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# Prescribing error reporting, facilitating learning and patient safety across primary care

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## BACKGROUND

- There are well-established benefits from reporting medication errors and identifying patterns to help prevent future harm<sup>1</sup>.
- Prescribing errors from general practice and community services are often identified and rectified in community pharmacy.
- In the UK, organisational structures within NHS primary care mean that boundaries between independent organisations may act as barriers to error reporting and associated learning.

## STUDY AIMS

- Identify key facilitators and barriers to facilitating cross-organisational prescribing error reporting and learning across primary care
- Explore the potential role of community pharmacy within this

## METHODS

- Qualitative semi-structured face to face and telephone interviews
- Purposive sample of pharmacists, primary care prescribers and other key stakeholders from across North East England (n=25)
- Interviews explored: facilitators and barriers to prescribing error reporting in primary care; the influence of decision-making processes and healthcare context; and the potential of community pharmacy in optimising prescribing error reporting. Approaches to learning from prescribing errors in primary care from reported errors.
- Data collection and analysis were underpinned by the Theoretical Domains Framework<sup>2</sup> and mapped to the COM-B model of behaviour change<sup>3</sup>.
- Framework analysis<sup>4</sup> was used for coding and charting the data with the assistance of NVivo software (v12).

## KEY FINDINGS

### 1. INCONSISTENT REPORTING OF PRESCRIBING ERRORS ACROSS PRIMARY CARE

Differences in professional and organisational reporting cultures, processes and reporting systems

“we’re always on the go, we’re always doing things, what we do is we identify it, rectify it and we move on.. and we’re not very good I don’t think at always recording them” (Pharmacist, large multiple, P,3)

“If I was being honest, I would think that most prescribing errors are not reported at all” (GP,11)

“Well, the- the ones that are picked up by community pharmacists, er .. on a routine basis, I don’t think are reported anywhere.” (GP 8)

Prescribing errors most likely to be reported:

- by GPs when error falls under significant event or serious incident reporting requirements
- by community pharmacists when error is associated with accountability for dispensing

Key facilitators: professional regulation, medico-legal concerns, upholding professional standards

Impact of nature of prescribing: Complexity of identifying and classifying prescribing “errors”

“If you’ve just got someone ticking boxes then there’s no proportionality because then it’s either right or wrong and in prescribing it’s often not like that” (GP,5)

“There’s loads of things where some things are not completely right.. Things that do not come to patient harm, but there are a lot of inaccuracies”... “it’s not even easy to describe what is a “clear” prescribing error” (GP,7)

### 2. INFLUENCES ON REPORTING MAPPED TO COM-B FRAMEWORK<sup>3</sup>



### 3. FEEDBACK AND LEARNING

“There’s lots of little bits and pieces around ...you know, people are all tackling the problem in, in different ways, I guess.” (Stakeholder, S12)

So, you know, it’s the other way around rather than relying on reporting necessarily ...as the way of gathering that data... Recognising that it’s a problem...and then looking for it I suppose rather than waiting for it to be reported.” (GP,22)

“Very rarely, sometimes the pharmacy would be present at the practice meeting. So, I’ve discussed prescribing errors at GP practice meetings before. You know, we have, like, MDTs.. But at the minute it’s just so, variable” (Pharmacist, P1)

Complex and ad-hoc feedback and learning across primary care

Overlap with quality improvement initiatives

Value of shared learning and perspectives

## DISCUSSION

- There seems to be a lack of clarity and consistency across primary care in relation prescribing error reporting and therefore a potential evidence gap for future learning.
- Reporting is most likely to happen when the error aligns with clearly established reporting processes and systems associated with ‘significant events’ in general practice or dispensing errors in community pharmacy.
- Our analysis is informed by an established model of behaviour change and includes perspectives from prescribers, community pharmacists and key stakeholders from a range of primary care provider and commissioner organisations. A limitation of our findings is the potential for bias due to the likelihood of attracting participants with an interest in the topic and a lack of perspectives from dentists or regulatory bodies.
- There is acknowledged potential to better facilitate learning and improve the quality of prescribing through more consistent reporting and sharing of information relating to error trends across organisations
- Further work to enable consensus on shared priorities and reporting thresholds is required to facilitate more consistency of reporting prescribing errors across primary care in a way that acknowledges the complexity associated with the classification of prescribing errors and the barriers to reporting.
- Feedback and learning may benefit from having a local focus, creating a perception of having a positive and significant potential to change practice, and tailored appropriately to each setting.

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