Project Leads: Ellen Marshall – Patient Safety Pharmacy Technician and Cecile Gascon – 9B Nurse Team Leader

Subject Matter Expert: Rachel Bulloch – Principal Pharmacist (Patient Safety) – Patient Safety Specialist

9B Ward Team

QI Lead – Bianca Viegas – Harm Free Care Programme Lead

Reducing delays and omissions of critical medicines: Ward 9B QI project

NHS East and North Hertfordshire NHS Trust

Introduction

- Rise in delays and omissions of critical medicines on ward 9B
- To improve safety and experience of care and minimise the delays and omissions of critical medicines;
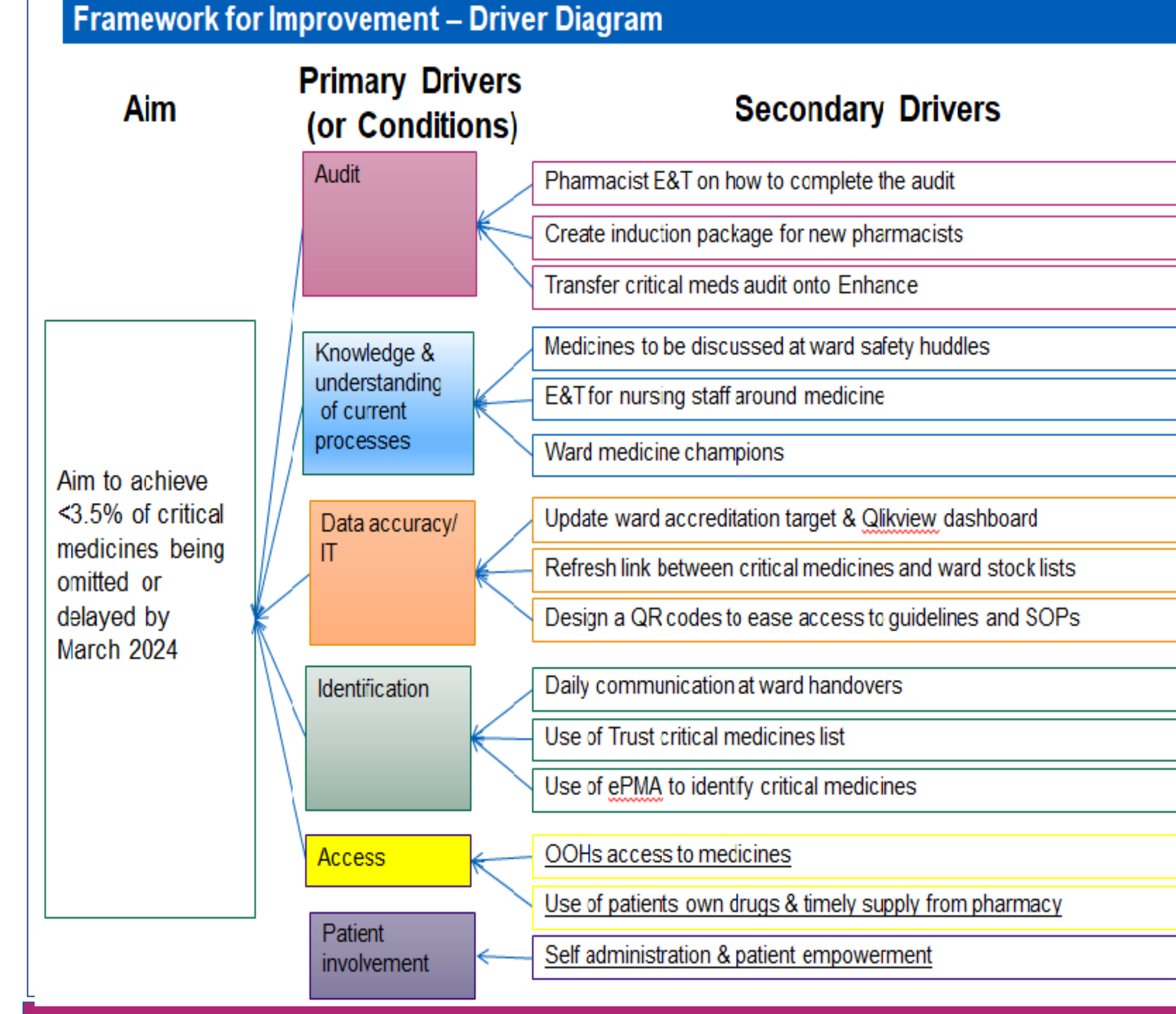- Key priority in harm free care programme and the quality account
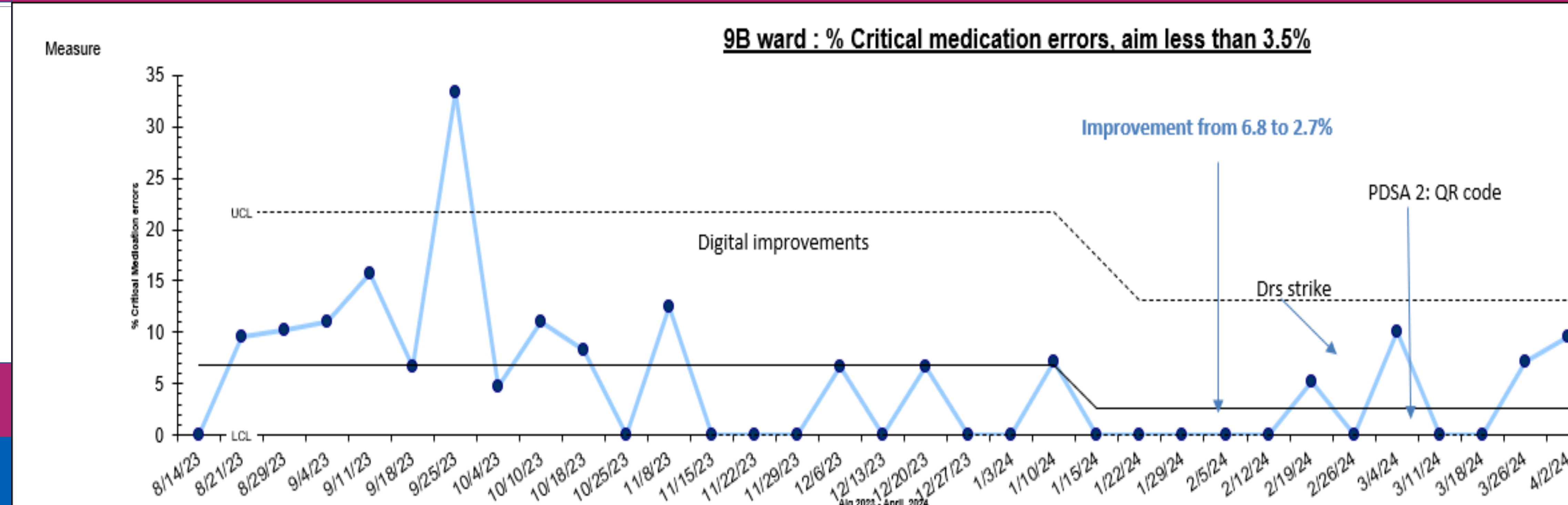
The approach

Project aim

To reduce the number of delayed and omitted medicines to <3.5% by March 2024.

Driver Diagram

Framework for Improvement – Driver Diagram

Aim to achieve <3.5% of critical medicines being omitted or delayed by March 2024

Primary Drivers (or Conditions)
- Audit
- Knowledge & understanding of current processes
- Data accuracy/ IT
- Identification
- Access
- Patient involvement

Secondary Drivers
- Pharmacist E&T on how to complete the audit
- Create induction package for new pharmacists
- Transfer critical meds audit onto Enhance
- Medicines to be discussed at ward safety huddles
- E&T for nursing staff around medicine
- Ward medicine champions
- Update ward accreditation target & Qlikview dashboard
- Refresh link between critical medicines and ward stock lists
- Design a QR codes to ease access to guidelines and SOPs
- Daily communication at ward handovers
- Use of Trust critical medicines list
- Use of ePMA to identfy critical medicines
- OOHs access to meicines
- Use of patients own drugs & timely supply from pharmacy
- Self administration & patient empowerment

Impact

9B ward : % Critical medication errors, aim less than 3.5%

Change ideas

- QR code poster to be used on ePMA drug trolleys which referenced the critical medicines list, drug location list and emergency drug cupboard list
- Bitesize nurse training on how to access medicines out of hours
- Changes made to medication administration rounds where the night staff started giving the morning medicines before their shift ended
- Prioritised giving critical medicines first during medication rounds
- Digital impact: enabled the ward to digitally transfer patients from ED to ward 9B and refreshed the link between critical medicines and ward stock lists

Improvement methodology

QI learning and challenges

- Through the use of QI tools such as process mapping and driver diagram, we were able to identify problems
- We improved the reliability of medication rounds by regular communication and this also increased the awareness of critical medicines
- Trust the process of using QI methodology
- Good MDT engagement and teamwork that lead to success
- Challenges: Staff availability to attend training, ward capacity issues impacting the pace of project delivery

Next steps

- Scale and spread QR code poster to other ward areas
- Provide training on how to use the posters
- Expand the project to pharmacy dispensary to strengthen our process across the patient pathway

References: ENHT critical medicines list