Prescribing error reporting, facilitating learning and patient safety across primary care

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Introduction

There are well-established benefits from reporting medication errors and identifying patterns to help prevent future harm[1]. Prescribing errors from general practice and community services are often identified and rectified in community pharmacy.

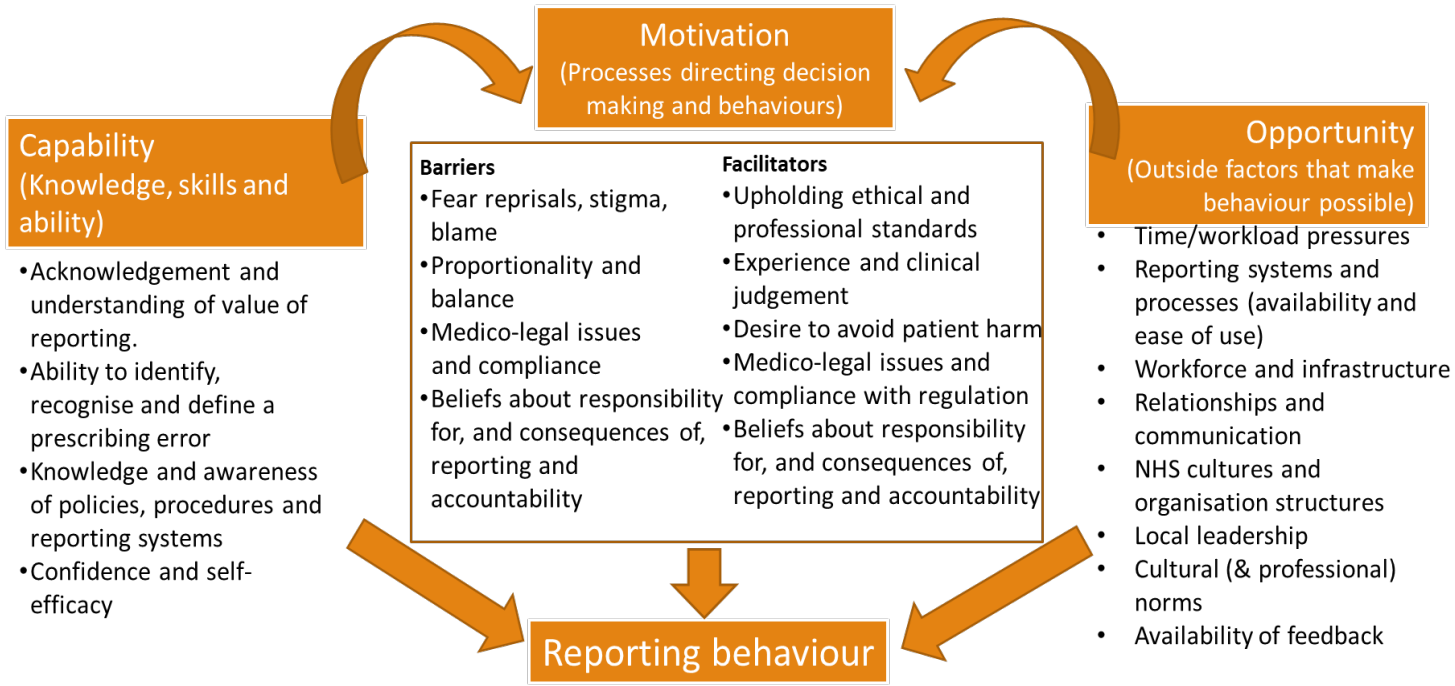
In the UK, organisational structures within NHS primary care mean that boundaries between independent organisations may act as barriers to error reporting and associated learning. We therefore aimed to identify key facilitators and barriers to facilitating cross-organisational prescribing error reporting and learning across primary care

Methods

Qualitative semi-structured face to face and telephone interviews (n=25) with pharmacists, primary care prescribers and other key stakeholders from across North East England

Results

There were three key areas identified in our analysis: inconsistent reporting of prescribing errors across primary care, the behavioural influences on reporting mapped to the Capability, Opportunity and Motivation framework (Figure 1) and how feedback and learning is linked to reporting behaviours.



What prescribing errors do you report?

Discussion

Prescribing error reporting in primary care is most likely to happen when the error aligns with clearly established reporting processes and systems associated with 'significant events' in general practice or dispensing errors in community pharmacy.

Further work to enable consensus on shared priorities and reporting thresholds is required to facilitate more consistency of reporting prescribing errors across primary care in a way that acknowledges the complexity associated with the classification of prescribing errors and the barriers to reporting.

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PREPARE Study

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