prn
CLINICAL PHARMACY SOLUTIONS SINCE 1997

REDUCING MEDICINES ERRORS IN CARE HOME RESIDENTS

Two thirds of care home residents in a recent study were exposed to one or more medicines errors; several errors had caused harm or were likely to.[1]

At PRN, we have extensive experience of providing ***high quality*** clinical medication review services in domiciliary settings, including Care Homes. In a recent contract we took action to improve medicines safety and ***productivity*** for example:

- *Reducing wastage by improving the process for issuing repeat prescriptions to Care Home residents*
- *Reducing communication and records problems by reconciling medicines records between the Care Home and the GP practice*
- *Preventing overuse of medicines that should be prescribed for a limited duration*
- *Reducing inappropriate use of antipsychotics in dementia*
- *Rationalising use of medicines to reduce cardiovascular risk in the very elderly*
- *Increasing treatment for fracture prevention*
- *Reducing blood glucose monitoring in diabetics controlled by diet and /or metformin*
- *Highlighting unmet training needs with regard to medicines administration amongst staff in the Care Home*

Reference

[1]Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people. N D Barber et al. Qual. Saf. Health care 2009; 18; 341-346

PRACTICAL SUPPORT FOR HIGH QUALITY MEDICINES ADMINISTRATION BY COMMUNITY NURSES

The National Patient Safety Agency (NPSA) report, *Safety in Doses, Improving the Use of Medicines in the NHS*, shows that there has been an increase in the reporting of medication-related safety incidents in 2007.

- *Community nursing and medical services reported over 5,500 (8%) of all incidents*
- *Most serious incidents were caused by errors in medicines administration (41%)*
- *Incidents involving injectable medicines represent 62% of all reported incidents leading to death or severe harm*

Among the NPSA's recommendations to minimise medication errors are improvement of staff skills and competence and introduction of robust procedures for handling medicines, particularly injectable medicines.

At PRN, we have developed and refined a patient safety toolkit to enable safer administration of medicines by district nursing teams. Our toolkit comprises:

- *A series of customisable Standard Operating Procedures (SOPs) covering all aspects of medicines handling in the community*
- *Administration checklists for "high risk" medicines*
  - *insulin*
  - *anticoagulants*
  - *strong topical and oral opioids*
- *Bespoke practical training solutions*

These ***innovative*** resources are designed to support ***high quality*** medicines administration and to ***prevent*** medicines administration errors.

DELIVERY OF SUSTAINABLE PRESCRIBING CHANGE IN GP PRACTICES

PRN has developed a standard model to support sustainable rather than short-term prescribing change. The model is underpinned by a programme of ***high quality,*** evidence based ***Medicines Education At Lunch (MEAL)*** interactive workshops designed to engage the full GP practice clinical team.

The 3 level model comprises:

Level 1 – In practice medicines education (MEAL)

Level 2 – In practice medicines education (MEAL) plus facilitation of a tailored action plan to enable the GP practice team to implement associated change in practice

Level 3 – Level 2 plus hands on operational support from the PRN team to implement prescribing and process changes

The MEAL programme is designed to support implementation of national and local priorities including, Better Care Better Value Prescribing Indicators, NICE guidance, National Service Frameworks and NPSA guidance.

The model is designed for flexible commissioning to address the different needs, ***productivity*** opportunities and capacity in individual GP practices within your organisation to deliver prescribing change within existing resources.

RECONCILIATION, MEDICATION REVIEW AND REPEAT PRESCRIBING REVISITED

In October 2009, the Care Quality Commission published a study which raised concerns about a number of areas in the medicines management process that occur between GP practices and hospitals. [2]

Subsequently there is a renewed emphasis on safe processes for reviewing medication changes and updating patients' records after they are discharged from hospital and for the quality and timeliness of medication review.

At PRN, we are experts at working with GPs to monitor their medicines systems, re-design their medicines processes and develop their practice staff to implement ***high quality*** change in line with good practice.

Over the last decade, we have created and refined a portfolio of tools including template medicines policies, medicines process audits and educational resources to support GPs to demonstrate safe medicines practice. All our tools can be tailored to meet the individual needs of PCTs and practices.

Reference

[2] Managing patients' medicines after discharge from hospital. Care Quality Commission, October 2009

ABOUT PHARMACEUTICAL RESOURCE NETWORK LTD (PRN)

The PRN team is expanding and our vision is to become a leading provider of professional clinical pharmacy services. We are actively seeking opportunities to contract for medium and long-term operational services including:

- **Hands on prescribing support to GP practices**
- **Domiciliary clinical medication review and medicines adherence services for patients that cannot access the GP practice setting (e.g. House bound patients and Cares Homes residents)**
- **Workforce development to increase the capacity of clinical pharmacists in primary care**

PRN is an independent clinical pharmacy service established in 1997 with extensive experience in delivery of clinical services in primary care. All of our products and services are designed to meet the Department of Health ***Quality, Innovation, Productivity, Prevention (QIPP)*** challenge.
More information about PRN and our team is available at *www.prn.org.uk*