NHS Resolution

Did you know?
General Practice Medication Errors

Advise / Resolve / Learn

Did you know?

- Medication errors are any Patient Safety Incidents (PSI) where there has been an error in the process of prescribing, transcribing, dispensing, administration and monitoring medicines.
- PSI can be divided into errors of commission or omission[1].
- NHS Resolution operates a state indemnity scheme called the Clinical Negligence Scheme for General Practice (CNSGP), covering clinical negligence liabilities in England arising in general practice in relation to incidents that occurred on or after 1 April 2019.
- Additionally, on 6 April 2020, a new state indemnity scheme for general practice in England, the Existing Liabilities Scheme for General Practice (ELSGP), was established to cover the historical liabilities of general practice staff.
- ELSGP currently covers historical liabilities for those who were members of the Medical and Dental Defence Union of Scotland (MDDUS) or the Medical Protection Society (MPS) at the time of the incident in respect of which a claim is made, and any practice staff working for a MDDUS or MPS member at the time of that incident.

Due to the recent creation of the general practice indemnity schemes, this leaflet is intended to provide a baseline for the volume and initial themes of general practice medication error claims only.

[1] psa-sup-info-med-error.pdf (england.nhs.uk)

Did you know?

The **NHS Patient Safety Strategy**[2] has a strategic focus on medication errors, with the **Medicines Safety Improvement Programme (MedSIP)** addressing the most important causes of severe harm associated with medicines. The programme aims to reduce severe avoidable medication-related harm by 50% by March 2024.

Key ambitions at time of publication are:

- to improve the safe use of anticoagulants
- to reduce harm from opioid medicines used for chronic pain
- to reduce harm from opioid medicines used for chronic pain **Discharge Medicines Service.**

The programme invites collaboration on **Medicines Safety Improvement.**

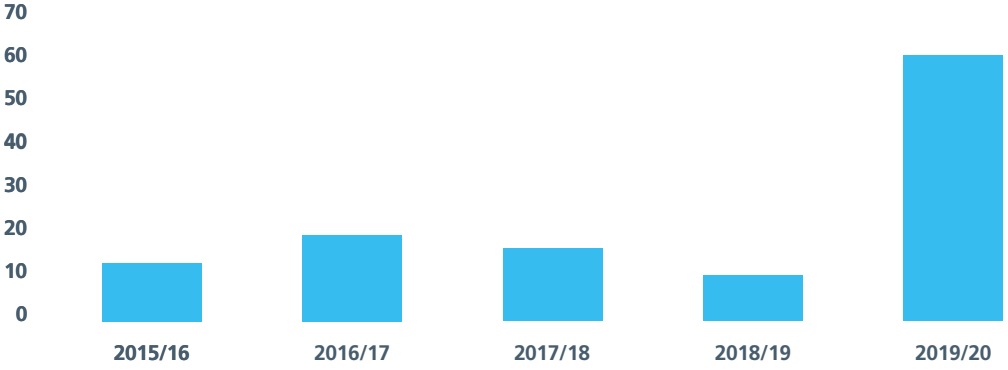
[2] https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/#patient-safety-strategy (2019)

Did you know?

NHS Resolution has received 112 claims into the CNSGP and ELSGP schemes relating to general practice medication error related incidents occurring (or reported) between April 2015 to March 2020. The British Medical Journal (BMJ) found that medication error rates are lowest in primary care, but because of the sectors size these account for nearly four out of every ten[3,4].

Of those claims 112 claims, 8 claims were settled with damages paid, 56 were closed with no damages paid and 48 of these claims remain open.

Figure 1 Total number of CNSGP and ELSGP claims by incident year (financial years)



[3] 237+ million medication errors made every year in England | BMJ (2020)

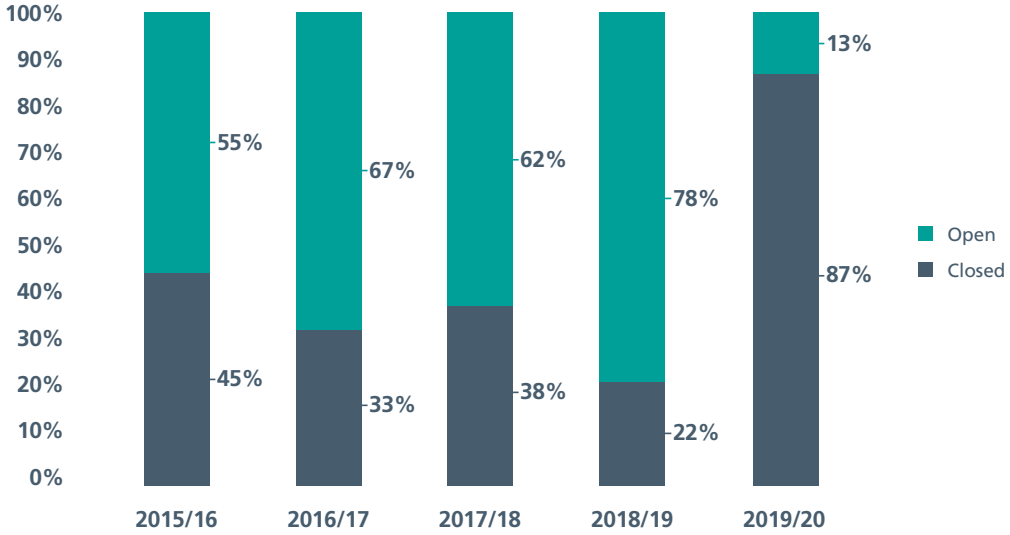
[4] Economic analysis of the prevalence and clinical and economic burden of medication error in England | BMJ Quality & Safety (2021)

Did you know?

The initial NHS Resolution data for general practice indicates that **anticoagulants, antimicrobials, anticonvulsants and opioids** are the **most common medications** to be implicated in incidents.

We recognise that these are currently small numbers of claims. The purpose of the data set is to provide a baseline for any future general practice medication errors.

Figure 2 Percentage of ELSGP & CNSGP medication claims by status - NHS Resolution 2021.



Did you know?

Medication errors can occur at many steps in patient care, from ordering the medication to the time when the patient is administered the drug. In general, medication errors usually occur at one of these points:

Prescribing

Transcribing

Dispensing

Administration

Monitoring

Patient safety incidents

Non-Steroidal Anti Inflammatory Drugs (NSAID) concomitantly prescribed with anticoagulants, despite being contraindicated, meant the patient was at risk of gastrointestinal adverse effects.

Alleged negligent prescription of antimicrobial to patient with a documented allergy resulted in an emergency admission to hospital.

Hospital letter uploaded to the wrong patient notes, the error was spotted prior to prescription issue, but the correct patient missed a month's medication.

What actions can you as a clinician take?

- Ensure a designated person monitors the Medicines and Healthcare products Regulatory Agency (MHRA) medication safety updates and cascades and actions accordingly;
- Review own organisation's medication error claims;
- Prescribing audit; recommend that prescribers use the Royal Pharmaceutical Society (RPS) competency framework as a benchmark when reviewing their prescribing practice in conjunction with NICE guidance on medications management;
- Professional bodies promote medication safety as being one aspect of their revalidation processes, consider including any medication errors as an optional focus of audit or improvement work.