Pharmacy Interface Incident Quarter 1 Summary Report 2016-17

This report provides an overview of the interface incidents reported during quarter 1, 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

5 reports were received during Quarter 1. A response was sent within the agreed 15 working day timescale for all reports. One report was deemed not an issue that that could be resolved via the interface reporting system so the GP was advised to contact the Consultant team directly.

6 reports were received during quarter 4 2015-16. The overall number of reported interface incidents has significantly declined over the past 2 years, with a total of 15 reports being received during 2015-16, compared to 20 reports during 2014-15, and 141 during 2013-14.

2.0 Types of Incident

3 of the 4 incidents investigated during quarter 1 relate to recommendations to prescribe non-formulary medication. One report relates to information provided on the discharge letter.

3.0 Actions taken as a result of incidents reported

The WUTH Medicines Management Team have 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

One report related to the request to prescribe a non-formulary drug, anagrelide on a discharge letter.

Upon investigation the Pharmacy Clinical Governance team clarified that the patient was already taking anagrelide prior to the admission. The patient is under the care of a Haematologist who prescribes the anagrelide, which WUTH Pharmacy supply. Anagrelide was listed on the TTH for information but the GP was not expected to prescribe it. This was therefore not classified as an incident.

The second report received related to a request to initiate Macushield Gold capsules, following an out-patient ophthalmology appointment. The GP did not prescribe the drug but suggested the patient purchase them from their community pharmacy. Macushield Gold capsules are indeed non-formulary and WUTH Medicines Management Team are not aware of a Wirral D+T application for the use of this medicine. As per the agreed escalation process, the Consultant has been informed that Macushield gold capsules are non-formulary and that a D+T application is required and will need to be approved before the drug is prescribed.

The third report relates to the inappropriate request to prescribe the non-formulary drug linagliptin. The patient had reduced renal function so sitagliptin had been withheld during the admission. The ward pharmacist advised linagliptin based on the clinical situation but did not refer to the formulary. The pharmacist has reflected on the incident, it was an oversight that they didn't check which gliptins are available on the Formulary and will now ensure they follow the correct process. Pharmacy have now amended dispensary processes so there is a prompt on the pharmacy dispensing system. A request for a non-formulary drug will require a valid reason being given by the ward pharmacist before it is dispensed.

3.2 Unclear medication discharge information

This report related to discharge letter comments suggesting that the GP should restart losartan, when the patient was already taking irbesartan. Upon investigation it was evident that this recommendation was made in error. The comment was written before the patient was discharged and was superseded by further comments documented in the 'additional medication comments' section of the discharge letter. The original comments should have been deleted. The additional comments state that the irbesartan has been restarted and the Pharmacy Clinical Governance team confirmed that this was correct. The intention was for the GP to review urea and electrolytes (sodium had been low during admission), blood pressure and review the need for bendroflumethaizide and dose of irbesartan.

4.0 Summary and Recommendations

2 interface reports highlighted the inappropriate request to prescribe non-formulary medication. In line with the agreed escalation process, these reached first stage escalation ie the prescriber was contacted by the Pharmacy Clinical Governance Team.

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.