Communicating Safety Plans

REPORT

- The Community Pharmacy Patient Safety Group (CPPSG) is aware of the tragic death of a 16-year-old patient.
- The vulnerable patient who had a history of self harm had a Safety Plan in place, which gave her parents responsibility for her medications.
- The Safety Plan was not followed by the prescriber, nor was the existence of a safety plan communicated with the community pharmacy.
- The patient attended the pharmacy, collected her new prescription as well as a number of older prescriptions (which she had not been previously aware were being held at the pharmacy).
- The patient subsequently died from an overdose of prescribed medication. The exact combination of medicines taken is unclear.

LEARN

- The CPPSG discussed the incident to consider actions which could be taken to prevent similar incidents in the future.
- Pharmacists are rarely aware of safety plans unless they are specifically informed about them. Although it is often assumed they are part of the Multi Disciplinary Team (MDT).
- Communication between community pharmacies and GPs / prescribers is crucial.
- Where a patient is vulnerable prescribers should be encouraged to add a note to the prescription to request pharmacists review the summary care record or local health record.
- If a pharmacist has concerns they should contact a patient's GP using NHS Service Finder which provides a fast-track number.

SHARE

- Details of the incident were shared with Medication Safety Officers (MSOs) at the CPPSG. MSOs will disseminate learnings via their networks.
- It will also be shared on the monthly Secondary Care MSO webex.
- Details were published on the Pharmacy Safety website, and shared with key stakeholders.
- Details will be shared with the CCA Digital Innovation Group (DIG) and RPS Digital Expert Advisory Group and the Community Pharmacy IT Group.

ACT

- Pharmacists and superintendents should consider whether routine “clear downs” of uncollected prescriptions may reduce the risk of patients picking up large quantities of previously prescribed medications.
- Pharmacy businesses should ensure front line teams are aware of the fast track number to communicate with local GPs.
- The CPPSG will communicate with Digital Groups including the CP Digital Expert Advisory Group to share their recommendation that a note should be added to prescriptions to tell pharmacists to check patient record, if necessary.
- In some cases, overfamiliarity can be the cause of issues. Pharmacy teams should ensure they carry out the necessary checks before dispensing medication.

REVIEW

- Members of the Patient Safety Group to consider how they can improve communication with prescribers and other HCPs to support the safeguarding of vulnerable patients.