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P184 -Patient focus group in addressing Immunosuppression related medication errors in a renal transplant centre

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Introduction

Medication errors can be catastrophic for patients. Indeed, medication errors in relation to immunosuppression in renal transplantation can result in either loss of the organ (if too little is given) or severe sepsis and drug related toxic effects (if too much is administered). Despite numerous attempts to find solutions to these problems, they seem to only be partially successful and issues still remain. One important component of medication errors, which tend to be ignored during this process, are the patients themselves. Thus, our aim was to create a focus group involving renal transplant patients exploring ideas around medication errors and issues.

Methods

12 renal transplant patients attended the one hour focus group session. Before the session, a questionnaire was completed by participants exploring demographics and personal experience of immunosuppression related errors. Within the session, six health care professionals (two renal transplant consultants, one renal registrar, one Darzi fellow, one transplant nurse and one ward manager) were present and their role was to ask clarifying questions when required. The session was lead by the renal registrar. With permission, the session was recorded and transcribed per verbatim.

Results

One of the main issues raised by the group was the lack of trust that healthcare professionals had for transplant patients in regards to their immunosuppression. It was commented that at home, transplant patients were expected to be able to take their medications at the right dose and time, but as soon as they stepped onto the ward, their medications would be locked up. This resulted in immunosuppression given much later than usual and occasionally incorrect doses. The patient group understood that sometimes, particularly if someone is unwell, they should not be given responsibility for taking their own medications but there are numerous occasions when it should be encouraged. This was even more difficult when admitted to hospitals without renal units, and it was near impossible for patients to challenge healthcare professionals in regards to incorrect doses of immunosuppression. Indeed, a few patients commented that immunosuppression had been withheld for no seemingly good reason. They felt that more knowledge on immunosuppression would allow them to challenge health care professionals more confidently.

Thus, three outcomes from the meeting were:
1) Self-medicating program on the renal ward
2) Patient educational program to address competencies
3) Immunosuppression credit cards with drug name, doses and timings

Next Step

A self-administration of medicines policy previously existed on the renal ward and is being re-introduced. For outcome 2 and 3, two patient groups will be created to help steer these solutions. Using, co-production methodology, patient will be equal partners in creating the solutions alongside healthcare professionals

Conclusion

In conclusion, the use of a patient panel has produced some useful insights into immunosuppression related medication errors. The hope is to use the same group of patient to create and implement possible solutions using co-production.