Reducing Prescribing Errors in a Hospice Setting - A Multimodal QI Project

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Introduction

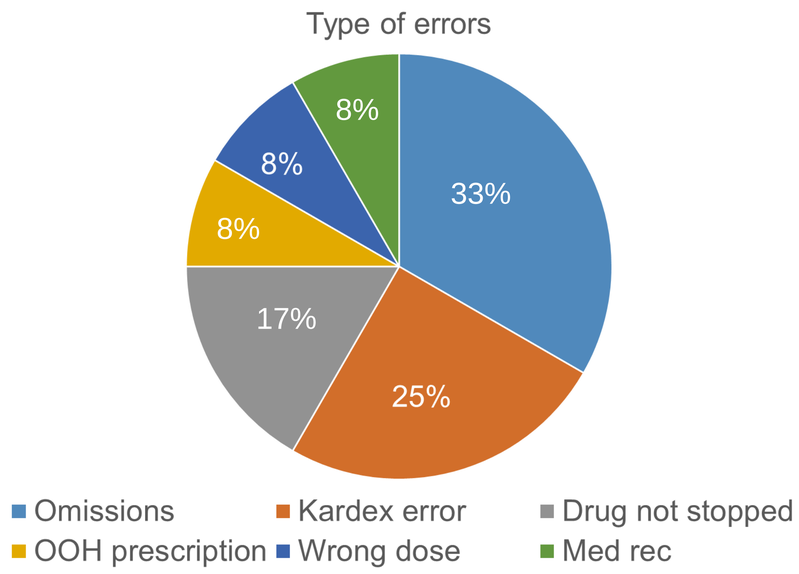
- Approximately 237 million medication errors occur at some point in the medication process in England annually with 66 million being potentially clinically significant[1]
- It was noted that prescribing errors seemed to increase after a change in the resident doctors at Marie Curie Hospice Glasgow.
- In a QI project done in a hospice in England, a similar trend was noted with prescribing errors increasing after a changeover of resident doctors[2]
- This was recognised as a significant issue due to the nature of the drugs prescribed in the hospice environment.
- After discussions with medical staff, it was recognised that the hospice still used paper drug charts, as opposed to electronic prescribing which has been widely adopted in hospital settings in the west of Scotland
- Another possible cause for error was identified as a lack of familiarity with palliative care prescribing e.g. syringe drivers
- Errors were dealt with in part by seeking written feedback from staff
- This multimodal QI project aimed to investigate prescribing errors, how staff felt about the error reflection process and then seek to decrease error volume

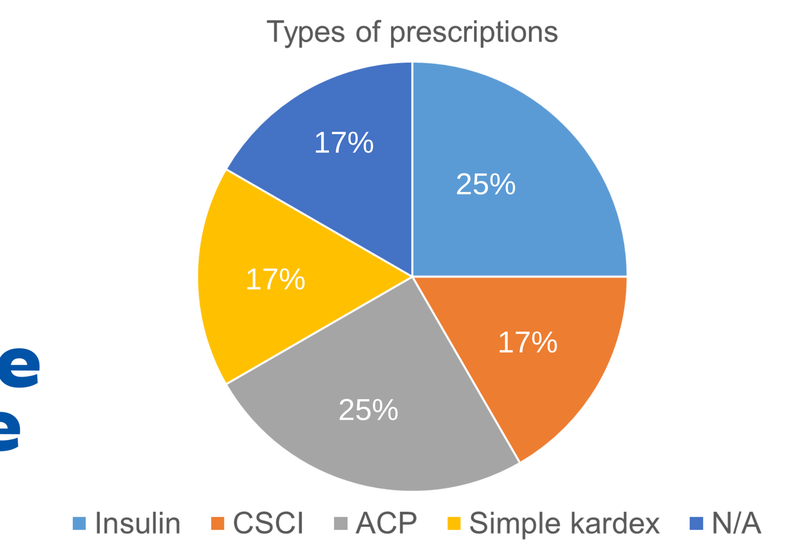
Methods

- We analysed the error reporting data from over a 3-month period to look at the number of error, types of errors, and when they occurred (during ward round, OOH, during ward work or during admissions).
- An online survey was completed by resident doctors looking at previous experience of drug charts, current induction processes, and about current written reflection process following errors, if this was felt to be helpful and how it made the doctors feel.

Results

- 12 errors were found to have occurred, mostly inappropriate prescriptions or drug omissions and across a variety of prescription types.
- Errors occurred during daytime prescribing mainly.
- The survey suggested that rotational doctors had limited experience with prescribing on paper drug charts and felt would have benefited from more preparation.
- The survey also indicated the doctors felt guilty or stressed about completing written reflections.



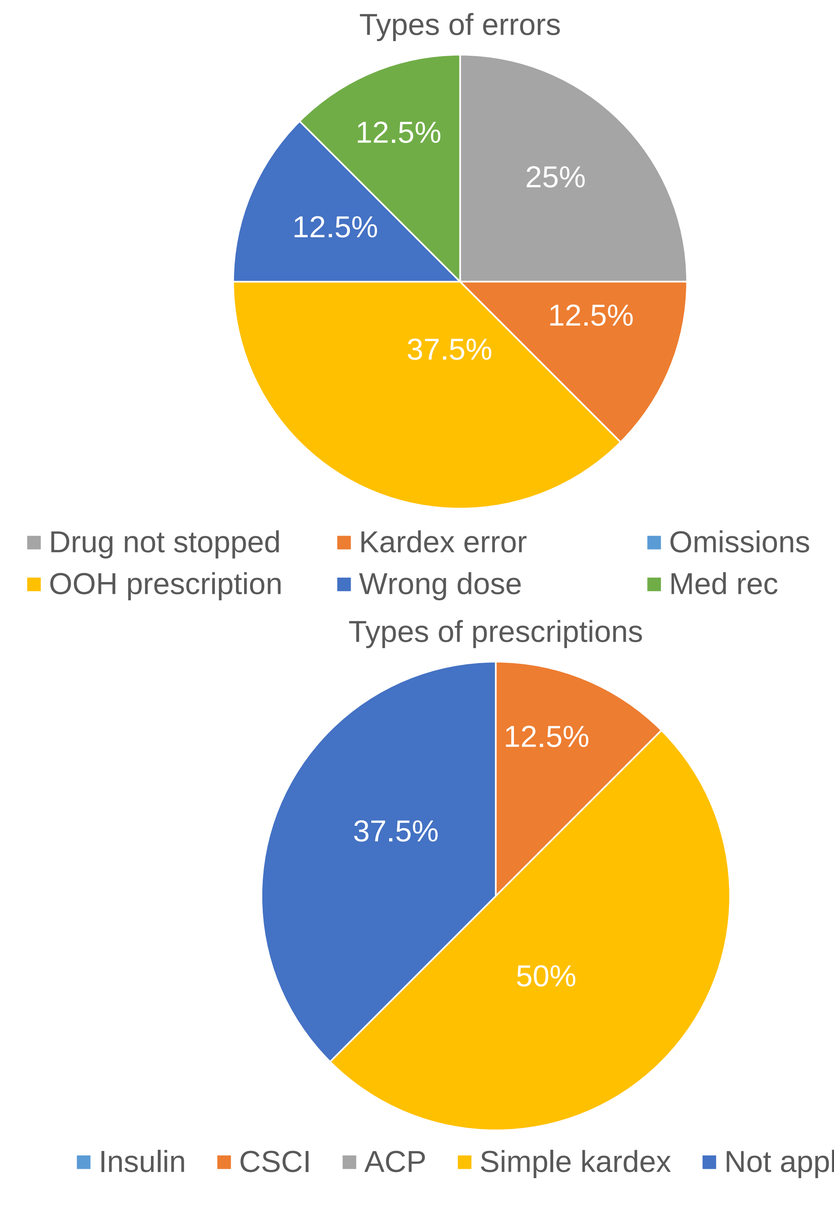


Intervention

- The findings were presented at departmental teaching to highlight issue and to ask for suggestions for improvements.
- We enhanced induction with hospice specific prescribing guidance added to existing hospice induction app.
- Physical guides created in conjunction with pharmacy staff in hospice and put on wards to be easy to find for staff.
- Revised reflection process to focus on supportive conversations with seniors rather than need for written reflections.

Follow-up

- Repeat analysis of prescribing errors over following 3 month period showed one third reduction in prescription errors
- Similar spread of types of errors and types of prescriptions as previous
- Further survey sent to different group of rotational doctors who reported higher confidence in prescribing and less distress around errors
- All who completed survey used new prescribing resources.



Conclusions

- Hospice specific prescribing inductions and resources are essential for resident doctors
- A supportive environment around errors and focusing on constructive conversations with supervisors to help learn and prevent future errors is crucial for safe prescribing

References

- 1 - Elliott, R.A. et al. (2021) Economic Analysis of the prevalence and clinical and economic burden of medication error in England, BMJ Quality & Safety. Available at: https://qualitysafety.bmj.com/content/30/2/96 (Accessed: 04 November 2024).
- 2 - Morton, I. (2019) 12 reducing prescribing errors amongst junior doctors at the beginning of their during hospice rotations- a quality improvement project (QIP), BMJ Supportive & Palliative Care. Available at: https://spcare.bmj.com/content/9/Suppl_1/A13.3 (Accessed: 04 November 2024).

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