Evaluating Discharge Medication Errors Identified via the Medicines Helpline at University Hospitals Birmingham (UHB)

Jagjit Sagoo (Medicines Information, Solihull Hospital, Solihull), Katy Davies (Medicines Information, Solihull Hospital, Solihull), Lois Cobblah (Aston University), Mark Brennan (Aston University) and Ruth Edwards (Aston University).

INTRODUCTION

Medication errors remain an issue for healthcare professionals in all sectors. These preventable adverse events can result in harm to patients and cost implications for healthcare providers. Medication errors cost the NHS approximately £200-400 million per year[1]. It is imperative that there is an effective and continually emerging reporting culture to maintain patient safety and prevent recurrence. Errors happen for various reasons but they are more frequent during care transition (i.e. discharge). In this study, the types of medicine-error related enquiries received by the Medicines Helpline were evaluated in conjunction with the process of error management in Medicines Information (MI).

METHOD

Aims

The aim of this study was to evaluate the medication-related errors identified via the Medicines Helpline, and the process of resolution by the MI team at UHB. The findings of this research will then inform recommendations to prevent future medication errors, improve patient discharges across the Trust, and improve error management processes in MI.

Objectives

➤ To collate the types of medicine errors identified via the Medicines Helpline
➤ To calculate the number of enquiries related to a medication error received via the Medicines Helpline
➤ To determine if there is underreporting of medication errors within Medicines Information
➤ To make recommendations based on the findings of this study to improve error management processes in MI and reduce medication errors at discharge.

Methodology

Data was collected by a pharmacy undergraduate student from Aston University. Retrospective data collection involved reviewing all helpline enquiries from MiDatabank over a 12 month period and identifying those involving a medication-related error. Medication-related errors were identified using an error category classification system formed in the pilot collection period. The data collection tool was designed using Microsoft Excel. The data was then further broken down using Microsoft Excel and results were presented using descriptive statistics.

'One part of a patient's discharge letter states aspirin + NOAC lifelong but pharmacists section states clopidogrel + NOAC lifelong'

'Telmisartan suspended during admission but this was not documented on the discharge letter and the GP surgery have issued a supply to the patient'

RESULTS

Table 1 : The types and frequency of errors identified (n=169)

Error Type	Occurrence (%)
Documentation Error	42
Medication Error	26
Patient counselling Error	10
Dose/Strength Error	6
Contraindication	4
Frequency Error	4
Insufficient Medication	3
Labelling Error	2
Incorrect patient	1
Route/Formulation	1
Quantity Error	1

➤ 590 helpline enquiries were reviewed. Of these 169 (28.6%) error-related enquiries were identified.

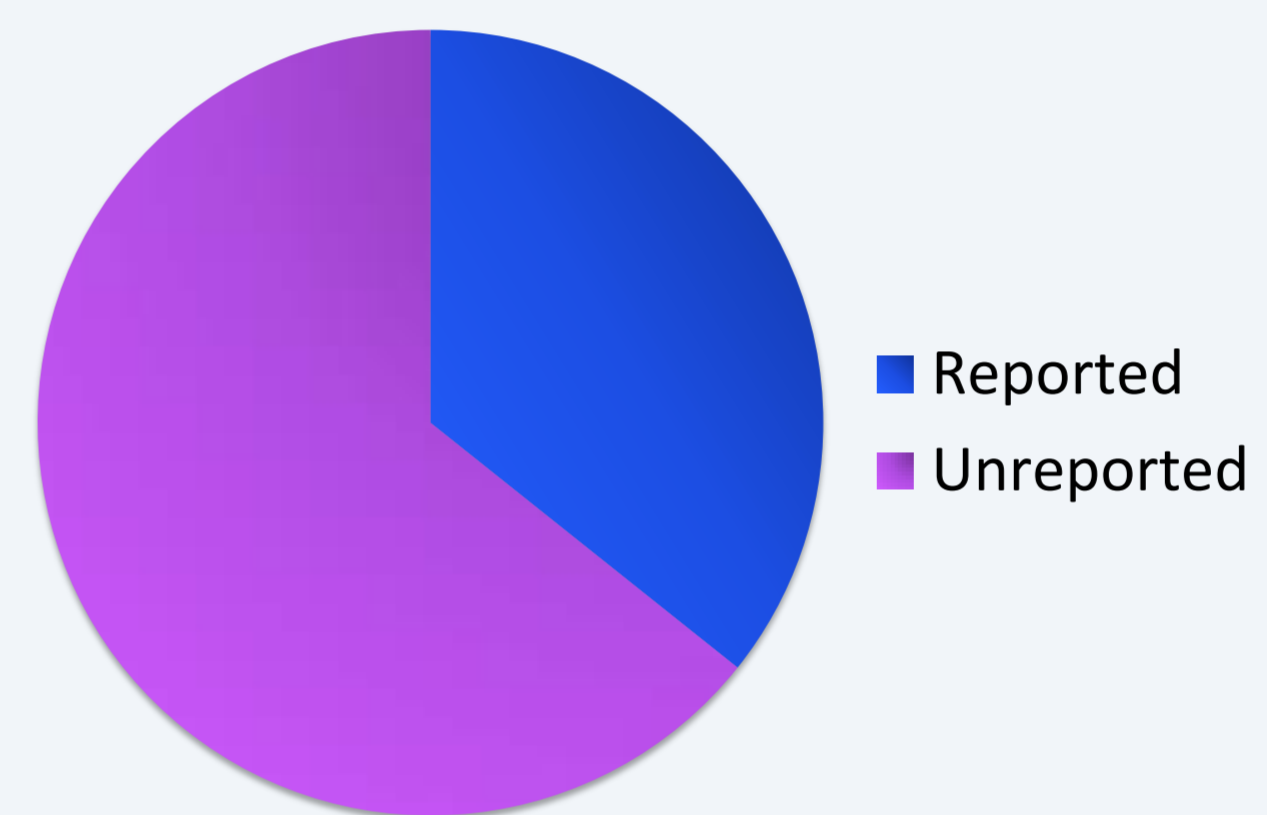
■ Reported
■ Unreported

Fig 1: The number of DATIX reports submitted versus the additional potential reports identified

'A patient was given someone else's co-amoxiclav'

'Enoxaparin not supplied on discharge post hemicolectomy'

DISCUSSION/CONCLUSION

➤ The most prevalent errors observed were documentation errors
➤ A large proportion of errors were not reported via DATIX.

RECOMMENDATIONS

➤ The introduction of a Medicines Helpline SOP, including criteria for when a DATIX should be completed, will facilitate consistent incident reporting within the MI team and reduce bias.
➤ This project has highlighted the need for regular feedback mechanisms to clinical pharmacy teams and Trust management via the Safe Medication Practice Group .
➤ Feedback to clinical pharmacy teams will raise awareness of issues and facilitate safer patient discharges at ward level and reduce the most frequent types of errors.
➤ Increasing awareness, and use of the Medicines Helpline, may lead to increased error identification, highlighting more areas for improved patient safety.

REFERENCES

1. Department of Health. Building a safer NHS for patients: Improving patient safety [Online]. London: Department of Health; 2004. Available at: https://webarchive.nationalarchives.gov.uk/20120504013729/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084961.pdf (Accessed: 24th June 2019).