ROYAL PHARMACEUTICAL SOCIETY

How to reduce medication errors & Quality Improvement (QI)

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Workshop Structure

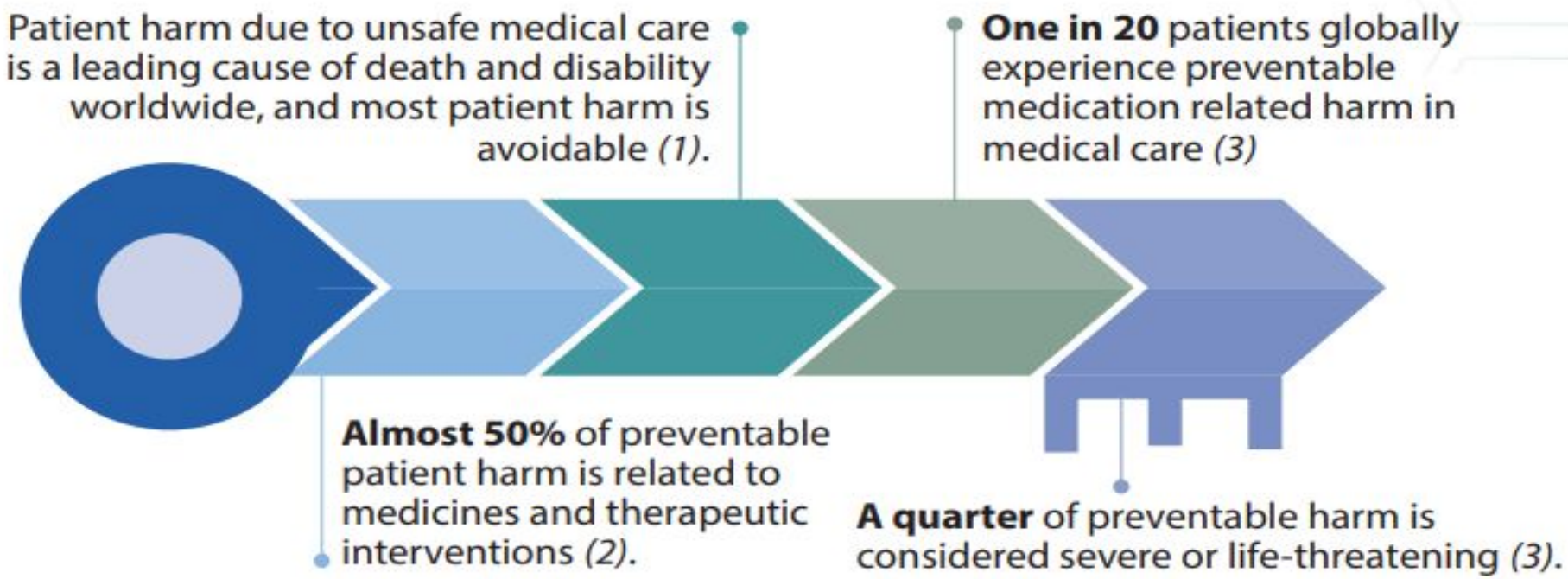
Definitions

***Preventable* ADEs** are **medication errors**, defined as "**any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer**.

Such events may be related to professional practice, **healthcare products**, procedures, and **systems**, including **prescribing, order communication, product labelling**, packaging and nomenclature, compounding, **dispensing, distribution, administration, education, monitoring, and use**."

[1]WHO, March 2024. Medication without harm, Policy brief. Available from: https://www.who.int/publications/i/item/9789240062764#:~:text=This%20document%20is%20a%20resource%20for%20policy-makers%2C%20health,WHO%20Global%20Patient%20Safety%20Challenge%3A%20Medication%20Without%20Harm.

Statistics (Global)



Statistics (England)

[2]RA, Elliott., et al., 2020. BMJ Qual Saf 2021;30:96–105. doi:**10.1136/bmjqs-2019-010206**
[3]NHSE Patient Safety Incident Data Quarterly Publication Quarter 3 (October to December 2024). Available from:**https://www.england.nhs.uk/statistics/statistical-work-areas/patient-safety-incident-data/2024-25/q3/**

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[2]RA, Elliott., et al., 2020. BMJ Qual Saf 2021;30:96–105. doi:10.1136/bmjqs-2019-010206

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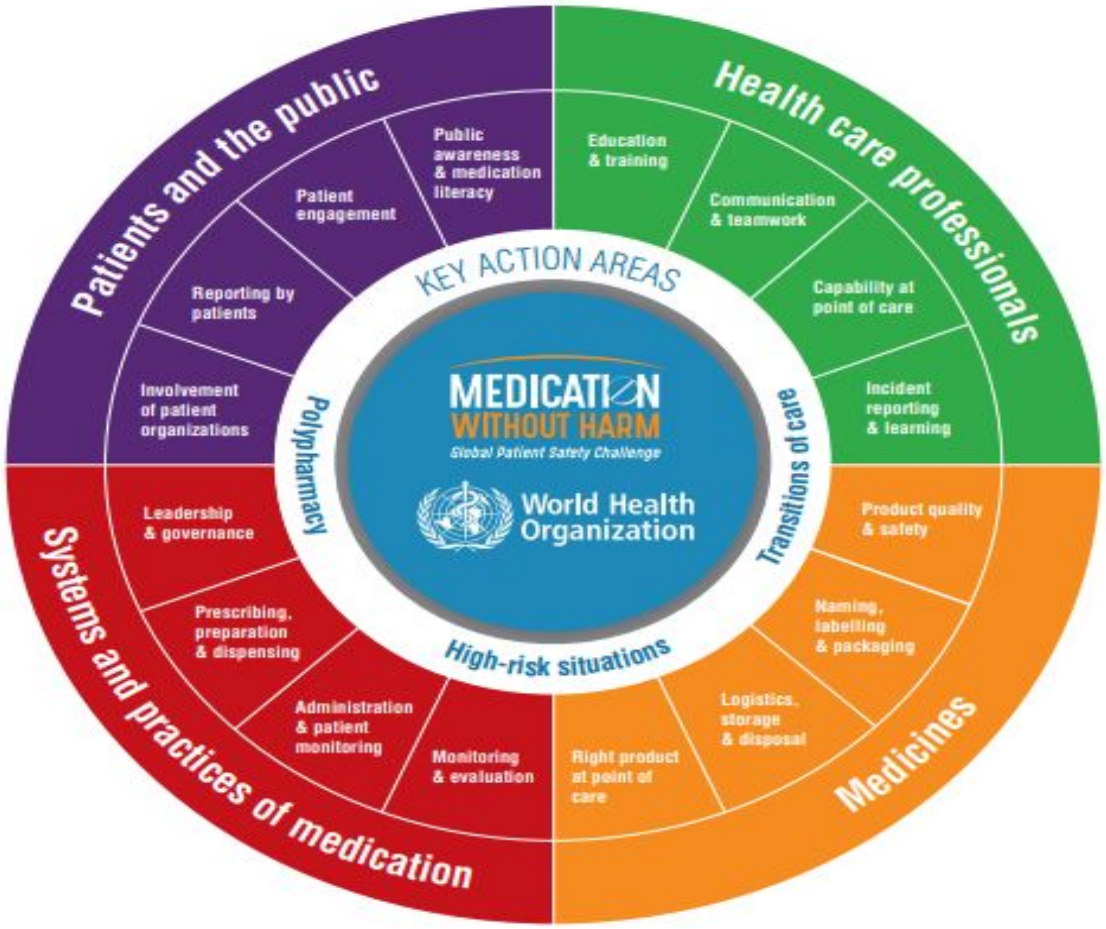
[2]RA, Elliott., et al., 2020. BMJ Qual Saf 2021;30:96–105. doi:10.1136/bmjqs-2019-010206

[4]Avery et al, 2020. Incidence, nature and causes of avoidable significant harm in primary care in England: retrospective case note review [Online]. Available from: https://qualitysafety.bmj.com/content/30/12/961

WHO Medication Without Harm – Key Messages



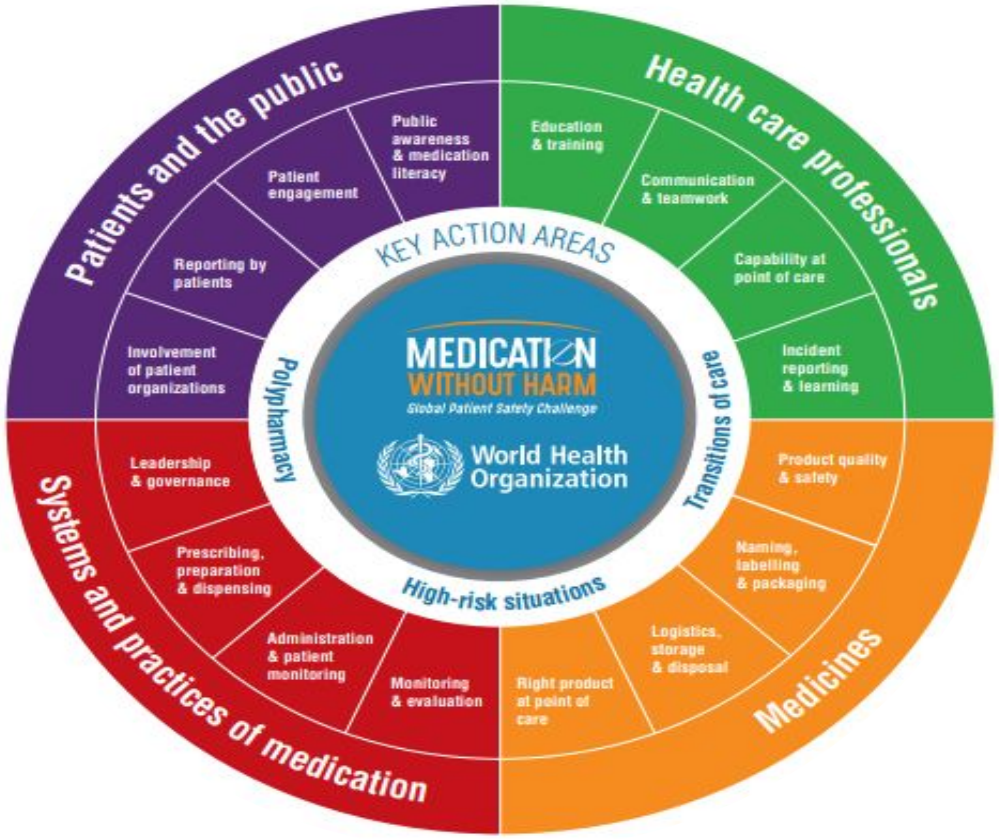
- The **WHO's Third Global Patient Safety Challenge: Medication Without Harm** aims to **reduce the global level of severe, avoidable harm related to medications by 50% over a period of 5 years**.

- WHO identified three early priorities for action: **high risk situations, polypharmacy** and **transitions of care**.

[1]WHO, March 2024. Medication without harm, Policy brief. Available from: https://www.who.int/publications/i/item/9789240062764#:~:text=This%20document%20is%20a%20resource%20for%20policy-makers%2C%20health,WHO%20Global%20Patient%20Safety%20Challenge%3A%20Medication%20Without%20Harm.

WHO Medication Without Harm – 4 domains of the Challenge

- Systems and practices of medication
- Health care professionals
- Patients and the public
- Medicines



[1]WHO, March 2024. Medication without harm, Policy brief. Available from: https://www.who.int/publications/i/item/9789240062764#:~:text=This%20document%20is%20a%20resource%20for%20policy-makers%2C%20health,WHO%20Global%20Patient%20Safety%20Challenge%3A%20Medication%20Without%20Harm.

Domain 1 - Systems and practices of medication (Leadership & Governance)

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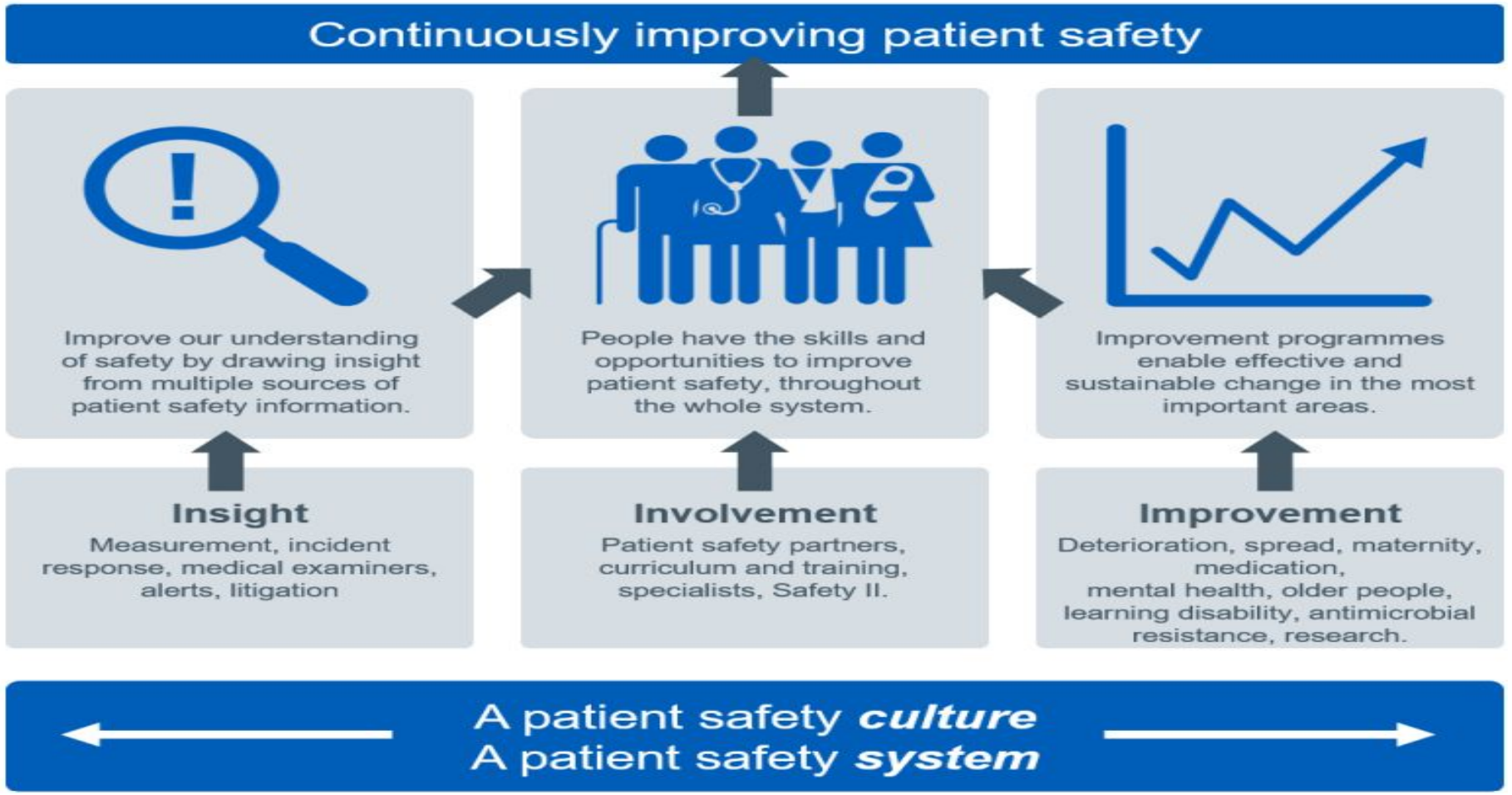
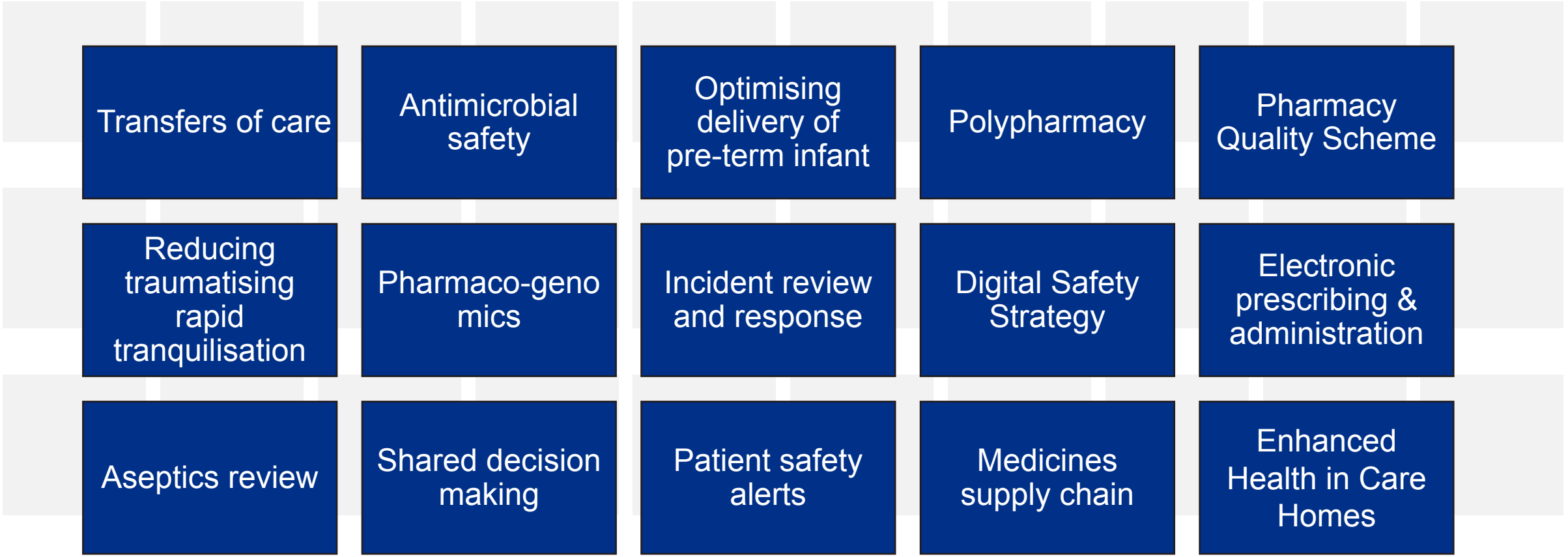


[5]The NHS Patient Safety Strategy Safer culture, safer systems, safer patients, July 2019. Available: https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

NHS England National Medicines Safety Improvement Programme



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NHS England Medicines Safety Priorities 2024-2027

Reduce severe avoidable medication-related harm by 1/3 by 2027

- **Medication safety leadership approach**
  - Empower the Medication Safety Officer workforce
  - Increase reliable administration of time critical medicines
- **Whole system approach**
  - Reduce harm from opioids used in chronic pain
  - Reduce harm from psychotropics in learning disability
  - Reduce harm from falls-risk inducing drugs in frailty
  - Reduce harm from valproate taken in pregnancy
- **Targeted approach (primary care)**
  - Reduce acute kidney injury inducing polypharmacy
  - Perfect dosing of direct oral anticoagulants

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Domain 2 - Healthcare professionals (Education & training; Incident reporting & learning)

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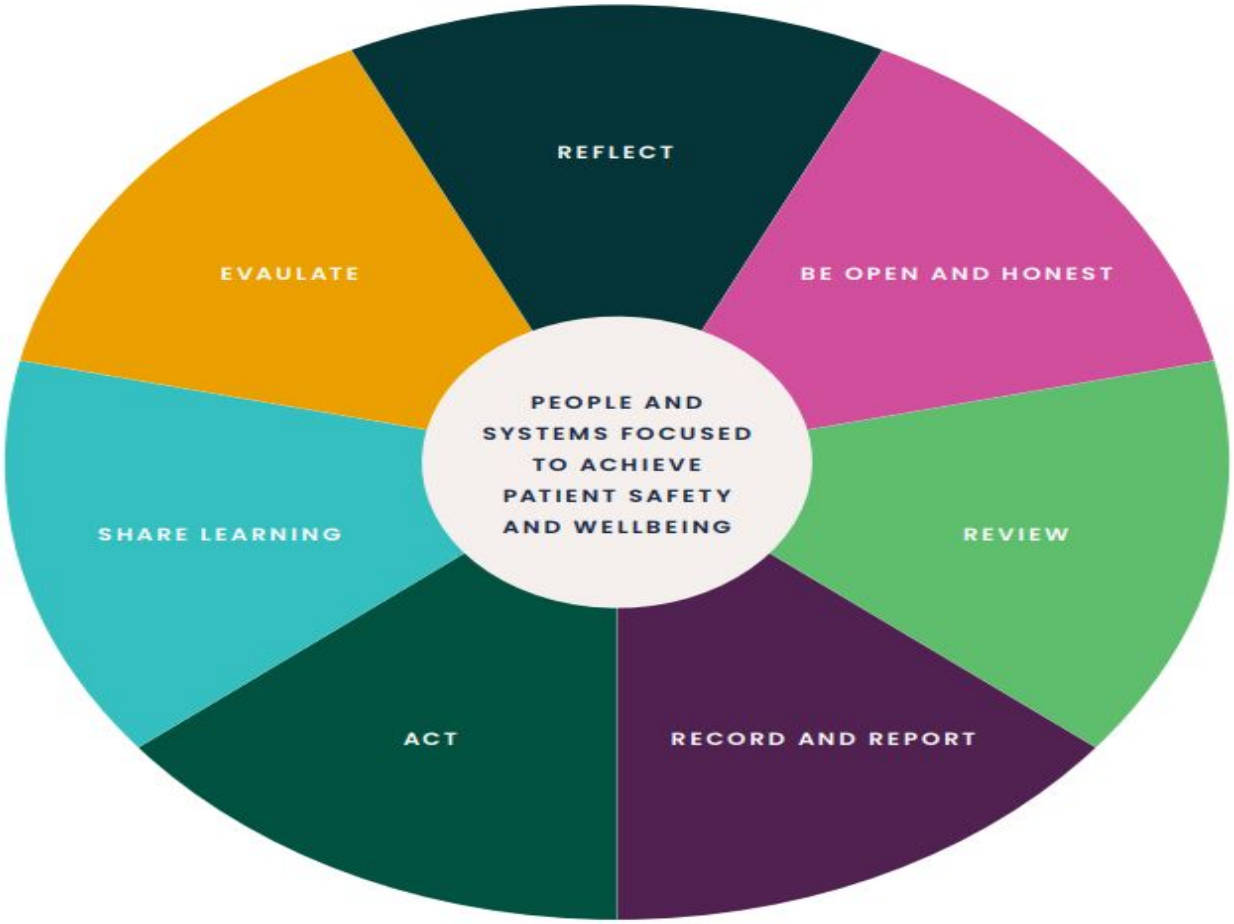
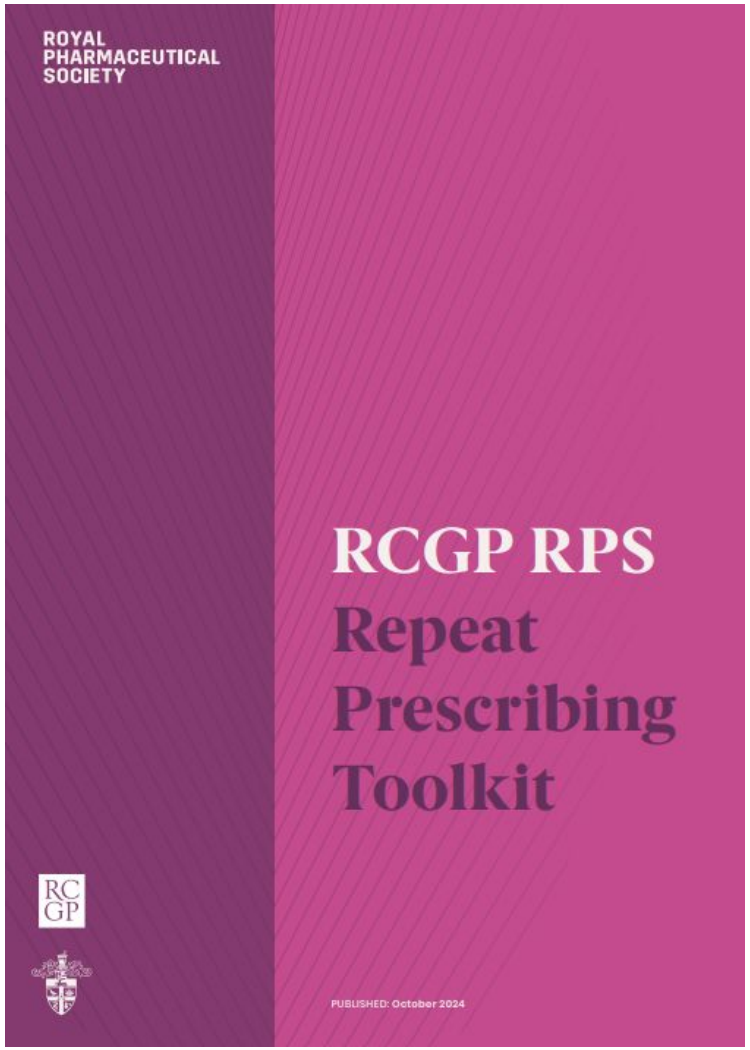


Domain 2 - Healthcare professionals



Domain 2 - Healthcare professionals

Domain 3 - Patients and the Public

[6]Patient Safety Commissioner England, 2024. Patient Safety Principles [Online]. Available from: https://www.patientsafetycommissioner.org.uk/

Domain 4 – Medicines

[1]WHO, March 2024. Medication without harm, Policy brief. Available from: https://www.who.int/publications/i/item/9789240062764#:~:text=This%20document%20is%20a%20resource%20for%20policy-makers%2C%20health,WHO%20Global%20Patient%20Safety%20Challenge%3A%20Medication%20Without%20Harm.

Quality Improvement (QI)

[7]Patient Safety Learning Hub, March 2024. Improving safety in healthcare—is quality improvement the answer? A blog by Claire Cox [Online]. Available from: https://www.pslhub.org/learn/improving-patient-safety/improving-systems-of-care/quality-improvement/improving-safety-in-healthcare%E2%80%94is-quality-improvement-the-answer-a-blog-by-claire-cox-r12833/

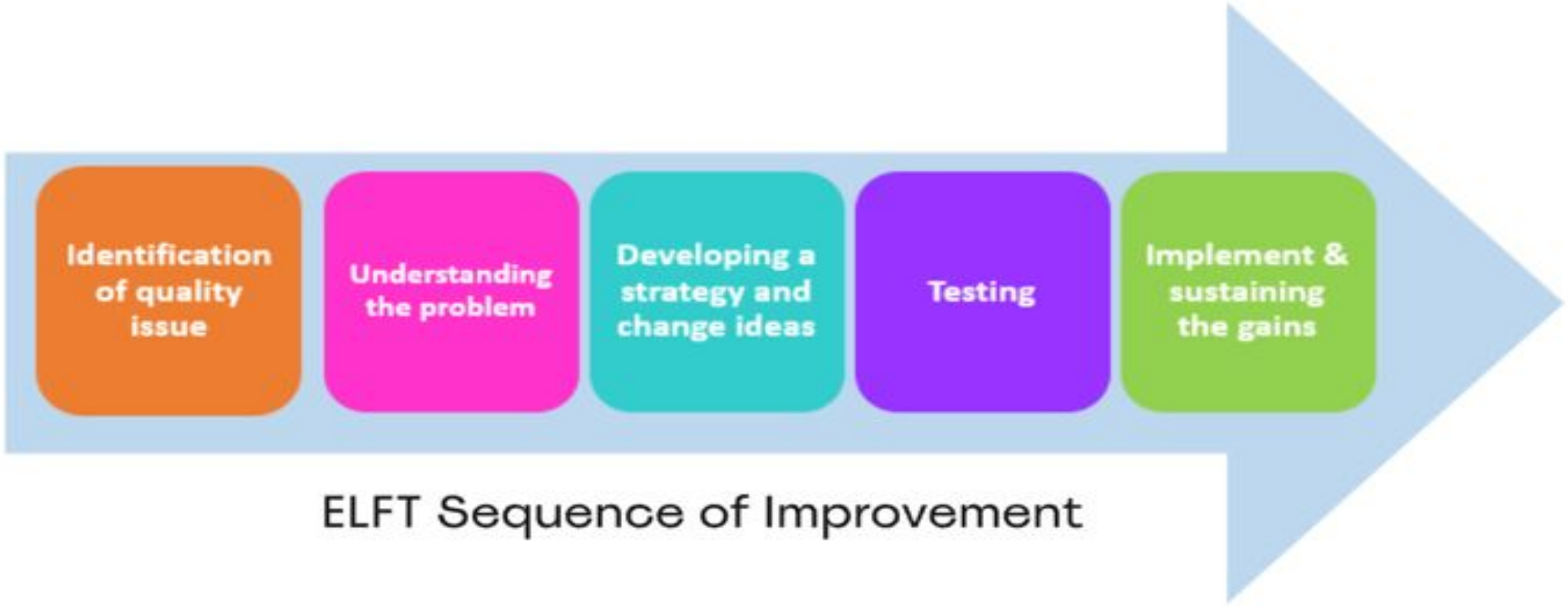
[9]NHS East London NHS Foundation Trust Quality Improvement. Available from: https://qi.elft.nhs.uk/

Quality Improvement (QI)

[7]Patient Safety Learning Hub, March 2024. Improving safety in healthcare—is quality improvement the answer? A blog by Claire Cox [Online]. Available from: https://www.pslhub.org/learn/improving-patient-safety/improving-systems-of-care/quality-improvement/improving-safety-in-healthcare%E2%80%94is-quality-improvement-the-answer-a-blog-by-claire-cox-r12833/

[8]Institute for Healthcare Improvement, https://www.ihi.org/

Quality Improvement (QI) – what is the problem?



Quality Improvement (QI) – Understanding the problem

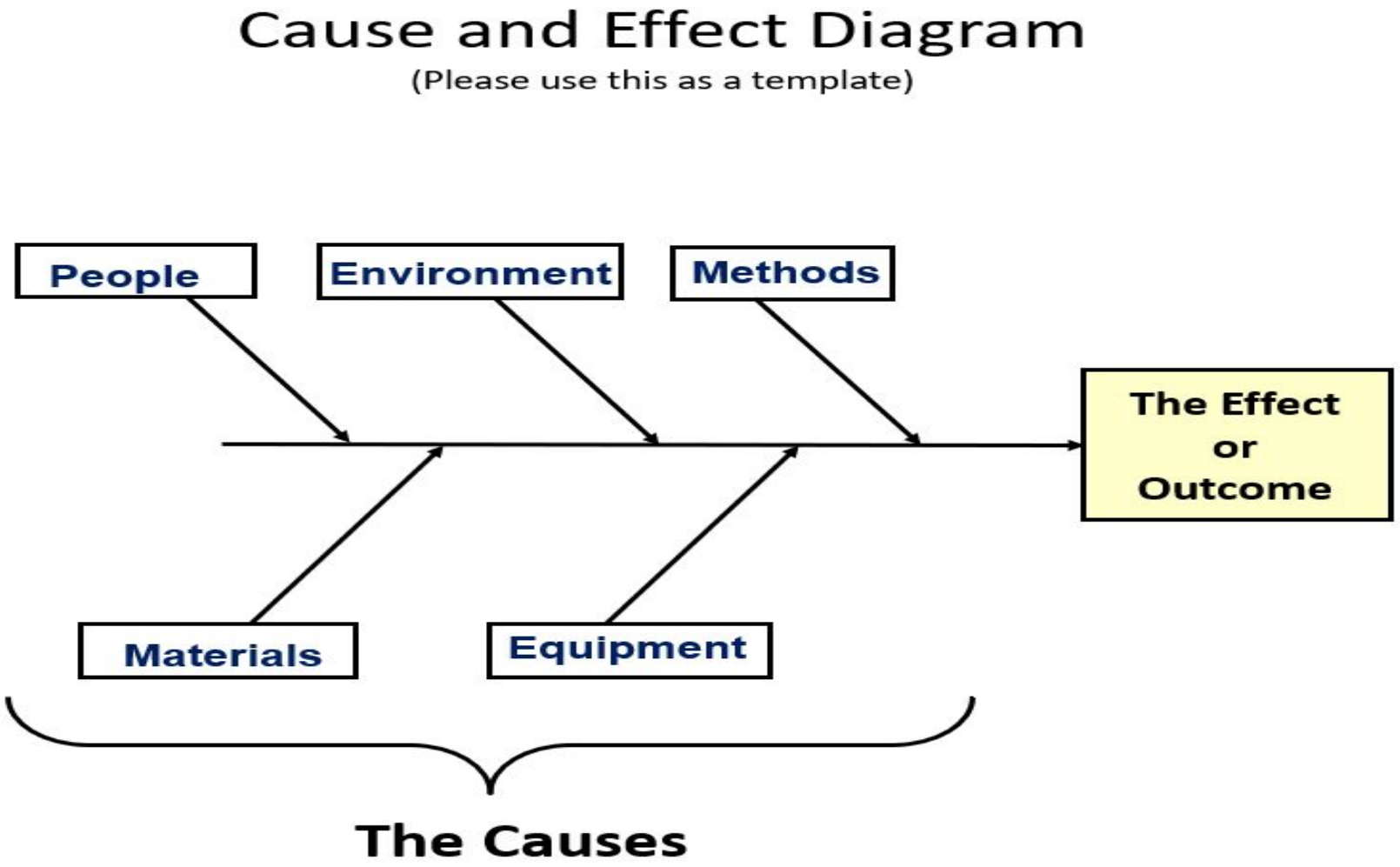
Purpose:

- Develop a shared understanding of what is currently happening
- See the system from multiple perspectives
- Identify key levers for change

Tools & Methods:

- Interviews
- Surveys
- Process mapping
- Pareto charts
- Fishbone diagram
- 5 Whys
- Baseline data - run charts/control charts

Quality Improvement (QI) – Understanding the problem QI tool



Key Take Home Messages

Useful resources and links

Thankyou!

SECTION – Q and A