

Publication title: [SMASH! The Salford Medication Safety Dashboard](#)

### Publication details (Vancouver format)

Williams R, Keers R, Gude WT, Jeffries M, Davies C, Brown B, et al. SMASH! The Salford medication safety dashboard. J Innov Heal Informatics [Internet]. 2018 Oct 18 [cited 2018 Oct 31];25(3):183

### What was known before your paper was published?

Sometimes mistakes are made when GPs prescribe medication. Usually there is no problem, but occasionally (1 in 550 prescriptions) the mistake is potentially life threatening. One way to stop these mistakes is to show the GP a report containing their mistakes so they can make corrections and learn for the future.

Researchers from the University of Nottingham and the Greater Manchester PSTRC have showed that having a pharmacist give the GP the report, and help correct the mistakes, is a better way to reduce the number of at-risk patients, than just providing the report.

### What did you do?

We wanted to see if we could reduce the number of errors even further. The previous study only provided the report twice in 6 months. We wondered what would happen if the GP and pharmacist had access to a report which was updated more frequently. We therefore set out to design and build an online interactive report (SMASH) that the GP and the pharmacist could view at any time, and which would be updated every day.

**What did you find?**

We successfully built the online report and linked it to patient data from Salford, UK. We deployed SMASH to 43 out of the 44 GP surgeries in Salford. By November 2017, 36 pharmacists had been trained to work with practices to use SMASH and reduce the numbers of at-risk patients. There were 135 registered users of SMASH, with an average of 91 user sessions a week.

**What insights/knowledge did you add?**

We have shown that regularly updated information in medical reports and dashboards may be an important contributor towards medication safety in primary care.