SCOTTISH PATIENT SAFETY PROGRAMME 2008-2018

Transitions, Omissions and High Risk Medicine

WebEx Series 2018–2019

Using a QI approach to reducing omitted medicines
EiC test sites and SPSP Medicines team

Thursday 18 October 2018
3pm–4pm

@SPSPMedicines
#SPSPMeds

As part of Healthcare Improvement Scotland's Ihub, SPSP activities support the provision of safe, high quality care, whatever the setting.

A few points for our WebEx today:

Please dial in on your phone:

0800 032 8069 and then use the pass code: 564 897 14 #

If you are not presenting your phone is automatically on mute

Phone lines will open at the end of the WebEx for Q and A with the presenters.

Meet the team

Arvind Veiraiah
National Clinical Lead

Lorraine Donaldson
Project Officer

Kirsty Allan
Administrative Officer

Polling Question 1

Which of the following professions best describes you?

a. Patient / Service User
b. Medical
c. Nursing
d. Pharmacy
e. Other (please type in chat box)

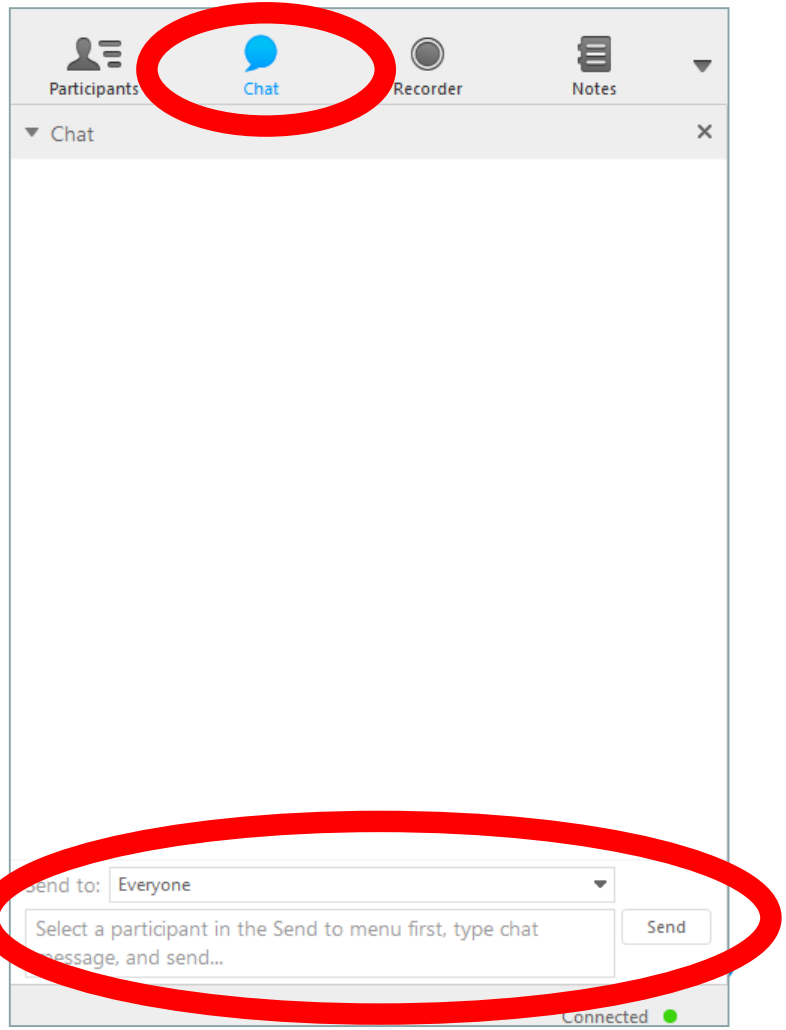
SCOTTISH PATIENT SAFETY PROGRAMME 2008-2018

Ten years of improving safety

To get involved in the conversation, please click on the Chat icon.

Select **Everyone** from the drop down menu, type your message then click send. Introduce yourself.

This WebEx is being recorded as a resource and will be available via the ihub website



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Ten years of improving safety

Using a QI approach to reducing omitted medicines- Introduction

Prepared by: Xenia Dennison, Improvement Advisor, Healthcare Improvement Scotland.

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NHS SCOTLAND

Context

Omitted doses of medicines are one of the most commonly reported type of medication incidents

A proportion of omitted doses can have a significant impact on patients

Consecutive dose omissions can lead to deterioration and crisis situations (e.g. hydrocortisone, Parkinson's medicines)

Context

A study by Graudins et al in 2015 identified dose omissions having a negative impact on patient experience:

- increased pain (oxycodone)
- atrial fibrillation (beta blockers)
- hypokalaemia (potassium supplements)
- increase in aggression (antipsychotic)

Context

In NHS England, between September 2006 – June 2009:

- 27 deaths
- 68 severe harms
- 21,383 other patient incidents

…….related to omitted or delayed doses of medicines.

Costs savings due to adverse drug event prevention: £34,000 p.a. across six wards.

Context

The underlying causes of omitted medicines are often multi-factorial

Considering the role of nurses and midwives in medicines administration, what are the opportunities to influence (and improve)?

Blank spaces and ‘Medicine not available’

What did we aim to do?

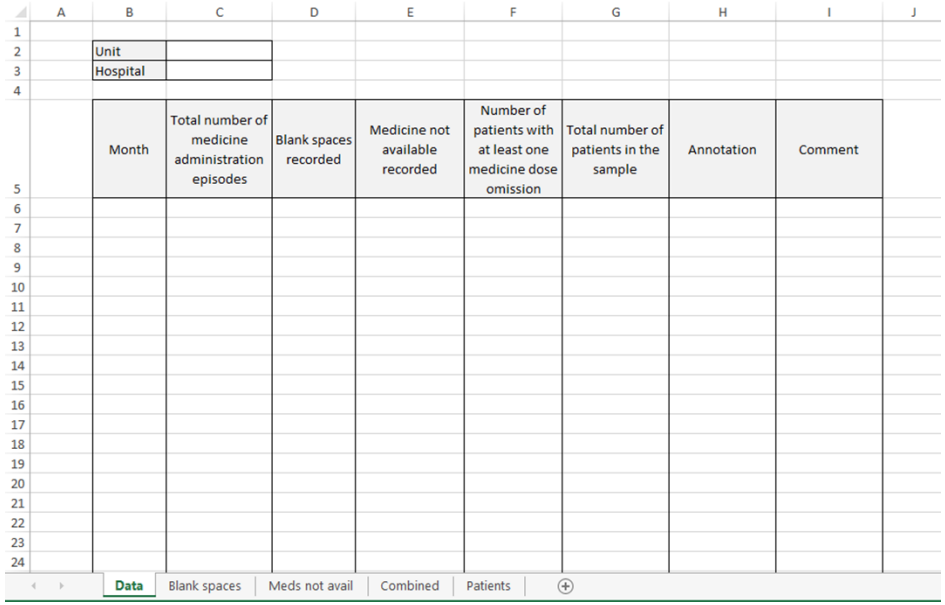
To develop a measure(s) related to omitted medicines for consideration for the EiC Framework (we started with six)

To identify an appropriate recommended national aim for omitted medicines improvement work

To use QI methodology to support improvement work in the reduction in medicines administration omissions (blank spaces and medicines not available).

How did we approach this?

Monthly data collection via a retrospective chart review of a random sample of patients.



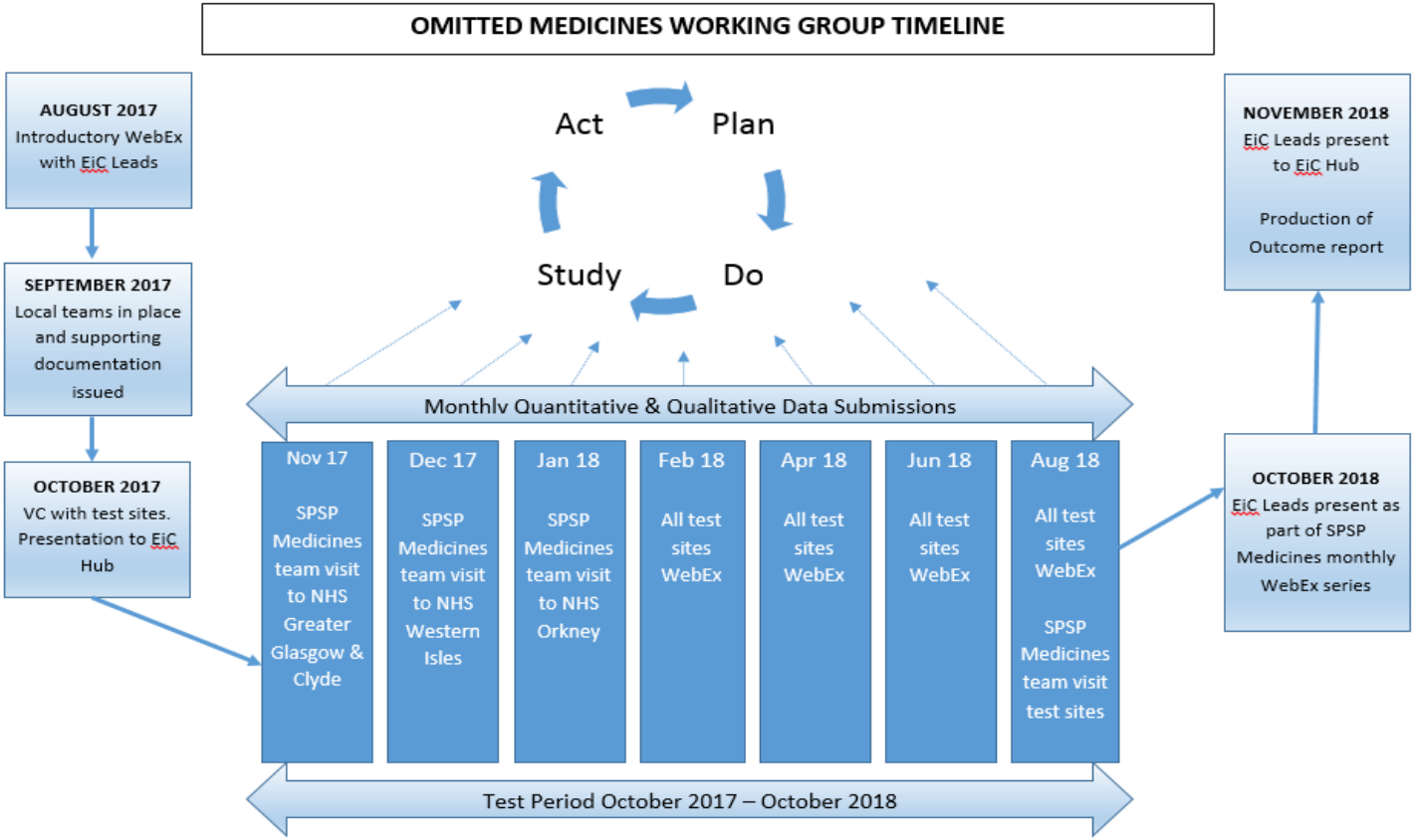
	B	C	D	E	F	G	H	I
2	Unit							
3	Hospital							
5	Month	Total number of medicine administration episodes	Blank spaces recorded	Medicine not available recorded	Number of patients with at least one medicine dose omission	Total number of patients in the sample	Annotation	Comment

Data | Blank spaces | Meds not avail | Combined | Patients

Six measures tested:

% of omitted medicines (omitted medicines rate)	Count of omitted medicines
% of blank spaces	% of medicines not available
% of patients with one or more omitted doses	Count of patients with omitted medicines

How did we approach this?



Ten years of improving safety

SPSP Medicines

Prepared by:
Noreen Macdonald & Joan Frieslick

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NHS SCOTLAND

Presenters – NHS Western Isles

Noreen Macdonald
EC Lead,
NHS Western Isles

Joan Frieslick
Senior Charge Nurse
NHS Western Isles

Angela Maclean
Rehabilitation specialist Nurse
NHS Western Isles

Omitted medicines :

NHS
Eileanan Siar
Western Isles

- **NHS Western Isles** is responsible for providing healthcare to the 26,000 people in the Outer Hebrides.
- There are 3 Hospitals, The Western Isles Hospital located in Stornoway, the Uist & Barra Hospital in Benbecula, and St Brendan's on the Isle of Barra.
- The Western Isles Hospital is a Rural General hospital with 80 + 20 contingency beds across a range of specialities, including General Medicine, General Surgery, Orthopaedics, Paediatrics, Obstetrics and Gynaecology and Psychiatry.

Omitted medicines : Story so far

Our test ward has 15 beds, consisting of General Medicine, Orthopaedic Rehabilitation, Acute Stroke, Stroke Rehabilitation & Intermediate Care.

Our small project team comprised the Senior Charge nurse, Rehabilitation Specialist nurse, Chief Pharmacist and EIC Lead.

What we did – Data Collection Process

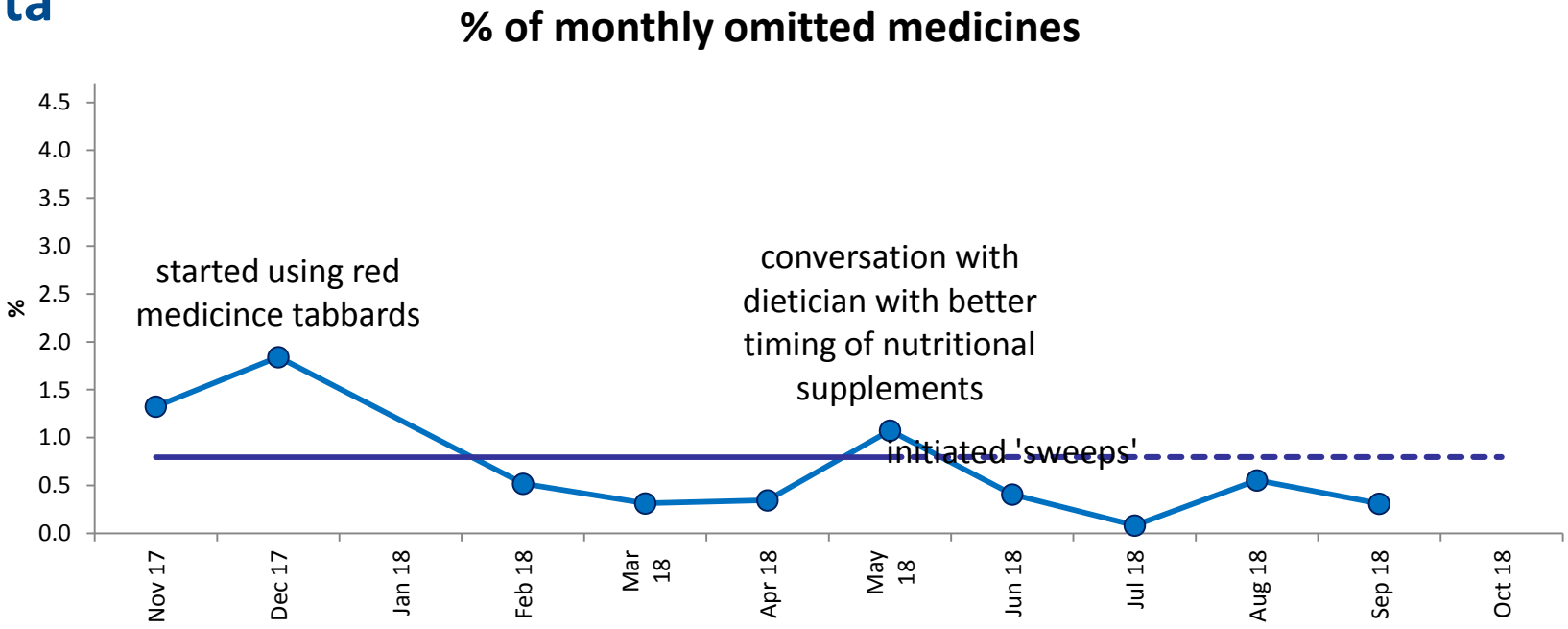
- It began with SCN/ and rehab specialist nurse for the first month
- 15 Bed numbers in hat and a member of staff picked 5
- Simple paper form was developed for collecting weekly data and once per month the data was enter on to collection spread sheet for submission
- Fixed day set for data collection and time (30 minutes) allocated to task.
- Once process understood & established it was introduce and carried out by Staff Nurse on shift

What we did

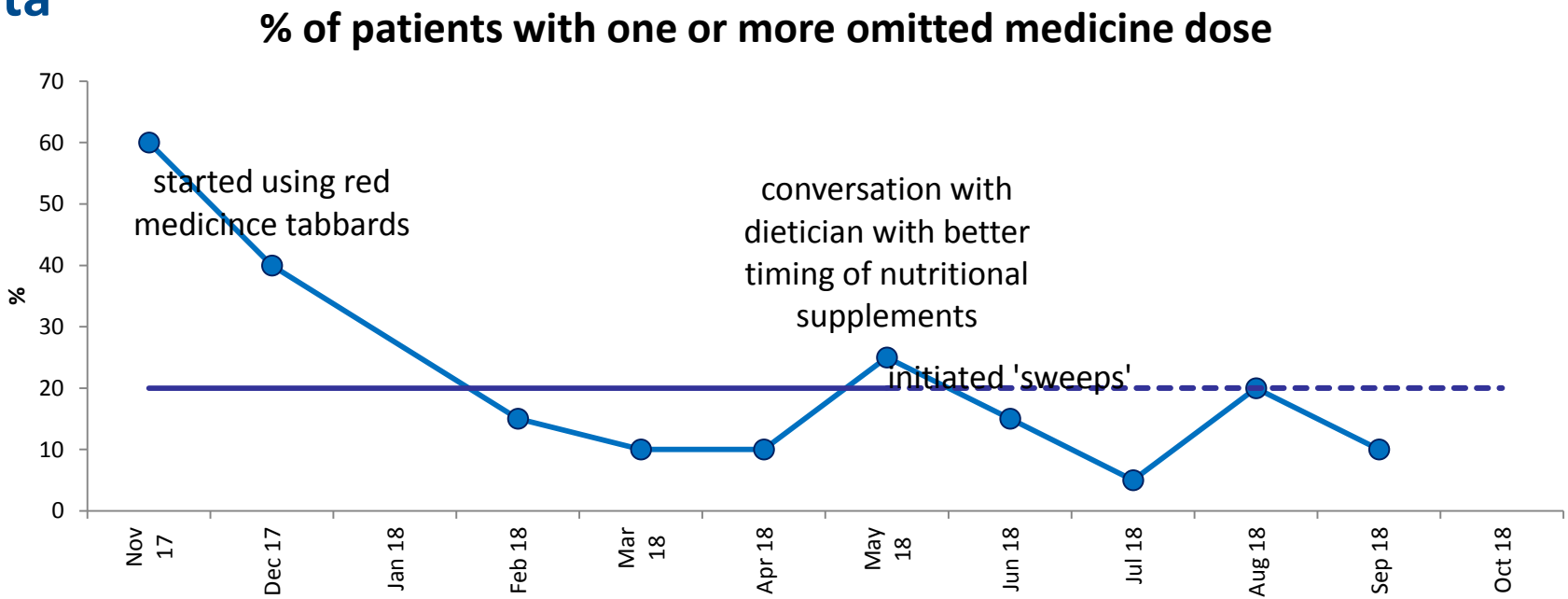
Red tabards were reintroduced to raise awareness of the medicine omissions audit and to focus on the importance of not omitting drugs.

It also aimed to minimise drug round interruptions.

Data


% of monthly omitted medicines
%
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
started using red medicince tabbards
conversation with dietician with better timing of nutritional supplements
initiated 'sweeps'
Nov 17
Dec 17
Jan 18
Feb 18
Mar 18
Apr 18
May 18
Jun 18
Jul 18
Aug 18
Sep 18
Oct 18

Data


% of patients with one or more omitted medicine dose
70
60
50
40
30
20
10
0
%
started using red medicince tabbards
conversation with dietician with better timing of nutritional supplements
initiated 'sweeps'
Nov 17
Dec 17
Jan 18
Feb 18
Mar 18
Apr 18
May 18
Jun 18
Jul 18
Aug 18
Sep 18
Oct 18

Successes

- The project has gone well in terms of outcomes and buy in and support from the SCN and her team.
- Raising awareness and focus among staff has been the biggest factor in improving and sustaining low rates.
- Sharing the responsibility for the audits. Relying on one person can make data collection person dependant.

Challenges

- Displaying improvement data in a meaningful way in order to maintain momentum and focus.
- Sustaining focus, momentum and outcomes
- Good taster to start QI in the ward but how to continue to grow, develop and embrace QI across the team

Omitted Medicines – a Unique Perspective

NHS Greater Glasgow & Clyde

18/10/2018

Shona Thomson

Senior Charge Nurse

Excellence in Care

EVERY PERSON EVERY TIME
SCOTTISH PATIENT SAFETY PROGRAMME
2008-2018
Ten years of improving safety

From old ←

To new →

And everywhere in between!

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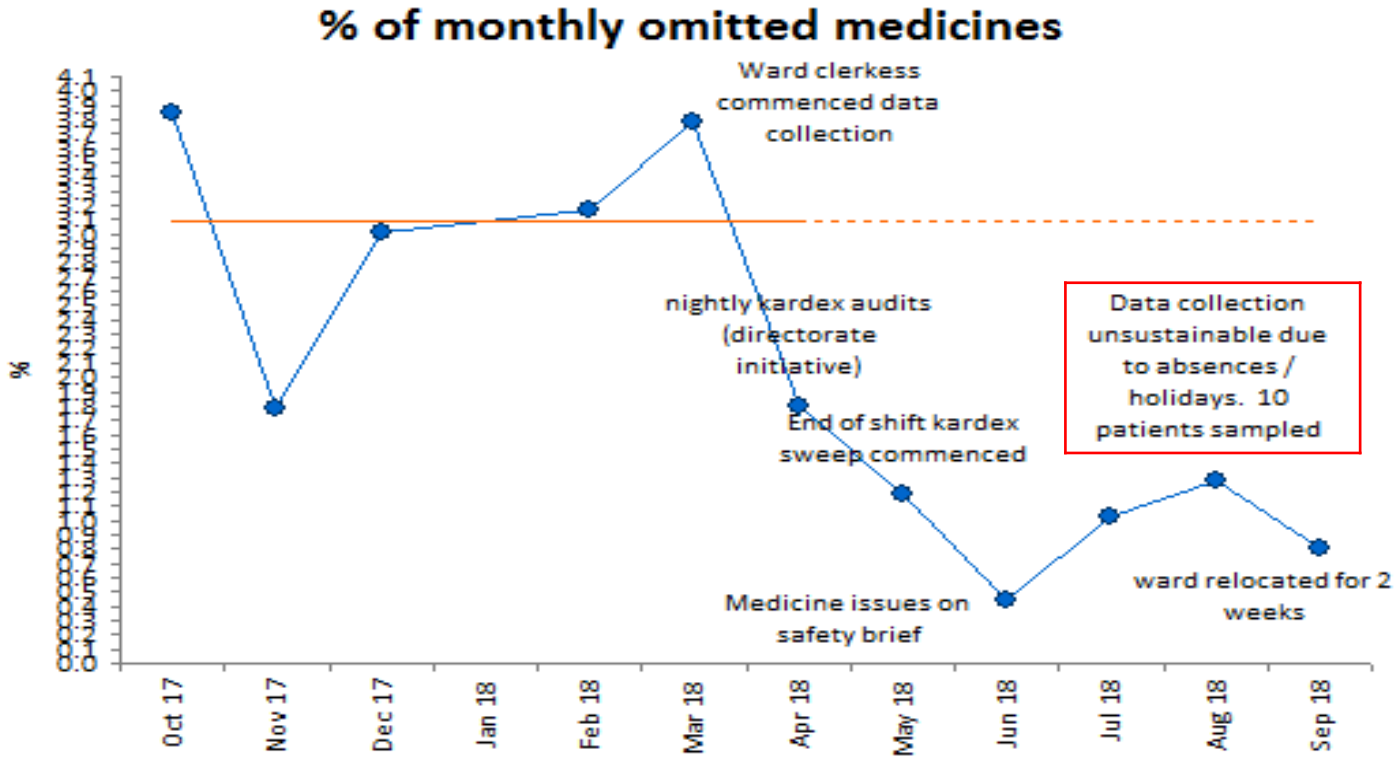
NHS SCOTLAND

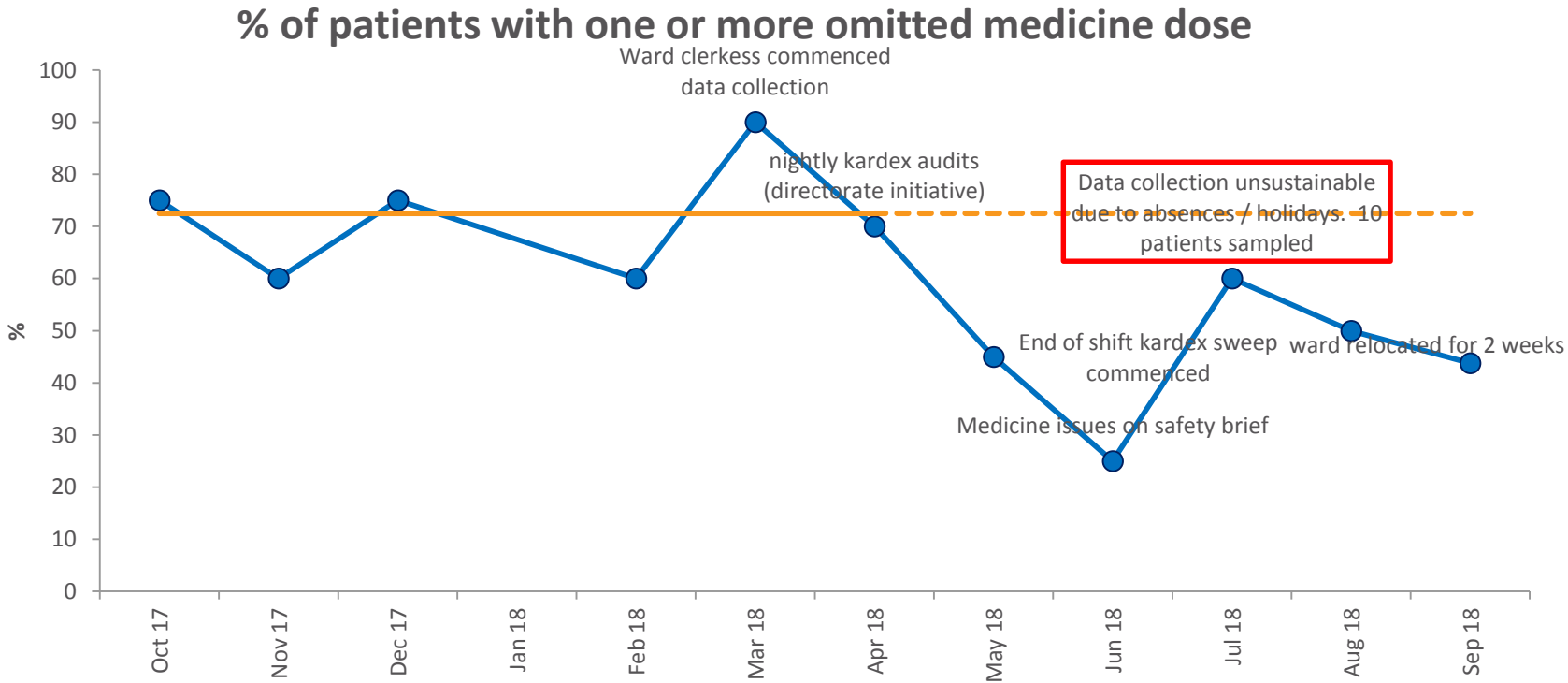
What did we do?

- MDT meetings
- Elderly 30 bedded rehab ward
- Initially lead by group & SCN/ward pharmacists
- Raising awareness around omitted & out of stock medicines
- Data collection by different staff members
- Review ward medication list
- Encourage where to look for medicines
- Post medicines sweep
- Raise awareness around missed doses & missed dose algorithm
- If missed dose discovered then investigate then & there

% of Monthly Omitted Medicines



% Patients with one or more omitted medicines dose



Bonus success:

- Enhanced medical staff involvement with prescribing – reading along the kardex – not just down the medication list
- Adding this inclusion to the audit training for junior medical staff
- Emphasised on induction programme
- Spreading awareness when on rotations to other areas

What Next?.....

- Plan the same data collection approach in the same hospital but with different ward areas - identify and recruit a rotational team? Back fill cost?
- Similar ward but different hospitals across multiple sites within NHSGGC?
- Getting buy in from clinical areas – leadership
- Achieving consistency in collection methods even though the outcomes may be different
- Time scale? 2019 is fast approaching!

Presenters:

Judy Sinclair

Excellence in Care Lead

Sam McCarlie

Excellence in Care E-health Lead

Ten years of improving safety

NHS Orkney

From old Balfour Hospital.....

.....to new Balfour in 2019

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NHS SCOTLAND

NHS Orkney Context

Population approx 22.000 - Smallest Health Board

Rural General Hospital – 48 beds

- 23 Acute Beds – mixed speciality/gender
- 14 Assessment and Rehabilitation - mixed speciality/gender
- A&E/Minor Injuries
- Day Surgery/Theatre/Outpatients/Renal dialysis satellite unit
- Mainland Orkney and Island Community Health Care x 10 islands

ASSESSMENT & REHABILITATION

14 bed ward - Assessment and Rehabilitation - mixed speciality/gender

3 Ward Registered Nurses -

Sheila, *(retired in March 2018)*, Joyce and Evelyn

Interim SCN Linda

Pharmacist Adelle

Dr Elaine

Excellence in Care Leads – Judy and Sam

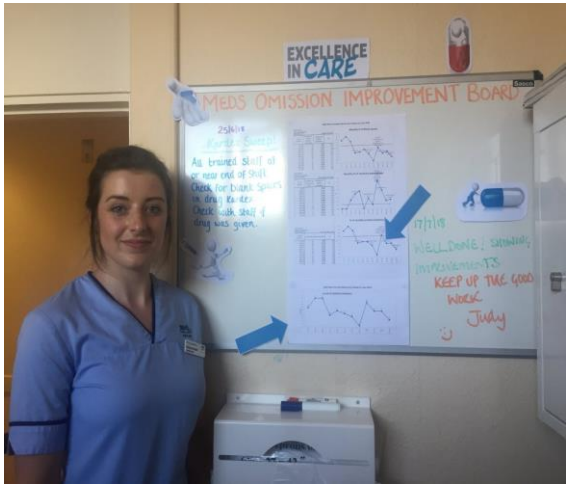
What did we do?

- All staff were included at all steps in the process
- Key individuals identified helped to ensure consistency and communication
- Change ideas tested and modified
- Raising awareness around omitted medicine's
- Regular national WebEx's and visit from national team - beneficial in keeping up momentum and sharing of learning with other Boards

WHAT WENT WELL

Tests of Change:

- Adding to daily safety brief
- Written process to guide staff in completion of audit
- Written guidance on data entry
- Kardex sweep at end of shift
- Reviewing stock medicines and processes
- Whiteboard to show results and provide encouragement
- Discussions at ward meetings

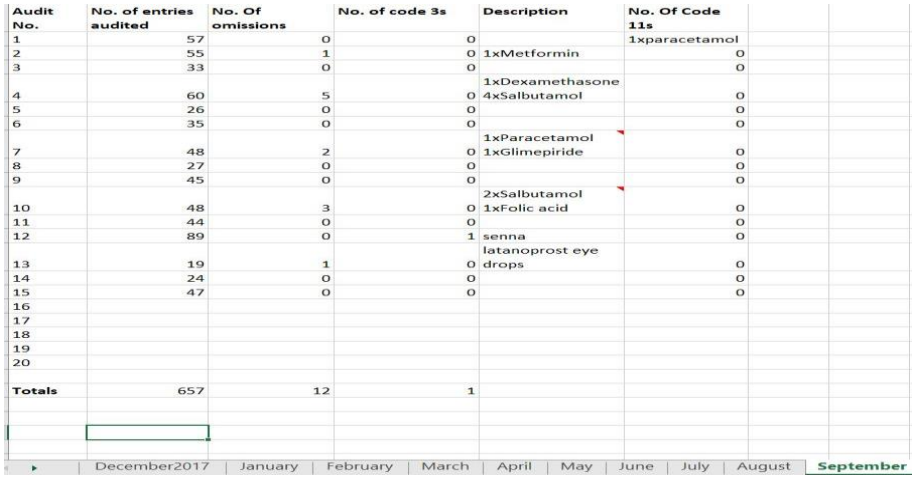


WOULD HAVE BEEN EVEN BETTER IF....

- Defining the inclusion/exclusion criteria earlier in process
- Earlier recruitment to senior nurse position
- Able to spend more time as an 'improvement team'
- Ensured earlier detailed communication in regard to audit process - *this resulted in incorrectly recording a high number of omissions for one month*

Omitted Medicines Data

Collection Process uses a local tool and written guidelines;



Audit No.	No. of entries audited	No. Of omissions	No. of code 3s	Description	No. Of Code 11s
1	57	0	0		1xparacetamol
2	55	1	0	1xMetformin	0
3	33	0	0		0
				1xDexamethasone	
4	60	5	0	4xSalbutamol	0
5	26	0	0		0
6	35	0	0		0
				1xParacetamol	
7	48	2	0	1xGlimepiride	0
8	27	0	0		0
9	45	0	0		0
				2xSalbutamol	
10	48	3	0	1xFolic acid	0
11	44	0	0		0
12	89	0	1	senna	0
				latanoprost eye	
13	19	1	0	drops	0
14	24	0	0		0
15	47	0	0		0
16					
17					
18					
19					
20					
Totals	657	12	1		

December2017 | January | February | March | April | May | June | July | August | September

Omitted Medicines Data Entry

The spreadsheets to populate are in folder:

G:\Clinical Safety & Quality\Excellence in Care\Group 3 Omitted Meds\local submission info

Audit data goes into spreadsheet: **Ward Monthly Feedback datasheets**

Data to be submitted goes into: **Omitted Medicines Orkney Submission2017_18**

1. Open up spreadsheet **Monthly Feedback datasheets**
2. Go to the tab for the correct month
3. In column B, enter the number of administrations in each audit
4. In column C, enter the number of omitted meds (blank spaces on cardex)
5. In column D, enter the number of medicines not available (code 3s)
6. In column E, enter a description of the medicines not available or omitted and the number of occurrences of each, if available.
7. **After every 5 records or so, save the spreadsheet (Ctrl+S is the keyboard short cut)**
8. Each numerical column will be automatically totalled. Make a note of the 3 totals for No. of entries audited, no. Of omissions and no. of code 3s
9. Make a note of the number of patients who had an omitted medicine or medicine not available and the number of patient audits for the month.
10. Open spreadsheet **Omitted Medicines Orkney Submission2017_18**
11. Open the Data tab. In column B, enter the 1st of the month being audited.
12. In column C, enter the No. of entries audited; in column D, the no. Of omissions and in column E, the no. of code 3s.
13. In column F, the number of patients who had an omitted medicine or medicine not available and in column G, number of patient audits for the month.
14. Save the spreadsheet.
15. Check each of the tabs to check the data is as recorded in the ward monthly feedback datasheet, and the graphs have updated correctly and are readable.

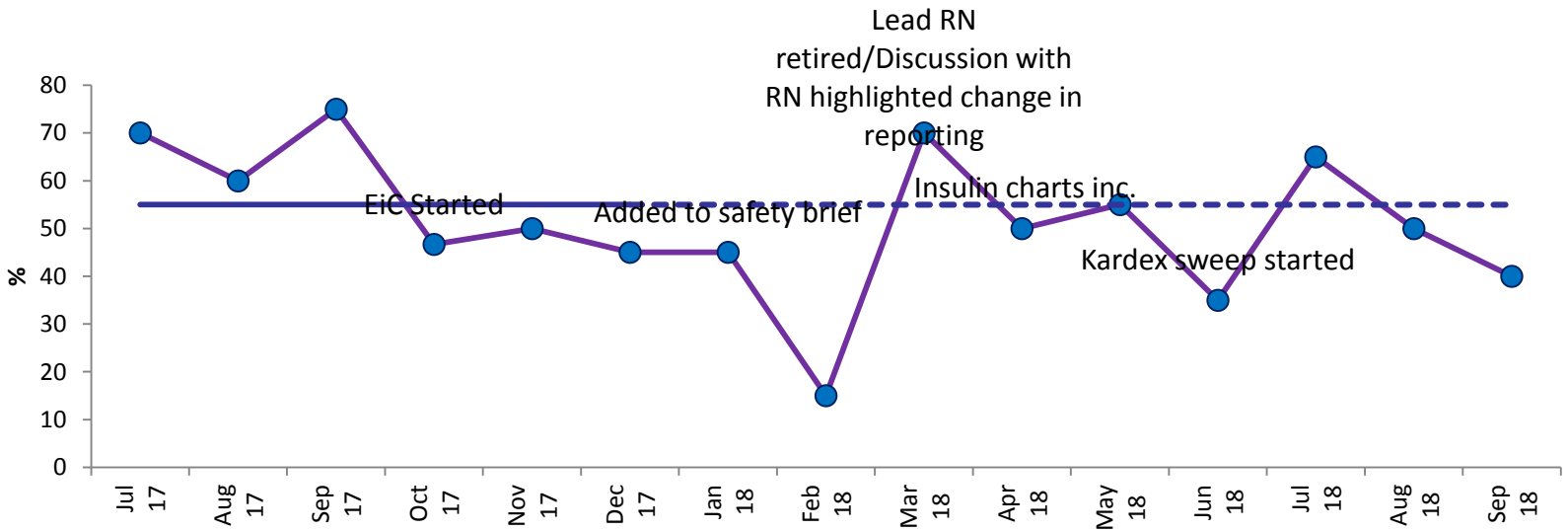
Update the text feedback sheet, as required;

Open the folder Monthly Feedback sheets, in the local submission info folder.
Click on the Word template 'Template OM EiC Test site monthly feedback form'. Enter the reporting period of the current month and save as a word document, in the format 'NHS Orkney <Month YY> Omitted Medicines EiC Test site monthly feedback form', where <Month YY> is the reporting month and year.

Add any comments deemed relevant and save.
This will be submitted to SG along with the data spreadsheet.

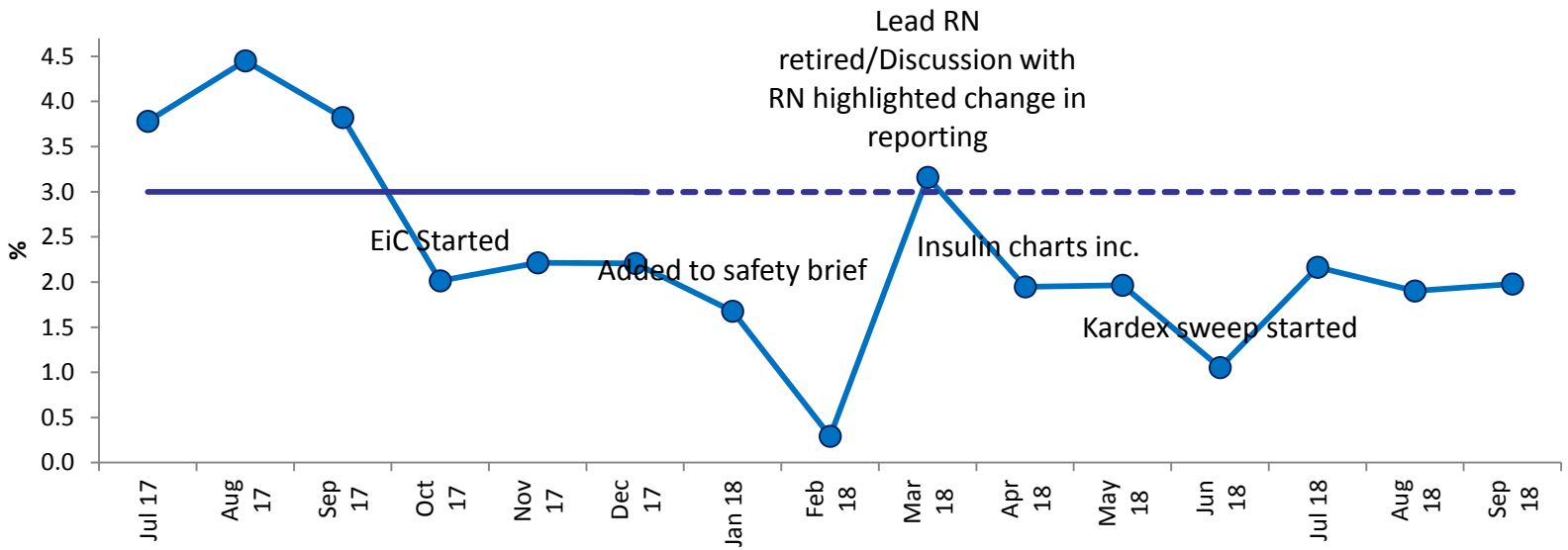
% Patients with one or more Omitted Medicine

Data transferred for submission and graphs created for use in ward safety brief



% of monthly Omitted Medicines

EiC OM measure – % OM rate



TOP TIPS FOR OTHERS

- Have an ‘improvement team’ and make time to meet
- Ensure leadership support from Team Leader/SCN
- Regular meetings/support from other areas- within own hospital or with others
- Have as much information as possible – learn from others
- Clear written guidance on processes to enhance consistency
- Positive feedback is encouraging and welcomed – verbal and on white board
- QI knowledge and skills are needed, at least one person in team

LOCAL NEXT STEPS

- Plan to continue with data collection and improvement work within existing team
- Agree timescales and process to roll out to other ward areas
- Spread quality improvement methodologies and learning and with more staff/teams
- Consider implications and plan roll out to community teams

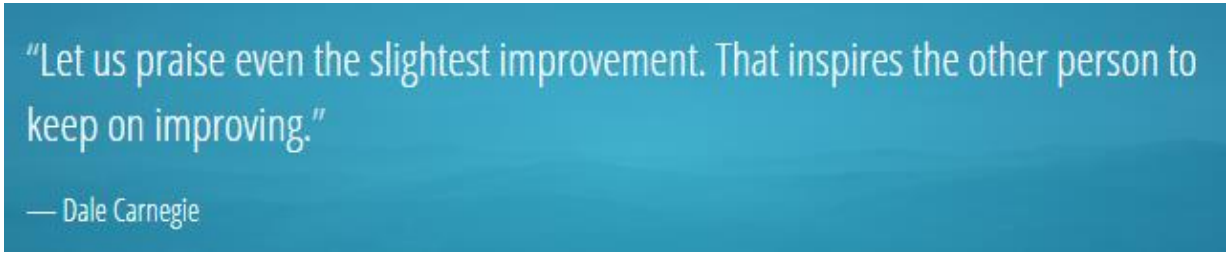
COMMON THEMES

NHS Eileanan Siar Western Isles

NHS Greater Glasgow and Clyde

NHS Orkney

- Defining and adhering to inclusion / exclusion criteria
- WebEx is powerful– encourages collaboration and networking
- Kardex sweep was identified as beneficial across all 3 sites
- Avoid one person doing data collection – needs to be shared



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Using a QI approach to reducing omitted medicines - Outcomes

Prepared by: Xenia Dennison, Improvement Advisor, Healthcare Improvement Scotland.

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Outcomes:

To develop a measure(s) related to omitted medicines for consideration for the EiC Framework:

% omitted medicines (rate)

% of patients with one or more omitted doses

Outcomes:

To identify an appropriate recommended national aim for omitted medicines improvement work:

50% reduction (improvement) from baseline

Outcomes:

To use QI methodology to support improvement work in the reduction in medicines administration omissions (blank spaces and medicines not available):

You have heard from the three test sites

Resources will be available on the SPSP Medicines website soon

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Any Questions?

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WebEx Series

- Patient empowerment
- Education
- QI support
- Work processes
- Recognition for excellence
- Digital [IT] systems

Every Person Every Time
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Webex Series 2018/2019			
Date	**Time**	**Presenters**	**Topic**
Thursday 8th November	3pm – 4pm	NHS Greater Glasgow & Clyde	Digital solutions to reduce medicines transcription
Thursday 17th January	3pm – 4pm	NHS Lothian and Northern Ireland	Medicines reconciliation and supervision for safer prescribing

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See you on 8th November…….

spsp-medicines.hcis@nhs.net

http://ihub.scot/spsp/medicines/

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to welcoming you to...

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FORUM