

# Risk Management In Prescribing

- What is risk management?
- How do we identify risk?
- How do we manage risk?
  - Reporting risk
  - Real-life scenarios

# What is Risk Management?

- Risk Management is an assessment and management of the risks
- It is recognising which events may lead to harm in the future and minimising the risk of them occurring

# Hazards and Risks

- A hazard is something that has the potential to cause harm, for example, a medicine
- A risk is the probability that an adverse event will occur – this is the aspect that needs to be controlled

# What Are The Most Common Medication Errors Reported in General Practice?

# The Most Common Medication Errors Reported in General Practice

The Medical Defence Union reported on the following types of errors in 2007:

- Incorrect drugs being prescribed
  - Tolterodine prescribed instead of tamsulosin
  - MMR vaccine being given with the other routine childhood vaccines when the child's parents had objected
- Wrong dose being prescribed or misinterpreted

# The Most Common Medication Errors Reported in General Practice

- Out of date medication being administered
  - Emergency bags and boxes
- Medications being prescribed to patients with known allergies
  - Augmentin being prescribed for a patient with a penicillin allergy

# Dosing Errors

- MCG can be misinterpreted as MG – write ‘micrograms’ in full
- U can be misinterpreted as O – write ‘units’ in full
  - E.g. 10u could be read as 100
- Zeros after decimal points can lead to the decimal point being missed
  - E.g. 10.0 could be read as 100

# 7 Steps of Risk Management

- Build a safety culture
- Lead and support your staff
- Integrate your risk management activity
- Promote reporting
- Involve and communicate with patients
- Learn and share safety lessons
- Implement solutions to prevent harm

# Where Do I Begin?

- Risk matrixes can be used as a guide to prioritise control measures

# Risk Matrix

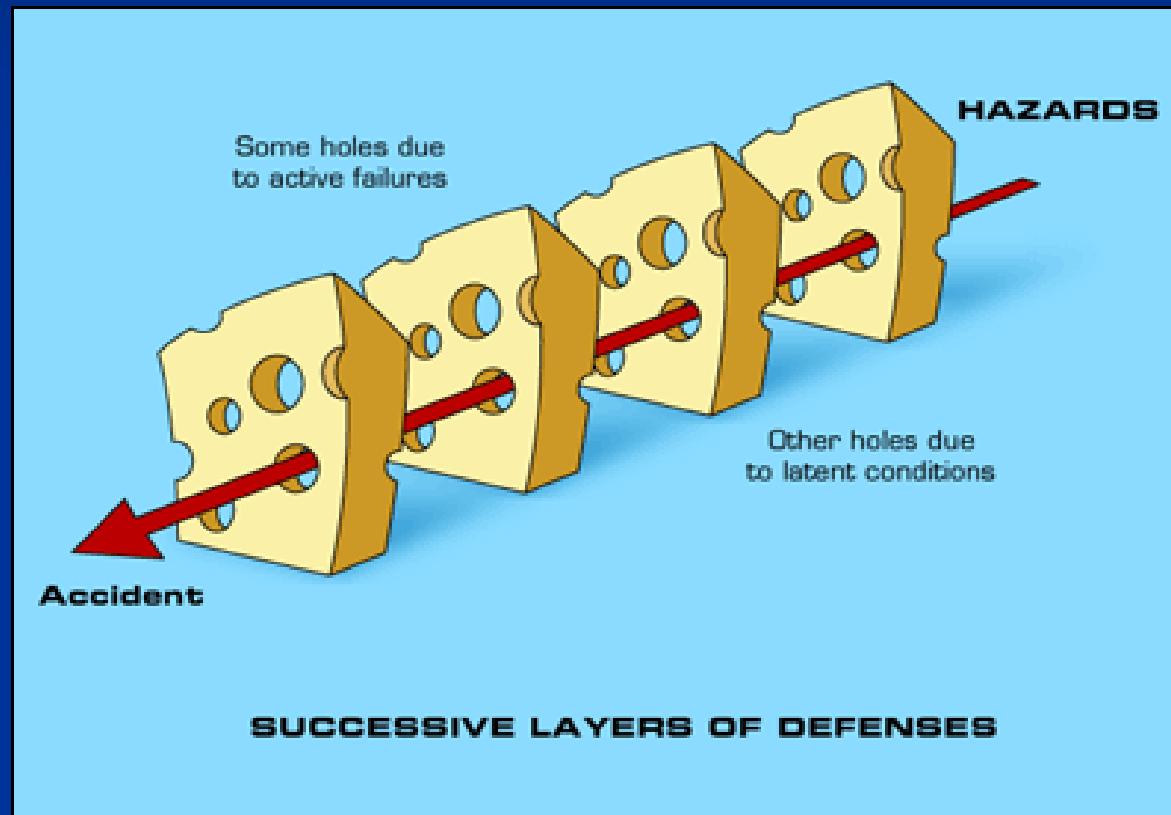
**Green = Low    Yellow = Moderate    Orange = High    Red = Extreme**

Consequence	Catastrophic	Yellow	Orange	Red	Red	Red
	Major	Yellow	Orange	Orange	Red	Red
	Moderate	Green	Yellow	Orange	Orange	Red
	Minor	Green	Yellow	Yellow	Orange	Orange
	Negligible	Green	Green	Green	Yellow	Yellow
		Rare	Unlikely	Possible	Likely	Almost certain
		Likelihood				

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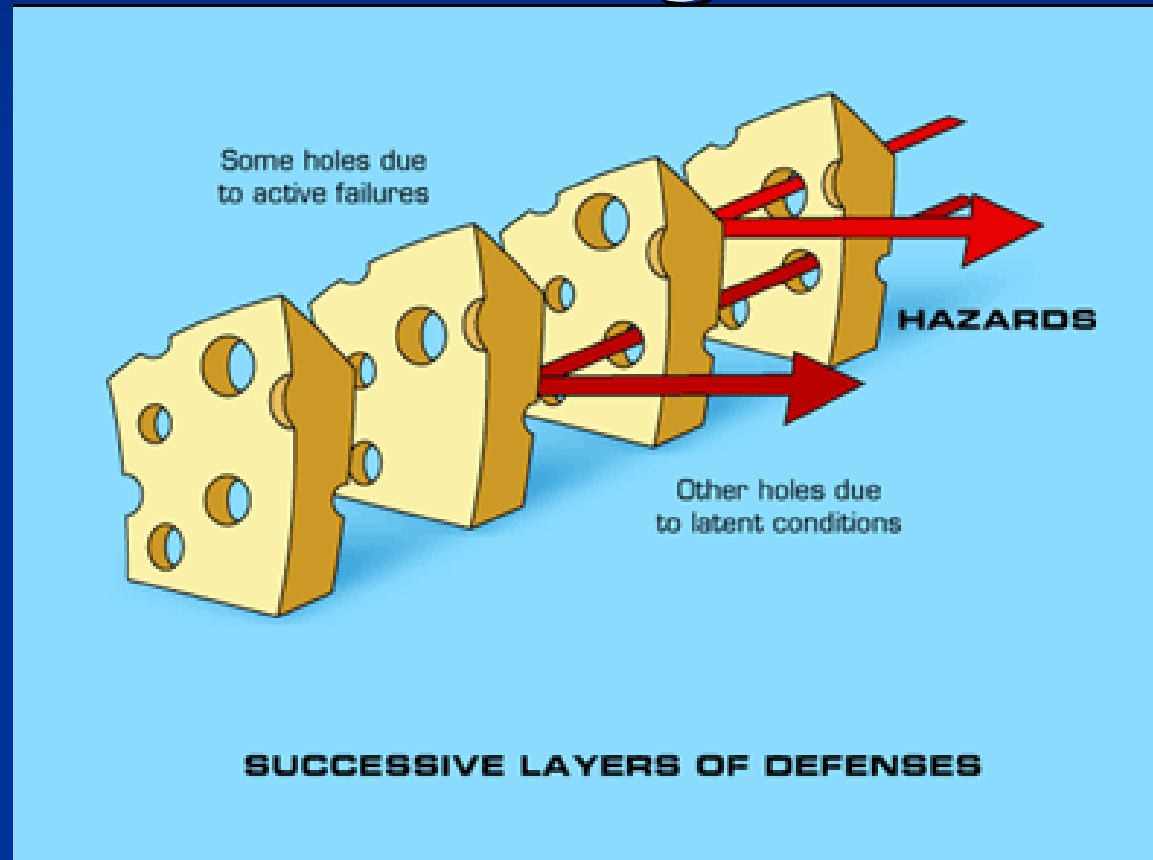
# When it Goes Wrong



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# Preventing Harm



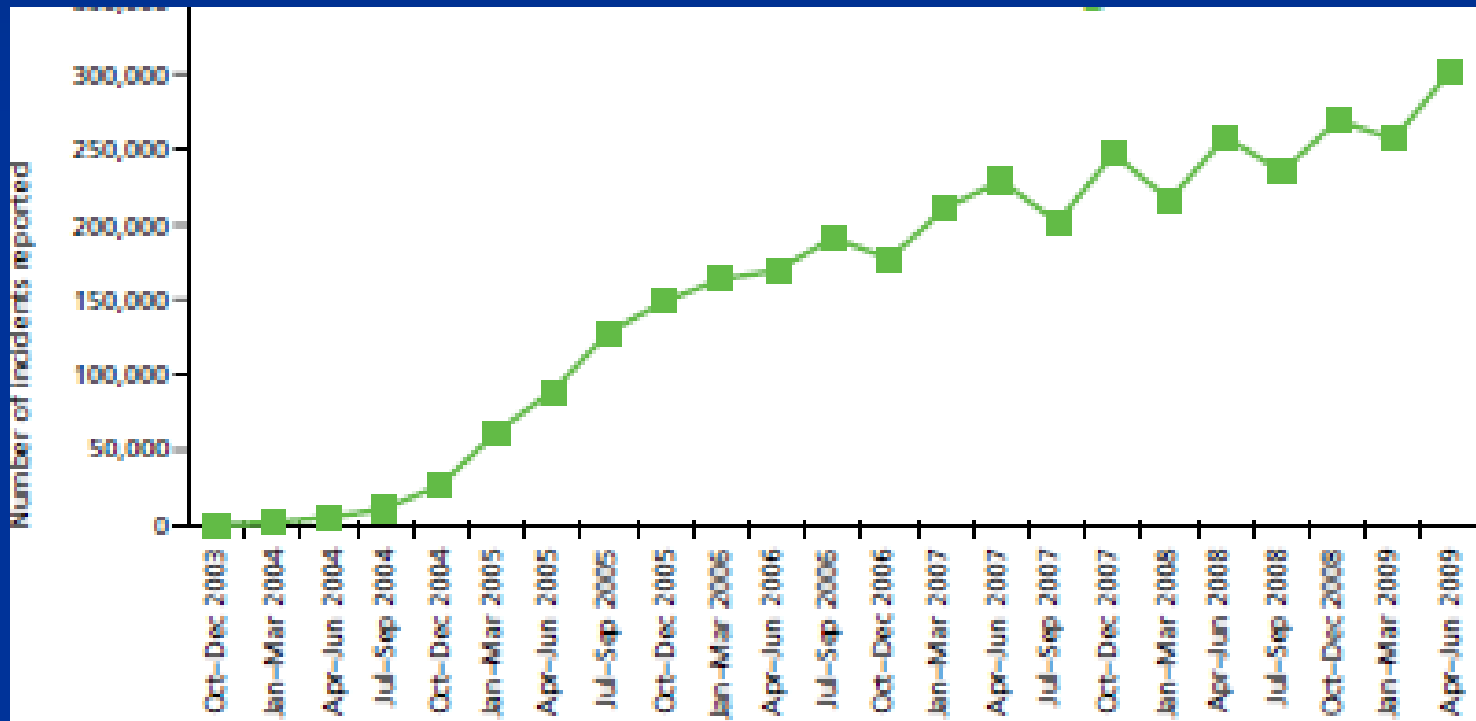
# Applying the Swiss Cheese Model to Practice

- Consider the case of clopidogrel and aspirin being prescribed in combination for a 12 month period
- How do you ensure that treatment duration is not exceeded resulting in the risk of a GI bleed? What defences can we put in place?

# Defences

- Hospital consultant specifies duration of treatment on discharge
- GP adds a stop date to the patient's clinical records
- Stop date added to directions: > GP > Community Pharmacist > Patient
- Discussion with the patient

# Incident Reporting Trends



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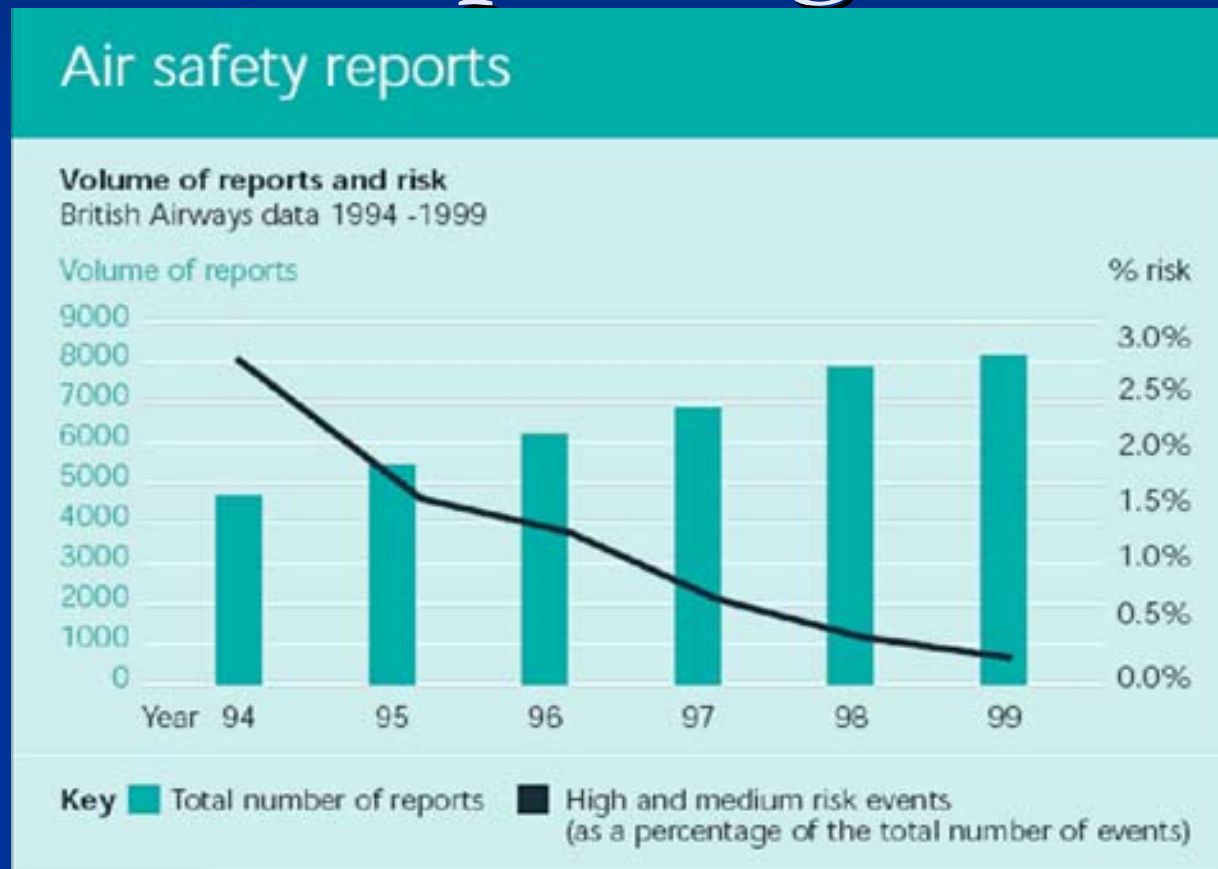
# Incident Reporting In General Practice

- Of the 914,150 incidents reported between April 2008 and March 2009, only 2,803 (0.3%) were reported from general practice
- Incidents have been shown to occur in up to 11% of all prescriptions
- Organisations with a poor reporting culture may be at greater risk of harming patients as there is less opportunity to learn

# How Are Serious Incident Reports Used?

- Serious Incident Reports are reviewed by clinical reviewers at the NPSA
- Opportunities for national learning and action are identified
- Rapid Response Reports are issued to raise awareness of the risks and to inform local action

# Does Reporting Work?



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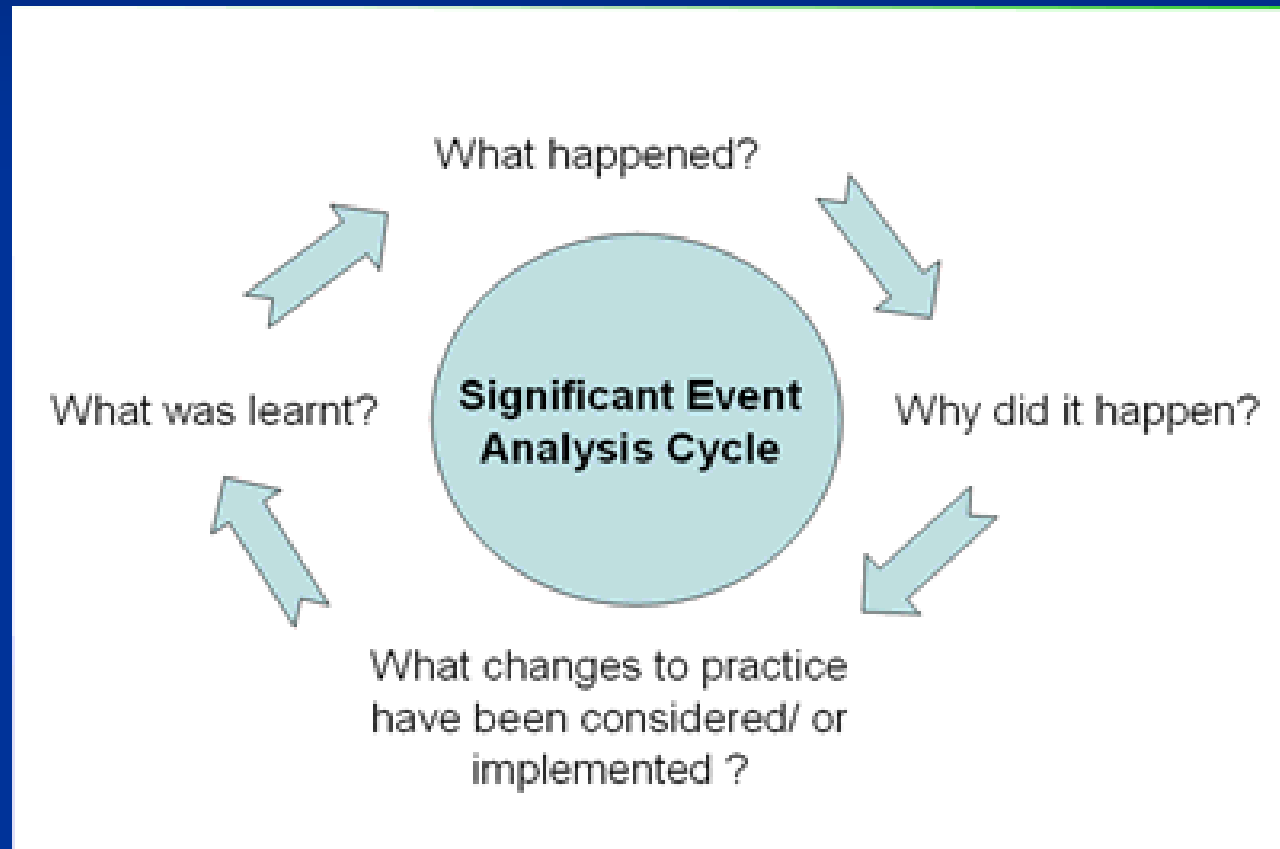
# How Do I Report?

- In 2004 the NPSA introduced a formal reporting and learning system
- An electronic report form is available at [www.npsa.nhs.uk](http://www.npsa.nhs.uk)
- Information is stored anonymously

# What Should I Record?

- Date of the incident
- Time of the incident
- Incident category
- Location where the incident occurred
- Description of what happened

# Significant Event Analysis



# Real-Life Scenarios

- Split into smaller groups
- Discuss the scenarios amongst your group
- Consider:
  - What went wrong?
  - Why did it go wrong?
  - What changes to practice are required to prevent it from occurring in the future?
  - How you will apply this to your work?

# Scenario 1

- Patient A was prescribed a cytotoxic by secondary care. This is not recorded in the patient's primary care records.

The GP visited the patient at home and treated the patient for a virus.

The patient died the next day.

## Scenario 2

- Patient B was prescribed an oral contraceptive by her GP.

The patient was buying St John's Wort OTC.

This resulted in an unwanted pregnancy.

# Scenario 3

- Patient C was taking methotrexate for rheumatoid arthritis.

The patient was attending secondary care for his monitoring, but the methotrexate was being prescribed by his GP.

The patient DNA'd his hospital appointments so the consultant stopped methotrexate and discharged him. The consultant wrote to the GP.

The patient continued to collect methotrexate from his GP, but was not attending monitoring.

The patient presented at a falls clinic and was found to have a Hb <8.0 and low WBC.

# Scenario 4

- Patient D was discharged from secondary care. The consultant recommended Zoladex 10.8mg every 3 months and Cyproterone 100mg tds for 2/52.

The discharge was a bad carbon copy . Both items were added to repeat and issued for 5 years.

The patient developed a blood dyscrasia and shrunken genitalia.