Reducing the risk of recurrence of medicines incidents by closing the feedback loop

June 2017

<table>
<thead>
<tr>
<th>Trust name</th>
<th>Cornwall Partnership NHS Foundation Trust</th>
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<tbody>
<tr>
<td>Provider type</td>
<td>Mental health trust</td>
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<tr>
<td>Site (if applicable)</td>
<td>Bodmin Community Hospital</td>
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<tr>
<td>Core service</td>
<td>Mental health rehabilitation wards for working age adults</td>
</tr>
<tr>
<td>CQC rating (SAFE)</td>
<td>Good</td>
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<tr>
<td>CQC rating (Overall)</td>
<td>Outstanding</td>
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The issue

Fettle House is a mental health rehabilitation unit for adults, with capacity for 18 male or female residents. It is staffed by two nurses supported by four healthcare assistants. Service users range from those recovering from recent acute illness requiring psychiatric intensive care unit (PICU) admission to those who are nearly ready for discharge. The average length of stay varies from six months to two years.

The team was concerned about the amount of potentially avoidable harm caused by prescribing incidents. International figures suggest that up to 1 in 10 patients admitted to hospital are subjected to avoidable harm, often due to prescribing errors. The team identified that there was no system in place to ensure that prescribers were made aware of their involvement in an incident and therefore given the opportunity to reflect and improve prescribing practice to reduce this risk.

Also, Fettle House staff who reported a prescribing incident didn’t receive any feedback once the relevant investigations had been completed. This was demoralising and made them question the value of reporting such incidents.

The solution

All relevant prescribing incidents are now notified to the clinical director directly from the trust incident reporting system.

A procedure has been devised to provide feedback to the prescriber and encourage them to engage in private and public reflection (with their supervisor) on the incident and its causes.

The prescriber is also invited to suggest how to improve processes, in acknowledgement of the huge part that such systems can play in reducing the risks.
Enablers and challenges

Consistently encouraging a learning approach to incidents and avoiding a blame culture were critical to the success of this initiative.

Good engagement with all relevant stakeholders was important, especially with junior doctors, who are the largest group of prescribers. The well-established relationships between junior doctors and educational supervisors were helpful in encouraging reflective practice.

Some aspects of organisational culture were difficult to change and required patience and tact; this included involving key individuals at an early stage.

Impact

The improvement initiative was evaluated quantitatively, using the number of incidents and level of harm in prescribing incident reporting as outcome measures. Although there was high variability in the number of incidents reported each month, following the introduction of this initiative the overall trend in prescribing incidents was downwards. This was triangulated with information from the pharmacy team, who were confident that most prescribing incidents continued to be reported centrally. Therefore, it was unlikely that this was a deterioration in reporting culture.

The fact that the share of low harm incidents increased is a further indication that there continued to be a good incident reporting culture in the trust.

Doctors have become more engaged in the process and it is now routine practice for trainees in relevant departments to discuss incident reporting with their supervisors.

Next steps and sustainability

The trust has introduced appropriate governance to ensure the sustainability of the initiative.

It has also now been presented to all the doctors in the organisation, through grand rounds presentation and other communication methods. This has triggered discussions about incorporating the same feedback mechanism for other types of incidents besides prescribing errors.

The trust is also considering how to adapt the technology used for incident reporting to automatically identify relevant incidents and notify appropriate stakeholders, triggering the feedback and reflection process as early as possible.
Want to know more?

Contact Dr Celice McDermott, Consultant in Rehabilitation Psychiatry, and Inpatient Service Clinical Director on celice.mcdermott@nhs.net

To see the other case studies in this series: visit the NHS Improvement website at: Improving quality and safety in healthcare.