A review of medication incident reports from general practices within a Clinical Commissioning Group (CCG)

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Introduction

237M medication errors occur annually in England[1] → **They cost the NHS £98M Annually [1]** → **34% of errors occur in primary care [1]**

Medication errors in England are reported to the National Reporting and Learning System (NRLS)[2]. Medication related incident reporting figures from primary care has remained low when compared to secondary care [1].

General practices (GPs) are the most common access route for patients seeking health care, with over 360M appointments annually[3].

NHS England (NHSE) Primary Care 2015 Incident Report indicated 49% of 171 incidents reported were medication related with ZERO (0) incidents from City and Hackney Practices[4].

The City and Hackney Clinical Commissioning Group (CH CCG) introduced medication incident reporting in its annual Quality Innovation Productivity and Prevention (QIPP) in 2017.

Aim & Objectives

Aim: To optimise the safe use of medicines by promoting identification and reporting of patient safety incidents.

Objectives:

- To determine numbers and types of medication incidents reported by the practices within the CCG from April 2017 – March 2020.
- To categorise medication incidents according to harm caused and the degree of harm (2018 – 2020 reports only).
- To determine the major drug classes involved.
- To explore links with the 'Transitions of Care' priority area of the WHO 3rd Global Patient Safety Challenge.[5]

Method

Retrospective review of CCG database of anonymised patient safety incidents reported via NRLS by practices within City and Hackney CCG between April 2017 and March 2020. Data was entered on SPSS version 27 and analysed by descriptive statistics and qualitative analysis.

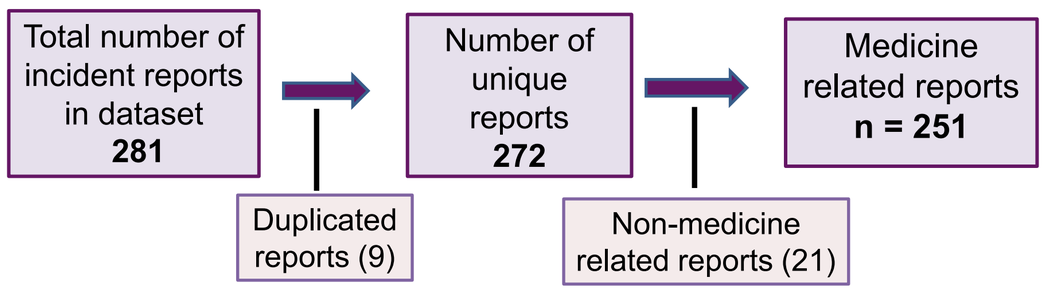

Figure 1: Flow chart showing how reports were selected for analysis.

Acknowledgement

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Results

Table 1: Overview of reports shared with CH CCG via NRLS

Total number of medicine related reports **96** (2017/18); **86** (2018/19); **69** (2019/20)	**251**
Female Gender (n)	124
Age ≥ 60 years (n)	117
Age ≤ 16 years (n)	21
Prescribing errors (%)	67.9%
Errors involving high-risk medicines (%)	21.5%

Patients' mean age was 55.6 years (SD= 23.5).

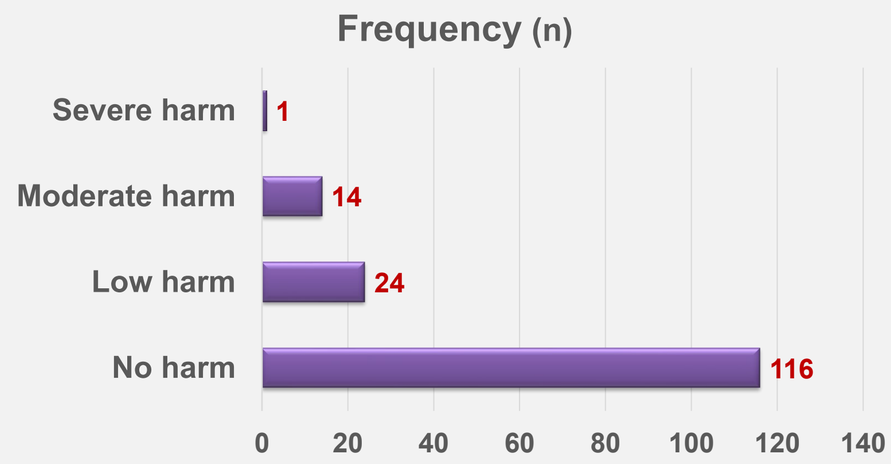

Figure 2: Degree of harm caused, 2018 – 2020 (n = 155)

71% of reports associated with CV agents were prescribing errors.

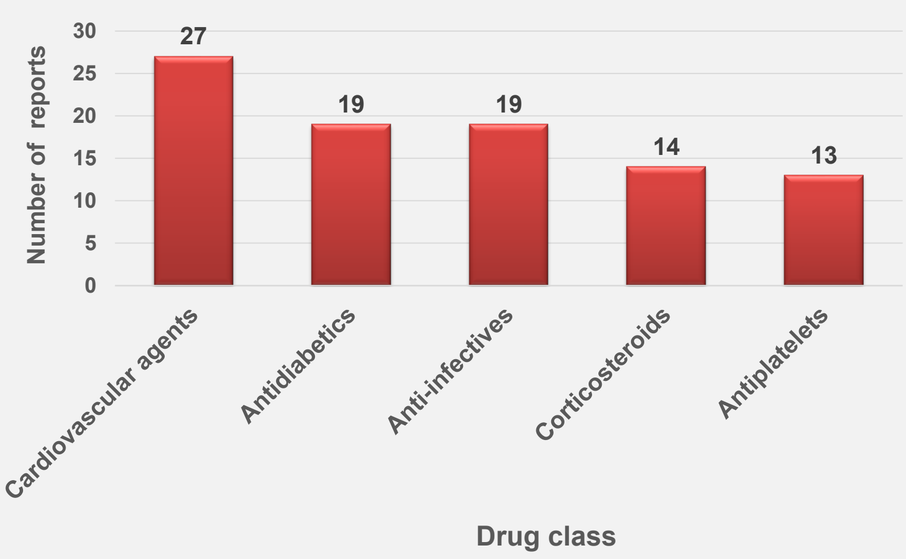

Figure 3: Top 5 drug classes in reported medication incidents.

Table 2: Incidents related to 'Transitions of Care'

Reason	N [%]
Involving hospital discharge letter	42 [58.3]
Lack of communication with pharmacy	12 [16.7]
Failed monitoring/follow up after discharge	7 [9.7]
Lack of communication from hospital	4 [5.5]
Insufficient supply from hospital	3 [4.3]
Transfer between GP practices	4 [5.5]
Total	72 [100.0]

Transfer of care around medicines is a key priority area of both the NHS and the WHO [5].

Discussion and Conclusion

Practices responded positively to the QIPP scheme and continue to engage with incident reporting. Medication incidents were the bulk (89.3%) of incidents reported in the period. In line with literature, most (75%) of the reported errors did not cause harm [5] . Prescribing errors were the most frequent [1] at approx. 68% which is unsurprising as GPs primarily prescribe. Errors relating to insulin were the most common (63%) of those relating to antidiabetic drugs (Fig 3). Insulin is a high-risk medicine [5] . Nearly 30% of the incidents reported were associated with transitions of care. According to the WHO [5], transitions of care increase the possibility of communication errors which can cause serious medication errors. The proactive approach to incident reporting encouraged by this CCG has the potential to identify trends and, with case review and shared learning, prevent repeats of incidents that could cause patient harm [5].
Generalising self-reported data is limited due to possible under and/or selective reporting, among other limitations.

References

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