Non-Medical Prescribing: How safe are we?

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NMP

- Cumberland Report 1986: first recommended community nurses prescribe from a restricted list
- NMC 2010: 54,000 Community Nurse Prescribers and 19,000 Independent/ Supplementary Prescribers on register.
- 2010: 12.8 million individual items prescribed by nurse prescribers.
- New Cross Hospital 2012: 86 nurse prescribers working for the trust with 47 acute nurse prescribers of which 2 work within Cardiothoracic's.
- DoH 2006: Non medical prescribers benefit patients by providing more efficient access to medicines and puts staff skills to better use.
- Nurse Independent Prescribers are specially trained nurses allowed to prescribe any licensed and unlicensed drugs **within** their clinical competence.




Who are we?

Cardiothoracic Nurse Practitioners

New role since Oct 2007
Replaced SHO's
Total 4 nurses –
2 x Band 7 Prescribers (INMP),
2 x Band 6 – undertaking prescribing course.

27 bedded ward inc 8 HDU/ Step-down beds
6000+ patients admitted for surgery since role introduced
Cover 7 days a week, minimum 12.5hrs a day.

10 Surgical Registrars and 7 CT Consultants

Why Audit?

- Lots of qualitative data looking at patient satisfaction and doctors perceptions of nurse prescribers.

- Minimal quantitative data looking at safety of prescribing and errors.

  Latter 2011 – safe and appropriate nurse prescribing.

- Constraints on medical staff = increased specialist nurses roles, such as prescribing.

  But are we supported, trained and ultimately safe for our patients, ourselves and the team?

Standards

Table 1. - Criteria and Standards audited against relating to Policy MP01 and MMH-004*

Policy Ref	Standard	Compliance% Required
4.1 (*1.1)	Prescriptions must be written in black ink	100
4.1 (*1.1)	Prescriptions must be written in block capitals	100
(*1.2)	Drugs should be prescribed by their approved drug names	100
(*1.3)	The SI system of scientific notation should be used in all cases.	100
(*1.3)	All prescriptions for inpatients should be written clearly on official stationary.	100
4.1 (*1.4)	All charts require as a minimum:	
4.1 (*1.4)	Patients full name	100
4.1 (*1.4)	Hospital number	100
4.1 (*1.4)	Date of Birth	100
4.1 (*1.4)	Name of responsible consultant	100
4.1	Current ward	100
4.9 (*1.4)	Allergies are correctly documented	100
(*1.7)	When cancelling a prescription, the doctor should draw a diagonal line through both the drug name and any unused administration record boxes	100
(*1.7)	If multiple treatment sheets are in use for one patient, they should be clearly numbered on the front cover in chronological order of use	100
	If warfarin/insulin treatment sheets are used for a patient, the drug should also be prescribed on the main sheet	100
	Total number of amended prescriptions	0
	Total number of amendments signed or initialled	0
	Total number of amendments with date of amendment	0
	Total number of amendments relating to:	
	Dose	0
	Frequency	0
	Route	0

It is important to note that according to policy reference number 1.7, if it is necessary to change a prescription, the original must not be altered, but should be cancelled and a new prescription written as a separate item. Therefore the compliance required for these standards is 0%.

Type 1 and 2 Errors

- Trust definition developed to define a prescribing error

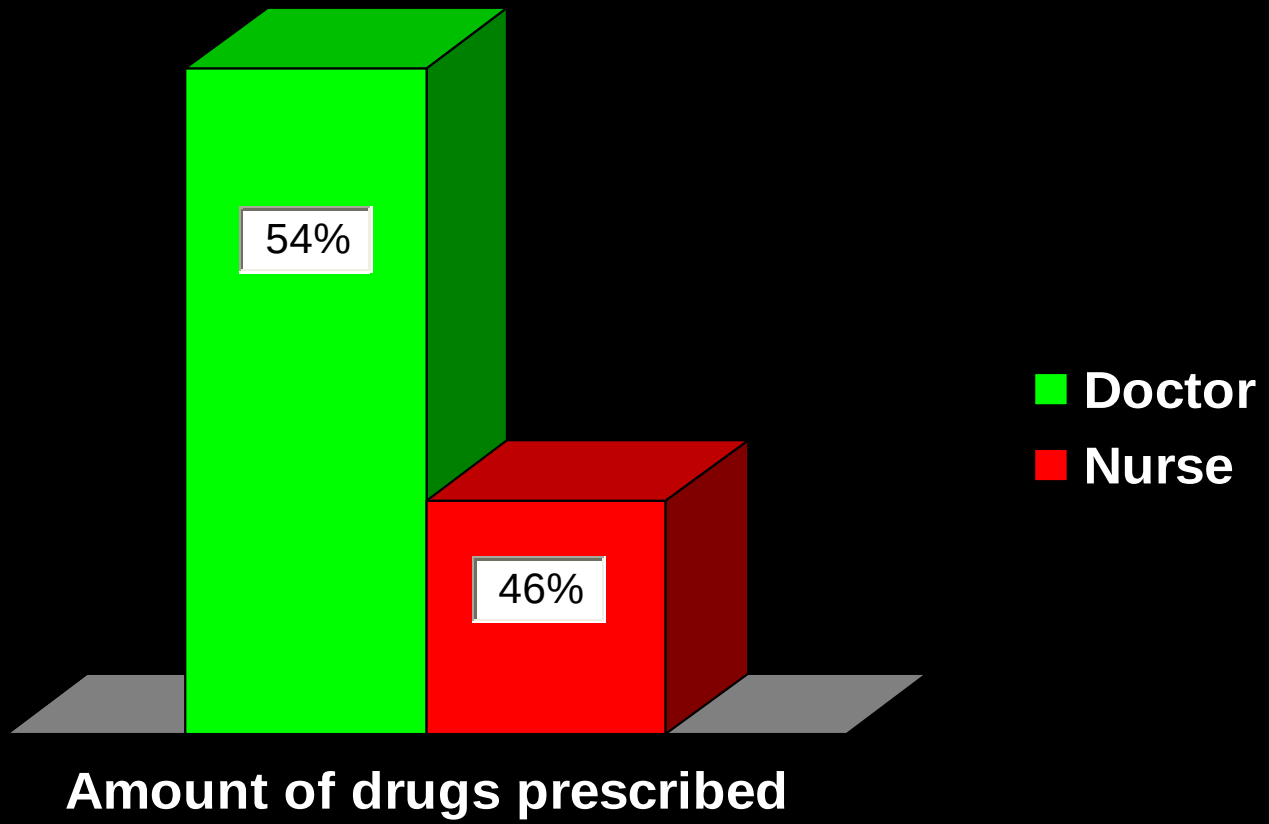
- Type 1
  Calculation errors (not administered)
  Incorrect dose, frequency, duration (no actual patient harm)
  Omission (no actual harm)

- Type 2
  Never Event
  Errors resulting in actual patient harm directly as a result of a medication error
  Errors involving controlled drugs
  Prescribed or administered by an incorrect route
  Administered to incorrect patient
  Allergy box non-compliance

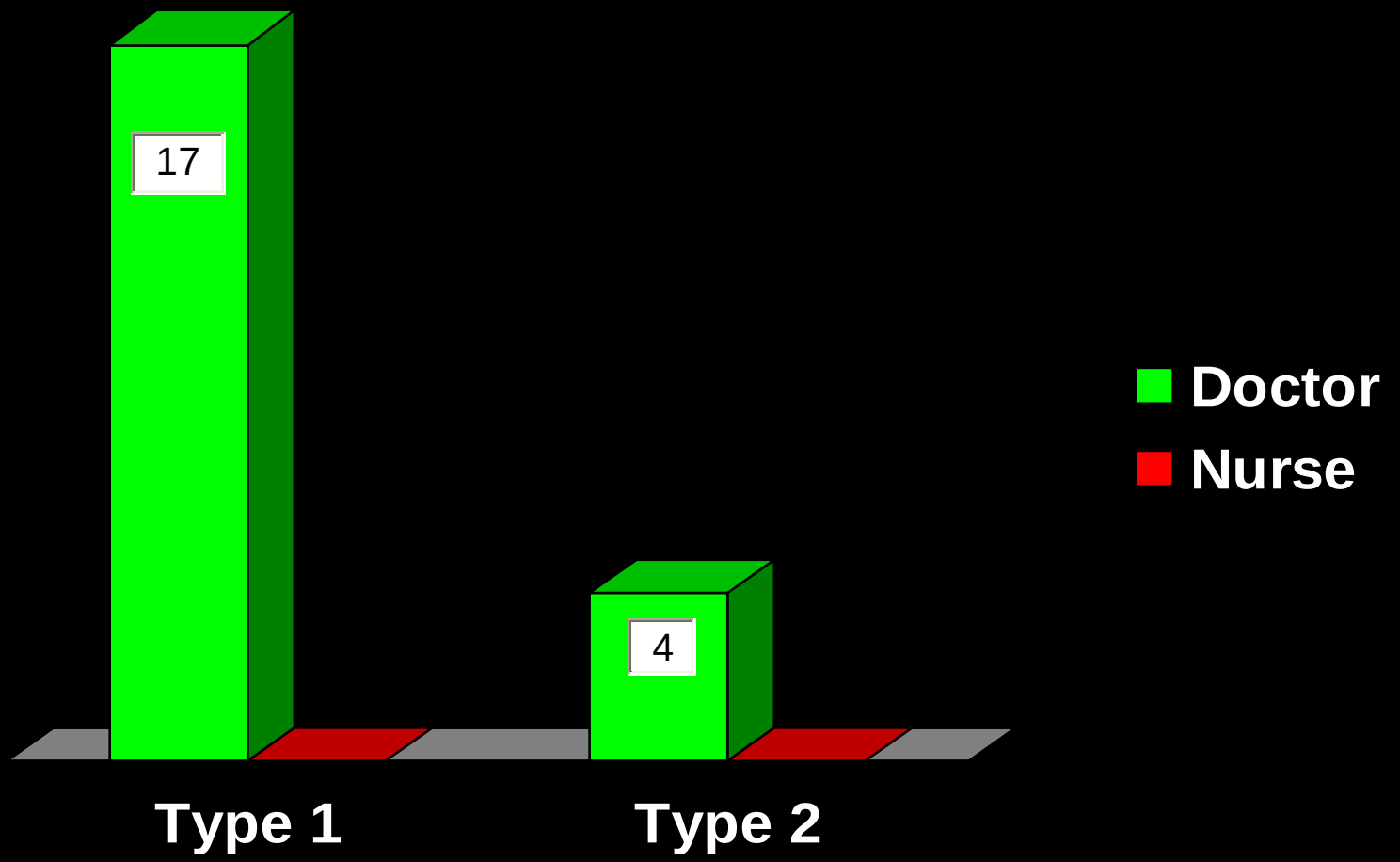
Audit

- 4 weeks in 2012 – 167 patients admitted for cardiac and thoracic surgery.
- Audit covered 84 patients during this time frame.
- Looked at drugs prescribed on admission/ pre-operatively only.
- Looked at the local 20 standards, who prescribed, amount prescribed, type 1 and 2 errors, and amendments.
- Prescription charts were looked at and scored by ward pharmacist.

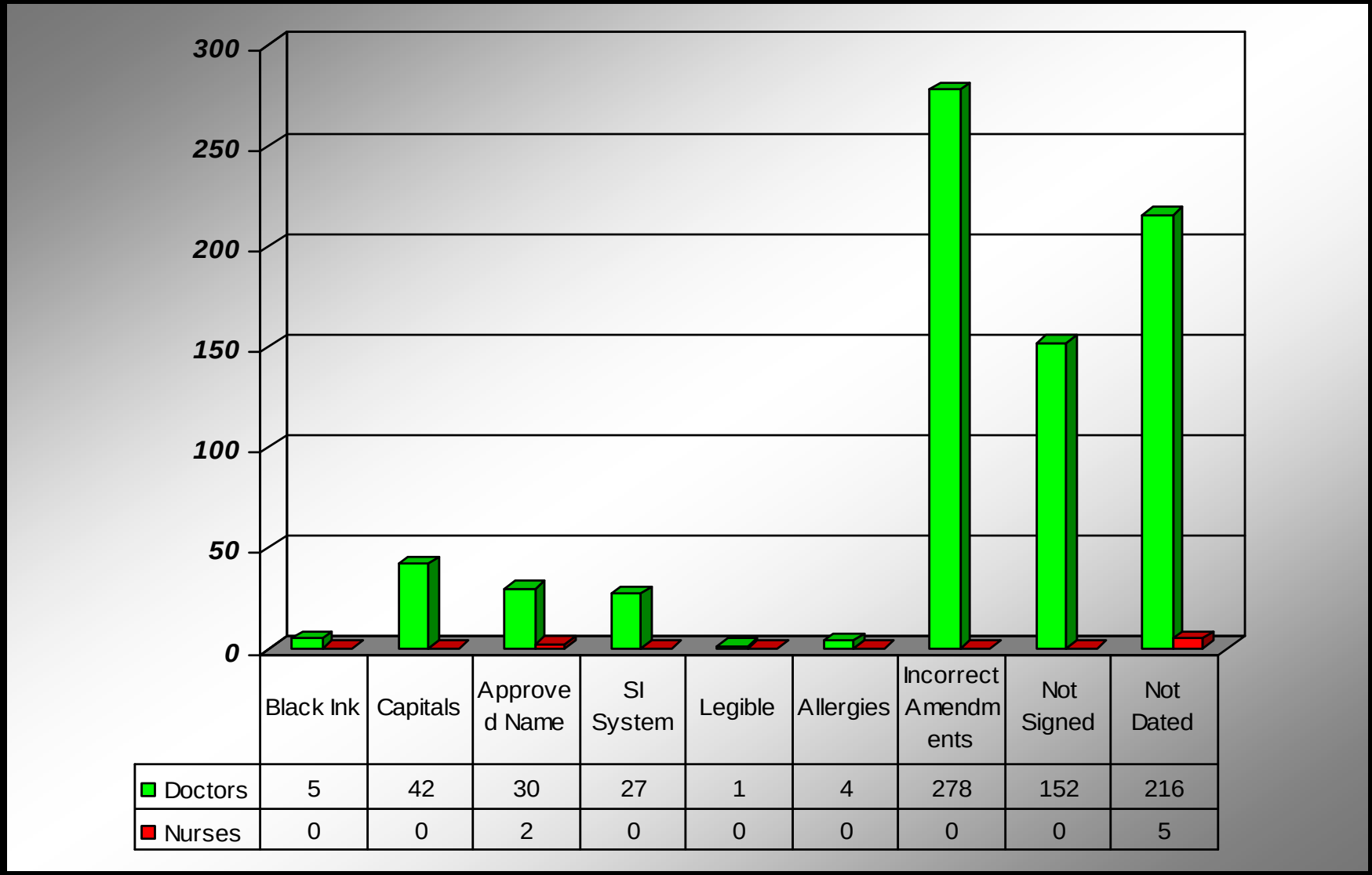
Audit Findings



Type 1 and 2 errors



Audit Findings



	Black Ink	Capitals	Approved Name	SI System	Legible	Allergies	Incorrect Amendments	Not Signed	Not Dated
Doctors	5	42	30	27	1	4	278	152	216
Nurses	0	0	2	0	0	0	0	0	5

Action Plan

- Support for prescribers where adverse prescription errors have been identified and appropriate education given.
- Frequent prescription audits and findings reported back to governance meetings and education supervisors.
- Increased pharmacist input especially on ward rounds.
- Re-audit to look at post-operative prescriptions and include critical care.

Prescription Error Evidence