Improving medications safety: group discussions

It's 2020, 99% of patients now receive the right medicine and the right dose at the right time…how have we achieved this?

- Electronic prescribing with decision support.
- Universal high quality 'prescribing' education.
- Electronic patient care records.
- Electronic patient identification.
- Patients routinely/always involved
- Self-medication by default/norm.
- Sharing of lessons learnt.
- Automated dispensing.
- Dedicated medicines administration.

At what points in their pathway are patients most at risk of harm from medication error? What can we do to make each of these points safer?

- Transitions in care/multiple transfers.
- Patients who have been on case load for a while.
- 1st week February new docs.
- No clear accountability for total drugs required by patient, i.e specialist nurses/tertiary centres etc.
- Shared records/access by all HCPs.
- MDT approach.
- Focus on medicines reconciliation.
- At risk: weekends/discharge/hospital/GP interface/1st 24 hours of admin – before med reconciliation.

How could patients be part of a reliable system for medications?

- Self-administration process using patient's own medicines.
- Medication history – part of reconciliation process.
- Patients on trust medicines committees.
- Reminder cards so they can prompt.
- Greater involvement in incident reporting.
- Lobby for safer systems/interest group involvement.
- Focus groups /membership events.
- More available/accessible information about medicines – but better quality assurance/quality mark.

- More interactive points of contact.
- Links involving all health economy e.g. community pharmacy.
- Patients held records – electronic/transferable.
- Understand the medicines they are taking.
- Be involved in decision making.
- At ward level – engagement e.g. self-medication.
- Being listened to.
- Being trusted/trust us.
- Bring medicines to hospital etc
- Passports.
- Blister packs.
- Technology.
- Accountability.

It's 2020, medication omissions in your organisations have reduced by 80%.....how did this happen?

- Electronic prescribing and administration system.
- Improved education of clinicians.
- Improved accountability.
- Barcodes.
- 80% self-administration of meds.
- Regular monitoring using point prevalence
- Human factors.
- Adequate staffing levels.
- Skill mix.
- Collaborative approach.
- Patient taking some responsibility
- Reduced reporting a risk.
- Additional support to vulnerable patients.
- Electronic prescribing – audit tool.
- Increased reporting.
- Openness.
- Ownership.
- Accountability.
- RFID.
- Access to summary care recs – better links between organisations e.g. 1 care - 2 care.
- Using the safety thermometer.
- Medicines safety officers.
- Dmg technology.

What technologies do you think will make a difference to reducing medication error?

- Barcoding – patients, medicines.
- Smart pumps.
- Electronic prescribing with clinical decision support linked to administration.
- Web based medication record – single record handheld?
- Dispensing robots/ward based drug disp. Systems.
- Automated ordering from pharmacy.
- Email notifications of high risk med admin.
- Development of apps on phones
- Biomarker chips
- Assisted technology/telehealth
- Automated patient dispensing systems/reminder alarms.

How can we make medicine safety everyone's responsibility including patients?

- Education.
- Posters on medication safety.
- Green bag.
- Self-administration policy.
- Accountability.
- Ownership of medication safety.
- Exec level sponsorship.
- Be open and transparent.
- Unit/ward level ownership.
- Lessons learnt/episodes of care.
- Frequent competency based education.
- Patient/public focus groups.
- Patient/public membership on medication committees.
- Incident reporting.
- Root cause analysis investigations/share outcomes/actions and learning points.
- Patient safety champion.
- Improve patient knowledge.
- External dashboard.
- Communication and information.
- Listening to patients and confirming understanding.

- Challenge the MDT.
- Easier reporting systems.
- Open & honest re errors and harm.
- Voice of the patient – self report adverse incidents.

You are in 2020, medication reconciliation between settings (admission and discharge) is 100% reliable. What changes have we made to achieve this?

- Electronic care records, fully integrated, and real time.
- 24/7 working for all (healthcare).
- Dedicated pharmacists & technicians per ward L(MDT).
- Smart card – patient carries data.
- Summary care record.
- Patient responsibility.
- MDT responsibility from ambulance to GP.
- Timely.

At what points in their pathway are patients most at risk of harm from medication error? What can we do to make each of these points safer?

- Admission – Patients own drugs – out of date/not fit for purpose.
    - Medicines recon.
    - Medication review.
    - Transcription on prescription charts.
    - Community – faxed prescriptions difficult to read.
        - Rag medicines.
        - MUR's.

- During stay – Multiple prescription charts.
    - Monitoring.
    - Contraindications & interactions.
    - Staffing shortages.

- Any point of transfer – Integrated I.T.
    - Reducing transfers.
    - Standardized communication.
    - Robust processes.
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- Out of hours (inc weekends) – 24/7 care.
    - Effective board rounds.
    - Briefings/handover.