Enabling safe prescribing conversations self-assessment tool

Background

Prescribing is a complex and error prone activity. Feedback on prescribing and prescribing errors is recommended to raise awareness of prescribing performance, and support development of prescribing skills. Evidence suggests that feedback, or safe prescribing conversations, can support prescribers to develop their skills, improve prescribing performance, and reduce potential harm to patients (Parker *et al*. 2019, Lloyd *et al.* 2018).

However, despite recommendations for junior doctors to receive regular feedback on their prescribing, doctors have reported limited feedback and a lack of awareness of their prescribing practice. In addition to this, successful feedback interventions have proven difficult to sustain beyond completion of any research.

In response to this, a diverse expert group, consisting of leading academics and external partners, with the support from the Economic and Social Research Council impact acceleration fund, was formed. A key aim of the group was to understand the barriers and enablers to implementing and sustaining prescribing conversations in practice.

Developing the tool

A self-assessment tool, to support successful implementation and engagement with safe prescribing conversations, was developed by an expert working group, comprised of senior academics, doctors and pharmacists, and other external partners.

The use of psychological theories to identify barriers and facilitators to a behaviour, such as engaging with safe prescribing conversations, is endorsed in the literature (Craig *et al.* 2008, Michie *et al.* 2010). COM-B (capability, opportunity, motivation, and behaviour) is one psychological theory with behavioural change occurring when one or more these conditions (Capability, Opportunity or Motivation) are met (Michie *et al*. 2011).

Pharmacists, nurses, doctors, senior leaders and policy makers from within a large acute secondary care NHS (National Health Service) teaching hospital were invited to participate in a number of focus groups. This allowed identification of key barriers and enablers of safe prescribing conversations,

mapped against COM-B, which were then used to develop an evidence-based self-assessment tool to support enabling safe prescribing conversations in practice.

Who is the self-assessment tool for?

This self-assessment tool is for organisations, teams or individual leaders who are looking to implement safe prescribing conversations across an organisation(s) or within a particular directorate, specialty or ward area for example.

Using the self-assessment tool

This self-assessment tool can be used to help organisations who want to enable consistent delivery of safe prescribing conversations in practice. Whilst it has been developed for use in acute hospital settings, there is potential for the tool to be adapted for use in other settings.

This self-assessment tool is free to use and adapt to local needs for organisations that identify the need for safe prescribing conversations. It contains eight layers (see figure 1) with seven themes influencing the ability to engage with safe prescribing conversations (the inner layer). Within these influencing layers are key elements that stakeholders can use to self-assess their preparedness to enable safe prescribing conversations.

There is a short version of the self-assessment tool (Table 1) and a more detailed version (Table 2) available for use.

Completing the self-assessment tool will allow identification of areas of strengths and readiness, and areas of weakness and in need of improvement, within your organisation to enable safe prescribing conversations.

Definitions

A prescribing error can have different definitions but for the purpose of this tool, it includes errors that have either harmed or have the potential to cause harm to patients. A commonly used definition of prescribing is:

> "A clinically meaningful prescribing error occurs when, as a result of a prescribing decision or prescription writing process, there is an unintentional significant (1) reduction in the probability of treatment being timely and effective or (2) increase in the risk of harm when compared with generally accepted practice" (Dean et al 2000).

A “significant error” is based on established definitions for example as used in the EQUIP study (Dornan et al 2009).

Citing the self-assessment tool

Enabling safe prescribing conversations self-assessment tool. Accessed on (inset date DD/MM/YYYY here). Available at https://sites.exeter.ac.uk/optimisingprescribing/resources/

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Figure 1: An illustration of the different levels of enablers for safe prescribing conversations

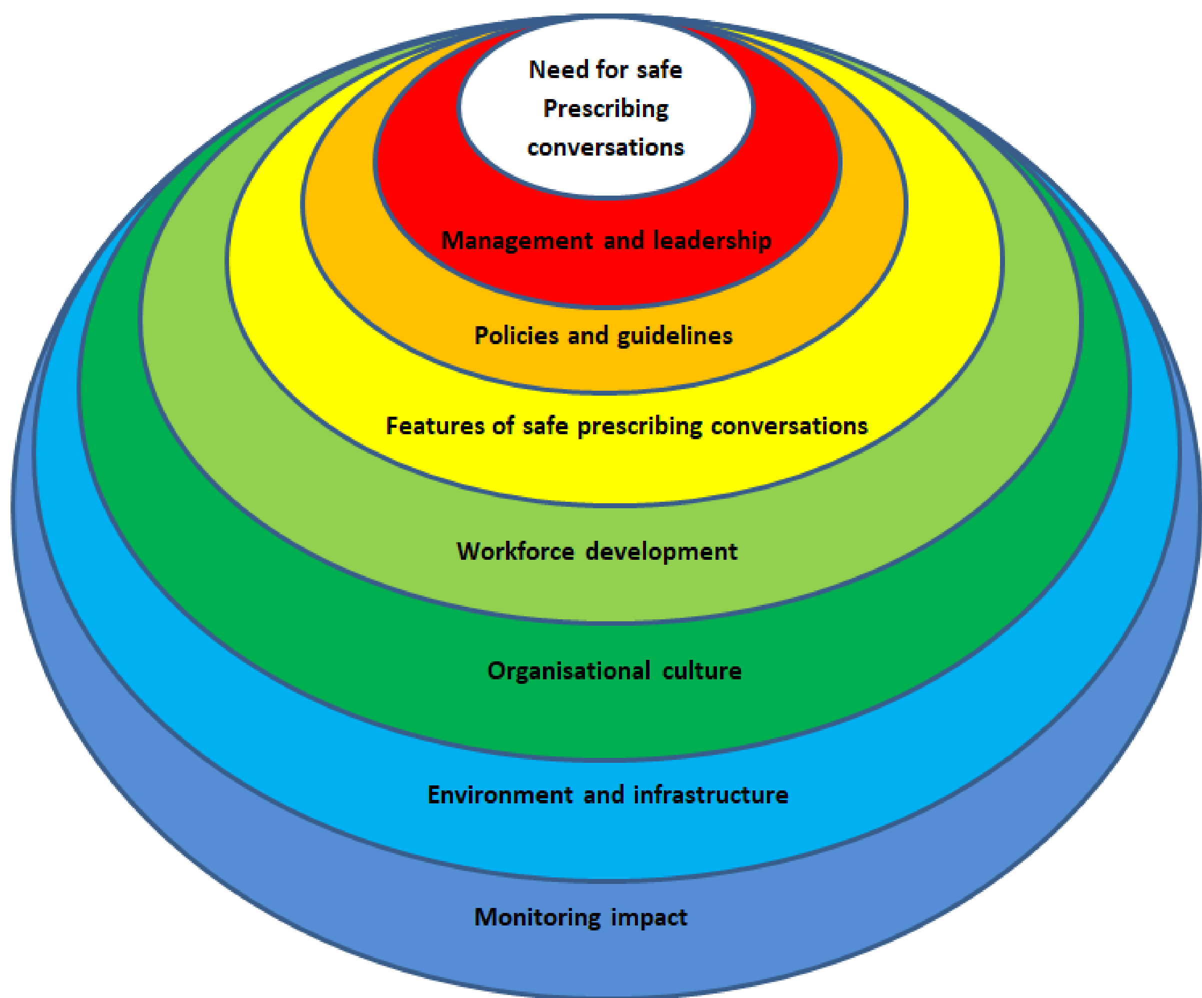

Table 1: Enabling safe prescribing conversations self-assessment tool (short version)

Domain	Enabler of safe prescribing conversations	Where are we now?	What do we plan to do next?
1. Management and leadership	1.1 There is a suitable named senior leader for safe prescribing conversations for the organisation.		
	1.2 There are appropriate facilitators, and prescriber groups, identified to enable safe prescribing conversations.		
2. Polices and guidelines	2.1 There are clear guidelines in place outlining the scope and processes of safe prescribing conversations.		
3. Features of safe prescribing conversations	3.1 There are opportunities for safe prescribing conversations to be routinely provided.		
	3.2 The safe prescribing conversations are delivered verbally and in writing.		
4. Workforce development	4.1 There is suitable training provided for both facilitators and prescribers involved with safe prescribing conversations.		
5. Organisational culture	5.1 The focus of any safe prescribing conversation is to learn from error and support prescriber development.		
6. Organisational environment and infrastructure	6.1 There is allocated service provision to enable safe prescribing conversations.		
	6.2 There is a suitable area identified to enable participation in safe prescribing conversations.		
7. Monitoring impact of prescribing feedback conversations	7.1 There are regular audits of prescribing, with any outcomes of safe prescribing conversations shared across the organisation.		

Table 2: Enabling safe prescribing conversations self-assessment tool (full version)

Domain	Enabler of safe prescribing conversations	Where are we now?	What do we plan to do next?
1. Management and leadership	1.3 There is a named leader or champion (e.g. executive sponsor, senior pharmacist, patient safety lead) for safe prescribing conversations within the organisation.		
	1.4 There is clear understanding of the need for and potential benefits of safe prescribing conversations, with case studies, evidence, and external resources to support them.		
	1.5 There are appropriately trained facilitators of safe prescribing conversations in each ward area, e.g. ward-based pharmacists or a colleague who observes prescribing practice and can deliver effective feedback as part of everyday practice.		
	1.6 The target group of prescribers to receive safe prescribing conversations has been defined by the organisation. (e.g. all professions/grades or targeted groups)		
2. Polices and guidelines	2.2 There are clear policies / guidelines outlining the scope and processes of safe prescribing conversations as an educational intervention		
3. Features of safe prescribing conversations	3.3 There are formal opportunities for safe prescribing conversations as part of routine clinical activity.		
	3.4 There is a mandatory inclusion of safe prescribing conversations in local curricula for relevant prescriber / staff groups to support development of prescribing skills.		
	3.5 There is encouragement for prescribers to seek opportunities for safe prescribing conversations with nominated facilitators.		
	3.6 The safe prescribing conversations are designed to be: • Individualised per prescriber. • Delivered verbally and in writing. • Delivered by a facilitator who works with the prescriber (for example the ward based pharmacist). • Conversational to understand the reasons for any prescribing outcome.		
	3.7 There is a template to enable written feedback to provide the structure and support for any safe prescribing conversation.		

Domain	Enabler of safe prescribing conversations	Where are we now?	What do we plan to do next?
	3.8 Arrangements are in place to audit prescribing at the start of each doctor in training rotation.		
	3.9 There are opportunities for safe prescribing conversations for all errors considered significant.		
	3.10 The details of any prescribing error are handed over to the nominated ward-based facilitator where the prescriber does not work alongside the person who has identified the error.		
	3.11 The prescriber is made aware of any prescribing error out of hours by e-mail, with an opportunity provided to discuss the situation when they return to normal practice.		
	3.12 The prescribing audit process is streamlined to minimise workload of facilitators.		
	3.13 The written documentation is clear and succinct and easily accessible to facilitators at ward level.		
	3.14 The written documentation is used to support reflective practice and review existing systems (and not for individual blame).		
	3.15 The facilitators reflect on safe prescribing conversations as part of their professional development.		
	3.16 The prescriber reflects on any safe prescribing conversations as part of their professional development, and as part of any training portfolio for example.		
	3.17 The documentation of any safe prescribing conversation is stored electronically following any information governance requirements.		
4. Workforce development	4.2 There is a training programme available to provide dedicated education and training on safe prescribing conversations, and understanding of the causes of prescribing error.		
	4.3 There is dedicated training provided for all new staff members who will facilitate safe prescribing conversations, including (but not limited to): • Appropriate questioning skills and techniques to encourage dialogue with prescribers. • Identification of reasons for prescribing performance. • Negotiation of actions for future prescribing practice.		

Domain	Enabler of safe prescribing conversations	Where are we now?	What do we plan to do next?
	4.4 There is training provided to all facilitators on the value of safe prescribing conversations including (but not limited to): • The role of feedback in national guidance and prescribing frameworks. • Evidence base for safe prescribing conversations. • Principles of effective safe prescribing conversations. • The importance of feedback as a positive experience. • Views of prescribers of receiving feedback on their prescribing. • Views of prescribers of receiving feedback from facilitators, for example pharmacists.		
	4.5 There are opportunities for facilitators to share positive experiences of safe prescribing conversations with other facilitators.		
	4.6 The facilitator training includes provision of feedback to the facilitator on their performance.		
	4.7 There is dedicated training for all prescribers on how to engage in safe prescribing conversations.		
	4.8 There is training provided for facilitators and prescribers on the understanding of prescribing errors and their causes, to support a systematic and structured approach to safe prescribing conversations.		
	4.9 There is training in time management provided for facilitators of safe prescribing conversations.		
5. Organisational culture	5.2 The organisation considers feedback on performance and safe prescribing conversations as a high priority to improve practice.		
	5.3 There is executive level and senior management support (eg consultants, education leads, senior pharmacists and senior nurses) throughout the organisation for safe prescribing conversations.		
	5.4 There are safe prescribing conversations provided for good prescribing practice in addition to any prescribing error.		
	5.5 There is a consistent approach to delivering feedback to individuals on their performance across the organisation.		
	5.6 The focus of feedback for any error is to learn from that error and support individual development.		

Domain	Enabler of safe prescribing conversations	Where are we now?	What do we plan to do next?
	5.7 The provision of safe prescribing conversations is separated from other performance related governance processes.		
	5.8 The findings of safe prescribing conversations are used to review and influence change in existing systems and processes.		
6. Organisational environment and infrastructure	6.3 There is allocated service provision (as time or additional professional support) for auditing prescribing.		
	6.4 There is allocated service provision (as time or additional professional support) for facilitators and prescribers to enable safe prescribing conversations.		
	6.5 There is senior facilitator support (for example specialist pharmacists) available for junior, or less experienced facilitators, to deliver safe prescribing conversations when needed.		
	6.6 Where clinical dashboards are used for ward activity, safe prescribing conversations are included as part of that ward-based activity.		
	6.7 There is benchmarking of safe prescribing conversations frequency available for facilitators.		
	6.8 There is a suitable, private area at ward level for safe prescribing conversations to occur in.		
	6.9 There is access to rota lists for facilitators of safe prescribing conversations to enable identification of location/area of work for each doctor.		
	6.10 Where in place, electronic prescribing systems can automatically generate individualised prescribing reports to support safe prescribing conversations.		
	6.11 The name of the prescriber is easily identified from the prescription.		
	6.12 There is financial investment to support delivery of safe prescribing conversations.		
7. Monitoring impact of prescribing feedback	7.1 Outcomes of safe prescribing conversations (for example prescribing error rates) are audited as part of routine practice (e.g. annually).		
	7.2 The benefits and local outcomes of safe prescribing conversations are shared with all stakeholders at least annually.		

Domain	Enabler of safe prescribing conversations	Where are we now?	What do we plan to do next?
conversations	7.3 Safe prescribing conversations are used to understand reasons for any prescribing error and support ongoing quality improvement.		
	7.4 This self-assessment tool is used annually for quality assurance and ongoing preparedness to enable safe prescribing conversations.		