Organizing for safety in general practice medicines management: findings from a field study

Denham PHIPPS¹, Anthony AVERY^{1,2}, and Darren ASHCROFT¹

1. NIHR Greater Manchester Patient Safety Translational Research Centre, Manchester Pharmacy School, Manchester, UK. 2. Division of Primary Care, University of Nottingham, Nottingham, UK

Keywords. Primary care; general practice; medication safety; resilience

1. Introduction

Medicines usage carries a substantial risk of patient harm; for example, medicationrelated adverse events have been estimated to account for some 7% of unplanned admissions to hospital (Royal et al., 2006). Effective and safe medicines management (that is, the supply, monitoring and use of medicines) in primary care depends on various human and organizational factors. These include individual and collaborative working amongst staff, interaction between staff and service users, management of task demands, interaction with technology and co-ordination between different organizations (Avery et al., 2002; 2012).

It is important, therefore, to ensure that general practices' systems of work provide resilience in medicines management activities (e.g. Jefcott, 2009). In order to suggest how this can be achieved, it is necessary to understand the work of general practice staff in medicines management, and how their work is facilitated or hindered by existing systems of work. The aim of our study was to examine how medicines management activities are organized and carried out across a sample of general practices.

2. Methods

We used a qualitative case study design; the sampling frame was general practices and other organisations involved in general practice medicines management. We have recruited seven sites (five practices, one local medicines management team and one regional medicines management team), all based in the North West of England. Within each site, we carried out observations of, and interviews with, staff working in a range of roles (including doctors, pharmacists, receptionists and administrators). During each observation, the first author accompanied a participant in the course of his/her usual work, and noted the tasks the participant carried out, the participant's interactions both with technology and with other staff, and how the participant dealt with any challenges that arose. During the subsequent interview, each participant discussed his/her role in medicines management, the challenges encountered in the course of his/her work, and how these challenges are dealt with in practice. The interviews were also used to elicit commentary from the participant in specific situations that had arisen during the observations. We have carried out a thematic analysis of the data, informed by concepts of organizational resilience (e.g. Wreathall, 2006).

3. Results

Emerging themes include the following:

Providing flexibility. The practices varied in the degree of autonomy they allowed staff and service users in medicines management. For example, some practices had strict protocols governing staff involvement in repeat prescribing and the circumstances under which it is permitted, while other practices had fewer restrictions. This appeared to reflect a trade-off between providing flexibility to meet work demands and maintaining control over potential hazards;

Maintaining awareness. In order to remain aware of risks to medication safety, each practice had developed its own work routines. These routines often involved relied on collaborative working amongst staff within a practice. For example, doctors, pharmacists and support staff may each play a role in monitoring medicines usage and detecting any problems, with assistance from information technology;

Collaboration between organizations. Crucial to medicines management is the communication and co-ordination with other healthcare organizations – notably, secondary care, care homes and community pharmacy. This occasionally poses challenges, for example variation in the quality of communication with care homes and hospitals. However, it also provides opportunities to foster resilience across all of the organizations, for example when community pharmacies assist in the monitoring of medicines usage.

4. Conclusions

Our findings to date have identified both similarities and differences across the practices with regard how they organize their work; for example the involvement of different staff roles in medicines management. These decisions about work design are likely to have an impact on each practice's ability to detect and deal with medication safety hazards. We intend to further investigate these issues, and use our findings in support of our ongoing work to improve medication safety in primary care.

References

Avery, A.J., Sheikh, A., Hurwitz, B., et al. (2002). Safer medicines management in primary care. British Journal of General Practice, 52(Suppl.), S17-S22.

Avery, A.J., Barber, N., Ghaleb, M., et al. (2012). Investigating the prevalence and causes of prescribing errors in general practice: the PRACtICe study. Report to the General Medical Council.

Jefcott, S.A., Ibrahim, J.E., & Cameron, P.A. (2009). Resilience in healthcare and clinical handover. Quality and Safety in Health Care, 18, 256-260.

Royal, S., Smeaton, L., Avery, A.J., et al. (2006). Interventions in primary care to reduce medication related adverse events and hospital admissions: systematic review and metaanalysis. Quality and Safety in Health Care, 15, 23-31.

Wreathall, J. (2006). Properties of resilient organizations: an initial view. In E. Hollnagel, D.D. Woods and N. Leveson (Eds.), Resilience Engineering: Concepts and precepts (pp. 275-286). Farnham: Ashgate.