Pharmacy Interface Incident Quarter 3 Summary Report 2016-17

This report provides an overview of the interface incidents reported during quarter 3, 2016-17. The report summarises the number of reports received, incident types reported and actions taken.

1.0 Number of incidents per severity

Table 1 demonstrates the severity and number of interface incidents received and recorded within the Safeguard incident report system at WUTH. This in turn reports to the National Reporting and Learning System (NRLS). The table outlines the **actual harm** score attributed to each incident or report.

1 – No Harm	2 – Very Low Harm	3- Low harm	4 – Moderate	5 – Severe/Death
4	0	0	0	0

Table 1: Severity and number of interface incidents

4 reports were received during Quarter 3. A response was sent within the agreed 15 working day timescale for all reports. A further report was received which upon investigation, was not deemed to be a secondary care prescribing error.

2.0 Types of Incident

2 reports were related to non-formulary drug requests, 1 was a dispensary supply issue and 1 report was related to a recommendation for prescribing interacting medication.

3.0 Actions taken as a result of incidents reported

The WUTH Medicines Management Team has an escalation system for managing incidents where the same prescriber repeatedly requests inappropriate formulary/shared care or non-formulary prescribing:

- On first occasion, the Pharmacy CG team will discuss with the prescriber
- On second occasion, the Wirral Drug and Therapeutics Panel (WDTP) Secretary will contact the prescriber
- On third occasion, a letter from the WDTP Chair and Director of Pharmacy will be sent to the prescriber, copied to the Clinical Service Leads and if necessary further escalation to Divisional Management Team.

3.1 Recommendations to prescribe non-formulary medication/ formulary medication for indications outside of Wirral Formulary

The first report related to the request to prescribe gold capsules for a patient seen by the ophthalmology department. This is the third time the prescriber has recommended the prescribing of gold capsules to primary care, hence the issue has been escalated in line with the agreed process.

The second report involved the recommendation to prescribe tadalafil on a daily basis, which is not in line with current guidance. The prescriber has been informed and advised not to prescribe for a non formulary indication. The interface report was received 6 months after the secondary care request was made and the patient has subsequently switched to a formulary alternative.

3.2 Dispensary supply discrepancy

A report was received regarding the supply of oral vancomycin capsules on discharge. A 14 day supply was dispensed but the prescription required a 31 day reducing course and the discharge summary stated 'GP not to continue'. Whilst is it agreed process for WUTH pharmacy to supply 14 days of medication, it would be usual practice to ensure the GP is aware that they will be required to prescribe the outstanding balance. An apology was offered to the GP and the Lead Dispensary Pharmacist has reminded staff to ensure that in cases like this we will ensure the discharge summary is clear regarding what medicines require a further supply by the GP.

3.3 Recommendation to prescribe interacting medication

The final report detailed the recommendation to co-prescribe clopidogrel and omeprazole. The Pharmacy Clinical Governance team have informed the prescriber and the pharmacist who had verified the prescription. The pharmacist has reflected and has apologised for the oversight. They are aware of the interaction and will make sure in future that the omeprazole is changed to lansoprazole if clopidogrel is co-prescribed. The prescriber has been asked to provide feedback on the error but this has not yet been received by the Pharmacy Clinical Governance team at the time of writing of the report.

4.0 Summary and Recommendations

2 reports were related to non-formulary drug requests, 1 was a dispensary supply issue and 1 report was related to a recommendation for prescribing interacting medication. In line with the agreed escalation process, one non–formulary request reached first stage escalation ie the prescriber was contacted by the Pharmacy Clinical Governance Team and the other incident reached third stage escalation ie the prescriber was contacted by the Wirral Drug and Therapeutics Panel (WDTP) Secretary.

GP practice and CSU MM team staff are recommended to review the current level of under reporting of prescribing issues so that inappropriate requests can be addressed and prescribing standards improved. Any feedback or improvements that can be made to the process are welcomed so that this goal can be achieved.