication safety champions in local professional committees, networks, multi-professional groups and commissioners.

Healthcare commissioners including Area Teams, and Clinical Commissioning Groups are invited to:

5. identify a MSO and email their contact details to the CAS team. This person will be a member of the National Medication Safety network, support reporting and learning and take local actions to improve medication safety. The MSO can also use learning to influence policy, planning and commissioning as part of clinical governance in the commissioning organisation; and,
6. regularly review information from the NRLS and the MHRA to support improvements in reporting and learning and to take local action to improve medication safety. This should done by working with medication safety champions in local professional committees and networks, and with a new or existing multi-professional group.

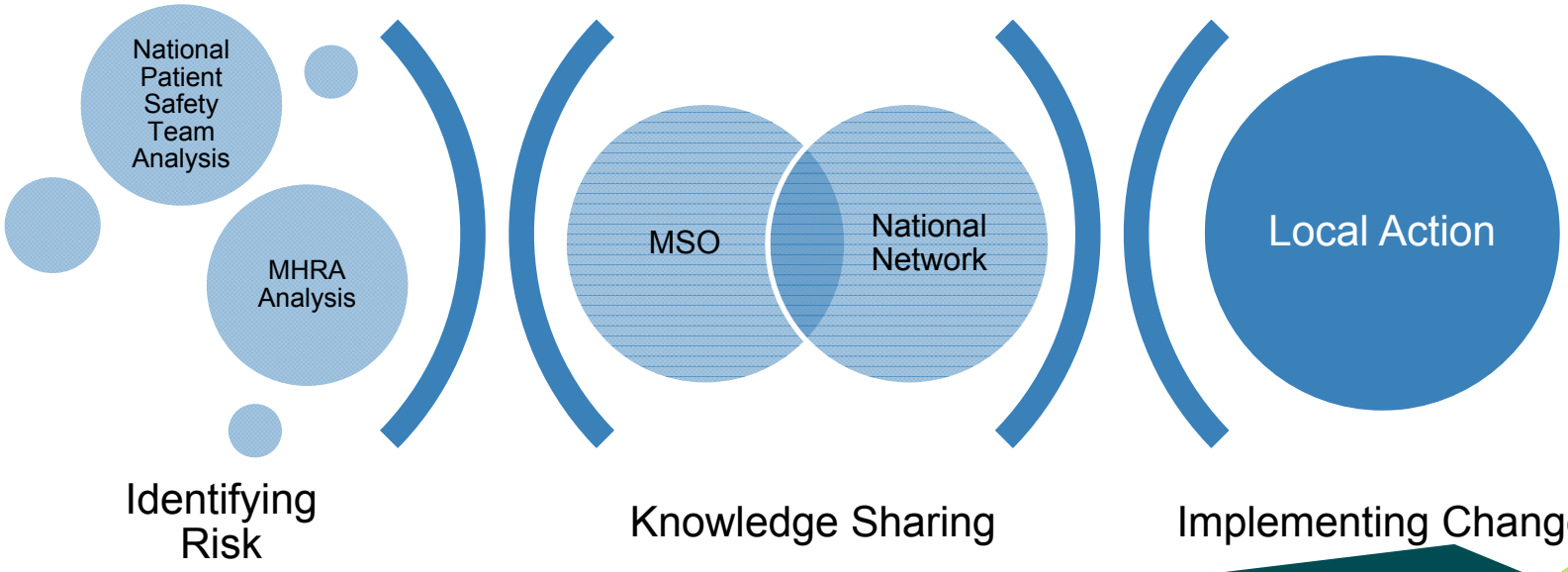
Supporting information

*More detailed information to support the implementation of this guidance is available at:
www.england.nhs.uk/patientsafety/PSA

Contact NHS England: patientsafety.enquiries@nhs.net
Contact MHRA: pharmacovigilanceservice@mhra.gsi.gov.uk

Publications Gateway Reference 01322

Vision of National Medication Safety Network



How can NMP be involved?

- Sign up to alerts from the Central Alerting System (CAS) or your local clinical governance email notifications
- Get in touch with your MSO
- Be vigilant to alerts from ePrescribing systems
- Take part in medication safety projects and quality improvement programs
- Know your competencies
- Know your weaknesses for error
- If you don't know ask
- Try and focus on what is relevant to your practice for your patients
- Reflect on practice and learn from mishaps
- Report incidents to encourage learning
- Look out for the World Health Organization Medication Safety Challenge

Patient Safety Tools

- High risk drug audits
- Steroid card
- Lithium card
- NOAC/DOAC
- Anticoagulant Yellow Book
- Insulin Passport
- Medicine Passport
- Hospital Admission Notifications
- Discharge Letters
- Updated Summary Care Record
- Blood monitoring requirements & results interpretations
- VTE assessments & therapeutic Vs prophylactic doses
- Medication Safety thermometer
- Therapeutic area dashboards

Conclusion

- Medication errors are serious and diverse
- Must have prevention strategies to ensure medication errors are minimised
- Find ways to reflect and assess competency
- Get in touch with your medication safety lead

Thanks!

Any questions?