Learning from medicine related safety incidents

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This is the first in a series of eight articles that will discuss the recommendations pertaining to medication safety, and provide insights into their application and implications for practice.

The recent NICE guidance on medicines optimisation makes eight overall recommendations to ensure the best possible use of medicines. Medicines optimisation is defined as “a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines.”

Preventable patient harm as a result of medicines is well recognised across the world and various initiatives have been tried to improve patient safety. The safety recommendations of the NICE medicines optimisation guidance comprise key messages and learning from a series of reports and alerts. The guidance emphasises the need for systematic identification, reporting and learning from medication-related patients safety incidents. Table 1 provides a summary of the recommendations grouped into four overarching themes.

Key factors in medication safety
Openness and transparency are critical to safety. These are all-encompassing, not just within and between healthcare teams and organisations, but more importantly with the patient as well. It has been suggested that transparency is the “magic pill” that will result in improved outcomes, fewer medical errors, more satisfied patients and lowered costs of care. In the NHS, dashboards are being developed to increase the visibility of safety parameters. Other data from the dashboards are designed to help CCGs improve and understand how well patients across the country are being supported to use their medicines.

Of the many factors that influence transparency and openness, the culture or “the way we do things round here” is fundamental. The safety culture of an organisation has been described as the ideas and beliefs that all members of the organisation share about risk, accidents and ill

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<th>Theme</th>
<th>Summary of recommendations</th>
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<tr>
<td>Openness and transparency</td>
<td>Organisations should support a person-centred, “fair blame” culture</td>
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<td>Culture</td>
<td>Consider assessing the training and education needs of health and social care practitioners to help patients and practitioners to identify and report medicines-related patient safety incidents</td>
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<td>Systems for identification and reporting of medicines-related patient safety incidents</td>
<td>Report all identified medicines-related patient safety incidents consistently and in a timely manner, in line with local and national patient safety reporting systems, to ensure that patient safety is not compromised</td>
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<td>Learning</td>
<td>Ensure that robust and transparent processes are in place to identify, report, prioritise, investigate and learn</td>
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Table 1. Safety themes: NICE medicines optimisation guidance

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health. In healthcare, this is when staff have positive perceptions of psychological safety, teamwork, and leadership, and feel comfortable discussing errors. Thus the safety culture underpins the willingness to be open, to develop and use systems to identify and report risks as well as incidents, and to use the learning to improve care. An effective safety culture requires clinical leadership, visibility of management, good communication and individual participation.

Risk mitigation strategies and recommendations have been made through thematic and trend analysis of reports to the National Reporting and Learning System (NRLS), resulting in the publication of patient safety alerts and the development of the Never Events Framework. The guidance recommends wider adoption and implementation of these systems and the use of new tools such as PINCER or STOPP/START to proactively manage medication risk at organisational as well as individual level. These tools provide a structured approach for medication review for elderly patients who may be at particular risk of medication-related harm either due to adverse events secondary to high risk medicines or polypharmacy, or unintended prescribing omissions.

The development of the medicines optimisation guidance is an example of how the willingness to learn through trend analysis of voluntary reports to the NRLS and specific research can translate to national guidance.

The focus of medication safety initiatives in general, as well as within the NICE guidance, is on reducing medicines-related patients safety incidents (unintended or unexpected incidents that are specifically related to medicines use, which could have or did lead to patient harm). Medicines-related patient safety incidents include avoidable medicines-related hospital admissions and re-admissions, medication errors, near misses and potentially avoidable adverse events.

In March 2014, a patient safety alert was issued by NHS England promoting the reporting and learning of medication incidents. While the focus of the alert was on large healthcare organisations, it included a recommendation for smaller organisations, including general practices, to report medication error incidents to the NRLS and take action to improve reporting and medication safety locally.

What does this mean for your practice?
The NICE guidance enables and encourages individual practitioners to share incidents, concerns and near misses that may be causing patient harm. If you are the clinical lead within your practice, it is an opportunity to review the systems that are in place to identify and report concerns.

Use the seven steps to patient safety to help you identify what you need to do.
1. Assess the maturity of the safety culture in your practice. A number of tools are available for this. One example is the Manchester Patient Safety Framework tool, which has been developed to help NHS organisations and healthcare teams assess their progress in developing a safety culture.
2. Lead and support your practice team by talking about patient safety, including safety in training and team meetings.
3. Integrate risk management activity through regular review of patient records; tools such as the PINCER software or the STOPP/START structured reviews may help identify patients, but are only effective with a team approach involving pharmacists, nurses and support staff.
4. Use the NRLS online reporting tool (available at https://report.nrls.nhs.uk/GP_eForm) to report errors that occur in your own practice as well as those made by others including hospital prescribers or community pharmacists.
5. Involve and encourage patients in their own medicines management and recognising adverse events.
6. Work with practice pharmacists, medication safety officers in local networks, multiprofessional groups and commissioners to learn and share safety lessons.
7. Review processes and the safety of your practice, and implement solutions to prevent harm.

Conclusion
Ultimately, safe practice begins with individuals; both patients and healthcare practitioners. It is important to share good practices among colleagues in your organisation while acknowledging when things go wrong and reporting appropriately. These are the first steps towards achieving safe and optimal use of medicine.

Table 2. Principles of the PINCER tool

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<td>1. Actively involving a multidisciplinary team,</td>
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<td>2. Agreeing an action plan with clear objectives</td>
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<td>3. Providing regular feedback on progress</td>
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<td>4. Providing clear, concise, evidence-based information</td>
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References
1. NICE guideline NC5. Medicines optimisation: The safe and effective use of medicines to enable the best possible outcomes. March 2015.
10. MHRA/NHS England. Improving medication...
Declarations of interest
None to declare.

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Forthcoming events

The forthcoming events section highlights some of the many courses, meetings and conferences of interest to prescribers planned over the coming months

IBS in general practice
Date: 10 November
Venue: Jury’s Inn, Liverpool
Tel: 0151 708 0865
Email: mersey@rcgp.org.uk
Website: www.rcgp.org.uk
The aim of this programme is to cover: how GPs can efficiently diagnose patients with GI conditions; how to decide which patients should be referred, being mindful of the use of primary and secondary care resources; how patients can be effectively managed; the importance of good patient communication throughout this process; and discussion of the recently updated NICE guidelines on management of IBS in primary care. Topics include: challenges associated with GI disorders; practical tips for management; commissioning referral and patient communications; and NICE — a local perspective.

Diabetes Professional Care 2015
Date: 11–12 November
Venue: Barbican Exhibition Centre, London
Tel: 07805 254814
Email: conference@diabetespc.com
Website: www.diabetesprofessionalcare.com
A free two-day CPD accredited conference and exhibition which brings together diabetes professionals. The event is expected to attract over 2000 attendees and speakers including Professor Chris Ham (Kings Fund), Sir Bruce Keogh and Tim Kelsey (NHS England) and the Rt Hon Stephen Dorrell.

BMJ masterclasses: GP general update
Date: 27–28 November
Venue: Etc Venues, Bishopsgate London
Tel: 0207 111 1106
Email: info.masterclasses@bmj.com
Website: http://masterclasses.bmj.com
The two days will focus on 12 core topics in primary care and collate the most recent guidelines, hottest evidence and expert advice. Topics include: cardiology, mental health, end-of-life care, endocrinology, contraception, diabetes, musculoskeletal medicine, abnormal blood tests, paediatrics, respiratory medicine, and ophthalmology.

Bipolar Disorder 2015
Date: 3 December
Venue: Hallam Conference Centre, London
Tel: 020 7501 6762
Email: conferences@markallengroup.com
Website: www.mahealthcarevents.co.uk/bipolar15
Diagnosis and management of bipolar disorder can be complex and it is imperative that all specialists within the field remain as up-to-date as possible. Bipolar Disorder 2015 is a one-day CPD certified event that will examine the challenges of managing this complex condition, with the aim of arming participants with practical information that can positively influence every day clinical practice.

Anyone who wishes to publicise details of events for GPs and pharmacists (at no charge) should e-mail them to: prescriber@wiley.com