# North West NHS primary care
# Dispelling the myth-towards safer practice

## Webinar four: Pitfalls to prescribing better care

Wednesday 3 July 1pm-2pm

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# North West Regional Team, NHS Resolution

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Introduction

## North West 3 (GPI)

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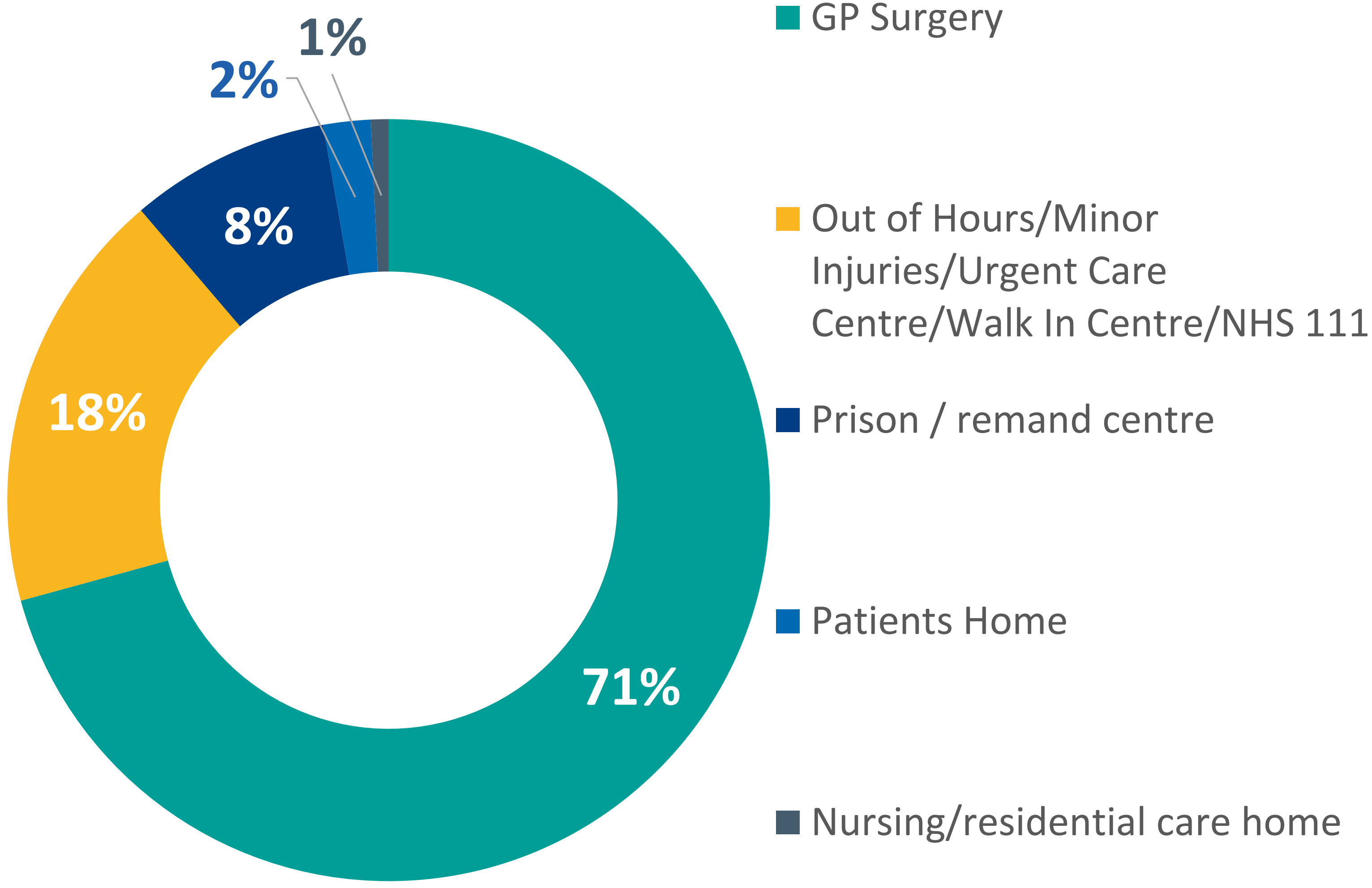
# Overview

- NHS Resolution statistics on medication errors
- Common medication errors
- Case Study 1 (system error/prescribing error)
- Case Study 2 (repeat prescriptions)
- Improving patient safety
- Role of clinical pharmacists
- Knowledge Hub

CNSGP Report

# Medication errors

## Location of Attendance



CNSGP Report

# Key recommendations

1. Consistent use of the Royal Pharmaceutical Society Prescribing Framework when reviewing prescribing
2. Structured medication review prioritizes patients receiving higher risk medication e.g. opioids, antipsychotics
3. Consider research into the use of medication system prompts and overrides

# Common Medication errors

## The stats

- 112 GP claims between April 2015 and March 2020 (1420 claims across primary/secondary)
- 237+million medication errors made every year in England: Lowest in primary care but still account for 4 out of 10 errors[2] [3]
- Involve medical and non-medical staff (system error)
- Financial and human cost.

[2]https://www.bmj.com/company/newsroom/237-million-medication-errors-made-every-year-in-england/

[3]https://qualitysafety.bmj.com/content/30/2/96

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# Common Medication errors

- Prescribing, transcribing, dispensing, administration and monitoring of medicines

- Anticoagulants, antimicrobials, anticonvulsants and opioids most common medications to be implicated in incidents.

# Common Medication errors

- Failure/delay in prescribing
- Adverse reactions (contra-indications/side effects)
- Monitoring (efficacy of medication and side effects)
- Vaccine/immunisation (site/dose)
- Dispensing errors (alert fatigue)

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# Case Study 1: prescribing/repeat prescription/monitoring/side effects

- Claimant was prescribed Nitrofurantoin as prophylaxis for recurrent UTIs from 2016.
- Advice to commence from Urology, but GP asked to prescribe.
- GP prescribed but did not advise the Claimant of the potential risks of long-term use or to return in the event of pulmonary symptoms.
- Repeat prescriptions were issued to the Claimant with no warnings.
- No monitoring of the Claimant’s lung and liver function
- In October 2017 the Claimant developed a cough and breathlessness which did not improve with antibiotics. This developed into respiratory failure. The Claimant was admitted to HDU when Nitrofurantoin was stopped.

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# Case Study 2: failure to prescribe

- Dec 2019: 57 y/o female, suffered a SAH and underwent coiling. Found to have another aneurysm.
- 24 June 2020 admitted for stent.
- Discharge letter 26.06.20 asked GP to continue Aspirin 2 years and Clopidogrel for 6m. Second letter 01.07.20 advised on discharge from rehabilitation.
- GP pharmacist looked at second letter 09.07.20 and didn't action medication changes. Hospital had given 14 days of aspirin and clopidogrel.
- 29.07.20 readmitted due to deteriorating condition and CT showed second stroke.
- GP practice apologised for not actioning medication on discharge.

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# Improving patient safety:

# What can you do to minimise medication errors in your organisation?

- Designate someone to monitor the MHRA safety updates
- Ensure prescribers use the RPS competency framework as a benchmark when reviewing prescribing practice in conjunction with NICE guidance on medications management
- Include medication errors as part of your audit process
- Annual medication reviews
- Medical reconciliations-hospital discharge
- Are your policies fit for purpose: repeat medication policy
- Role of Clinical Pharmacist

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# Improving patient safety

# Role of the Clinical Pharmacist

- Qualified experts in medicines registered with the General Pharmaceutical Council (supported by BMA, RCGP and RPS).
- 1000 Full Time equivalent clinical pharmacists since NHS England Clinical Pharmacists in General Practice programme started in 2015.
- [1]NHS England funded report, showed that clinical pharmacists significantly increase patient appointment capacity and reduce pressure on GPs.
- Medication reviews: releasing capacity for GPs, educating patients, deprescribing medicines, managing long term conditions, side effects
- *"They contribute significantly to patient safety, bring medicines and prescribing expertise and support with prescribing tasks and provide support for patients with long term conditions including support for healthy lifestyles".*

[1]*https://www.nottingham.ac.uk/news/pressreleases/2018/july/clinical-pharmacists-in-general-practice-improve-patient-care-new-report-finds.aspx*

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# Polypharmacy Action Learning Set (ALS) programme

Home » Programmes » Medicines » Polypharmacy

## Polypharmacy

Supporting healthcare professionals to identify patients at potential risk and facilitate better conversations about medicines

### The programme

**Session 1:** Polypharmacy – the scale, impact and challenges around stopping medicines safely. We will define inappropriate medicines and look at the patient perspective.

**Session 2:** What tools are available to help? We will explore shared decision-making, the evidence and tools to help conduct high-quality medication reviews.

**Session 3:** Workshop and facilitated discussions with consultant geriatricians to share experience of medication reviews and consolidate learning.

Cohort 19: 11, 25 September, 9 October 2024

Cohort 20: 16 October, 6, 20 November 2024

Cohort 21: 13, 27 November, 11 December 2024

- Polypharmacy Action Learning Sets - Health Innovation West of England (healthinnowest.net)

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Knowledge Hub

Did you know?

- General Practice Medication Errors - NHS Resolution
- Did you know? Insights into medication errors - NHS Resolution
- Anti-infective medication errors - NHS Resolution
- Paediatric medication errors - NHS Resolution

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# Experiences and questions

- Over to you......

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