NHS SCOTLAND
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NHS Greater Glasgow and Clyde

ONLINE MEDICINE WORK EXPERIENCE

VIRTUAL WARD ROUND – SELF-REFLECTION

4 PRESCRIBING ERROR

University of Glasgow | College of Medical, Veterinary & Life Sciences

Why is it important to flag up and report errors?

Can you think of other industries which also have a tight safety culture?

Why is it important to tell the patient about this error even though no harm came to the patient?

Does the Junior Doctor who made the error get into trouble?

Is the Junior Doctor the only one at fault here?

What are the roles of the Pharmacist, the Senior Nurse and the Consultant here?

Why is it important to flag up and report errors?

- Offer the opportunity to learn from previous mistakes by having a record of errors made over the years
- Spot patterns of errors to prevent them happening again
- Identify system weaknesses
- Potential long-term consequences from errors even if not initially recognised so it is important this has been recorded

Can you think of other industries which also have a tight safety culture?

- Airline (and all transport industries)
- Construction
- NB – *The Checklist Manifesto* by Atul Gawande is a good pre-medical school read

Why is it important to tell the patient about this error even though no harm came to the patient?

- Maintains trust in the honesty of healthcare staff
- The concept of “Duty of Candour” is important. This is a legal duty that says every healthcare professional must be open and honest with patients when something goes wrong with their treatment and causes, or has the potential to cause, harm or distress.
- Some errors may lead to downstream harms even if they aren’t immediately apparent

Does the Junior Doctor who made the error get into trouble?

- No. We aim for a supportive, learning, blame-free culture.
- The emphasis is not on punishment but on learning.
- We all recognise that no one is perfect. The key is to minimise errors but we will never fully eradicate them.

Is the Junior Doctor the only one at fault here?

- Although the Junior Doctor made the initial error there should have been a number of other processes in place to stop this error occurring – eg Allergy checking at the time of actually giving the antibiotic to the patient. So a number of other processes have also failed.
- Most human errors also involve some "system" error
- The "Swiss-Cheese model" of errors is useful to read about.

What are the roles of the Pharmacist, the Senior Nurse and the Consultant here?

- Support of the Junior Doctor
- Maintaining safety
- Ensuring these errors are addressed and do not happen again – eg Incident Reporting System
- Pharmacist – takes an oversight of the medicines being prescribed on the ward and so provides a safety net. Ultimately the pharmacist was the one to spot the error here and to raise it. Also a source of advice and huge knowledge on medicine dosing, interactions and safety.
- Senior Nurse – ensuring the patient is appropriately monitored. Ensuring safe practices are carried out on the ward. Supporting the team.
- Consultant – taking overall responsibility for medical decisions that are made and supporting the rest of the team – eg speaking to the patient with the Junior Doctor. Responsible for teaching and guiding the Junior Doctor through the process of incident reporting. Instilling a culture of learning through errors rather than punishment.

Associated Student Interview Videos

- What are your biggest fears about starting on the wards as a doctor?
- Working with the Multidisciplinary Team