

Scenarios

This is a summary of the points raised and discussed by the delegates in the Risk Management in Prescribing Workshop. These are the thoughts and ideas of the group.

Scenario 1:

Case - Patient A was prescribed a cytotoxic by secondary care. This was 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.

What happened? - The GP was not aware of the cytotoxic at the time of the home visit. As such the patient's neutropenia was missed and the patient subsequently died.

Why did it happen? - The cytotoxic was not listed in the patient's records. If it had been recorded on the patient's repeat medications, this information would have been available for the GP on the summary printout. Additionally, members of the group felt that this should have also been recorded in the problem summary.

What barriers could be implemented to prevent this from occurring again? :-

- Counselling from secondary care on the signs of neutropenia, instructions of the actions to be taken should these signs arise and a contact number for secondary care
- The hospital letter should be reviewed by a GP, the relevant aspects picked out and read-coded or added to the primary care notes as appropriate. Then the letter should be scanned into the patient's primary care records
- The patient's current medication should be confirmed with the patient at the time of the homevisit or at the time of a medication review, by asking do you take any medication that is not prescribed for you by your GP?
- The externally prescribed medication (the cytotoxic in this case) could be added to the patient's list of repeat medications in the primary care records, with the directions, "Hospital Only Medication – not to be issued" and a quantity of zero. If this was issued in error, this would be queried by the community pharmacist

Scenario 2:

Case: 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.

What happened? – A drug interaction reduced the efficacy of the oral contraceptive

Why did it happen? – The GP was unaware of the St John's Wort at the point of prescribing the oral contraceptive

What barriers could be implemented to prevent this from occurring again? :-

- Counselling by the community pharmacist at the time the patient purchases the St John's Wort and at the time of dispensing the oral contraceptive
- Advising the patient to read the patient information leaflet for the oral contraceptive, which would alert the patient to the need to discuss the St John's Wort with her GP or pharmacist

- Asking the patient if she is taking any externally prescribed medications at the time prescribing and at medication reviews and recording this in the patient's primary care records as per scenario 1, so that it can be seen at the point of prescribing the oral contraceptive

Scenario 3:

Case: 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 appointment and the consultant stopped his methotrexate and discharged him. The consultant wrote to the GP to inform him of this. The patient continued to collect methotrexate from his GP, but was not attending monitoring. The patient later presented at a falls clinic and was found to have a Hb<8.0 and a low WBC.

What happened? – The group felt that there was a lack of patient responsibility leading up to the event. Although this is accepted, it is also a responsibility of the prescriber to check that the patient is being appropriately monitored prior to prescribing

Why did it happen? :-

- The patient did not take responsibility for his own health by attending hospital appointments
- There was no robust mechanism in place to ensure that the patient was being monitored prior to prescribing the methotrexate
- The hospital letter was not acted upon, i.e. methotrexate should have been removed from the patient's list of repeat medications, upon receiving the letter from secondary care

What barriers could be implemented to prevent this from occurring again? :-

- Robust system for acting on letters from secondary care
- Use of monitoring booklets and requesting these at the time the high-risk drug is ordered
- Checking on ICE and in clinical values in the primary care records to ensure that monitoring is up-to-date prior to issuing a prescription
- Reinforcing the importance of attending monitoring to the patient at the time of medication reviews