Omitted Doses Re-audit 2015

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South Eastern Health and Social Care Trust

Background…..

- Medicines are often omitted and delayed
- Omitted & delayed doses *second largest cause of medication incidents reported to* NPSA

  (National Patient Safety Agency 2007)
- Drug omissions can have serious even fatal consequences e.g. antibiotics, anticoagulants, insulin

Drug non-administration codes :

Regular Non - Injectable Medicines

Codes for Recording Omitted Doses

- (N) = nil by mouth
- (R) = patient refused
- (P) = patient not available
- (S) = unable to swallow
- (V) = vomiting
- (D) = drug not available*
- (DR) = prescribed omission*
- (O) = other*

*Record reasons for omitted doses on page 12

Write in CAPITAL LETTERS or use addressograph

Surname: .....

First names: .....

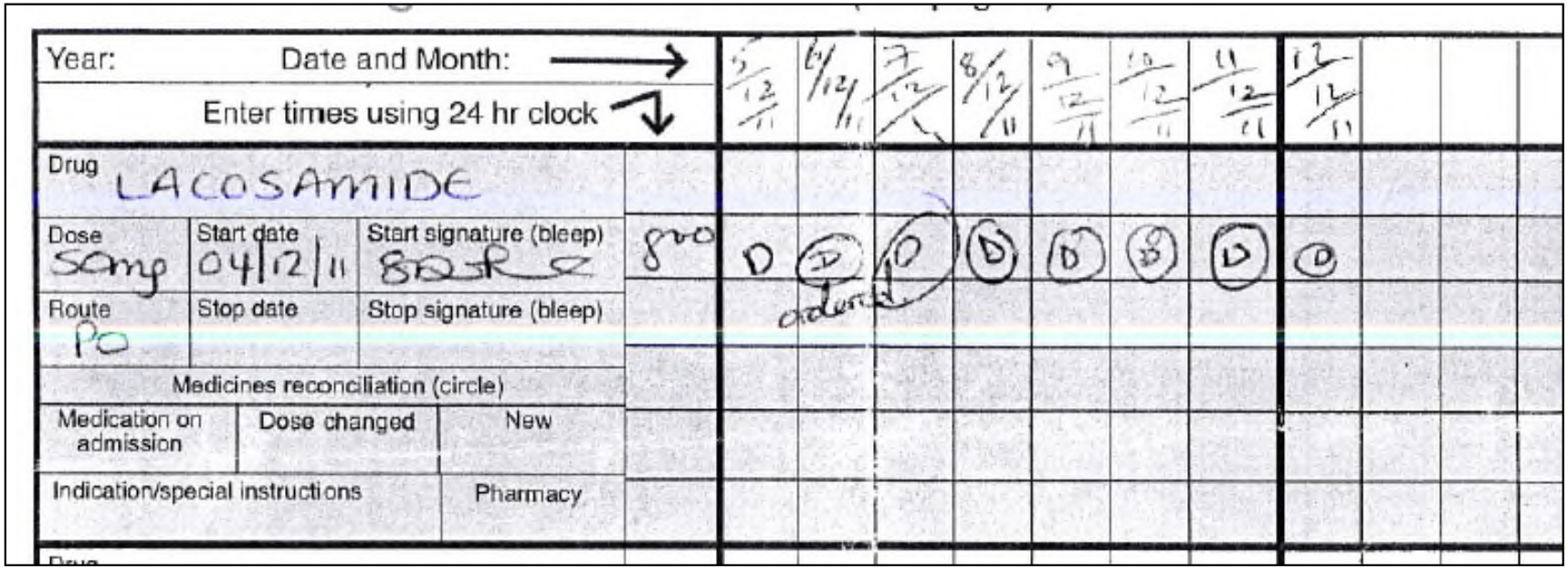
Hospital number: .....

D.O.B.: .....

Codes for recording omitted doses Review delayed or omitted doses at each medicine round

- (1) = Nil by mouth
- (2) = Patient refused
- (3) = Patient not available
- (4) = Route not available
- (5) = Vomiting
- (6) = Drug not available
- (7) = Other (Record on pg.9)
- (8) = Prescriber enters for each dose to be withheld

Kardex Examples :



NHS
National Patient Safety Agency

Rapid Response Report

NPSA/2010/RRR009

From reporting to learning — 24 February 2010

Reducing harm from omitted and delayed medicines in hospital

Issue

Medicine doses are often omitted or delayed in hospital for a variety of reasons. Whilst these events may not seem serious, for some critical medicines or conditions, such as patients with sepsis or those with pulmonary embolisms, delays or omissions can cause serious harm or death. Patients going into hospital with chronic conditions are particularly at risk. For example, patients with Parkinson's disease who do not receive their medicines on time may recover slowly or lose function, such as ability to walk. This has been highlighted by the Parkinson's Disease Society's 'Get it on time' campaign, which has produced resources for both patients and staff to help raise awareness and enable patients to get their medication on time.

The Productive Ward initiative from the National Health Service Institute for Innovation and Improvement (NHS III) provides information on minimising interruptions and streamlining the medicines ward round and National Patient Safety Agency (NPSA)/National Institue for Health and Clinical Excellence (NICE) guidance on medicines reconciliation supports the reduction in omitted doses. These are useful resources, but further work is needed in the NHS to address this as an important patient safety issue.

Patient safety incidents

Between September 2006 and June 2009, the NPSA received reports of 27 deaths, 68 severe harms and 21,383 other patient safety incidents relating to omitted or delayed medicines. Of the 95 most serious incidents, 31 involved anti-infectives (antibiotic and antifungals), and 23 involved anticoagulants. Wider evidence suggests that the true rate of harm may be much higher, as events such as these are often not reported.

Work on reducing risks with omitted and delayed critical medicines is needed over a long period. The NPSA is recommending a staged approach, with initial actions now focused on specific critical medicines and longer term work with stakeholders over the next two years to sustain improvements over time.

For IMMEDIATE ACTION by all organisations in the NHS and independent sector who admit patients for in-patient treatment. Deadline for ACTION COMPLETE is 24 February 2011.

An executive director, nominated by the chief executive, working with the chief pharmacist and relevant medical/nursing staff should:

1. identify a list of critical medicines where timeliness of administration is crucial. This list should include anti-infectives, anticoagulants, insulin, resuscitation medicines and medicines for Parkinson's disease, and other medicines identified locally;
2. ensure medicine management procedures include guidance on the importance of prescribing, supplying and administering critical medicines, timeliness issues and what to do when a medicine has been omitted or delayed;
3. review and, where necessary, make changes to systems for the supply of critical medicines within and out-of-hours to minimise risks;
4. review incident reports regularly and carry out an annual audit of omitted and delayed critical medicines. Ensure that system improvements to reduce harm from omitted and delayed medicines are made. This information should be included in the organisation's annual medication safety report;
5. make all staff aware (by wide distribution of this RRR) that omission or delay of critical medicines, for inpatients or on discharge from hospital, are patient safety incidents and should be reported.

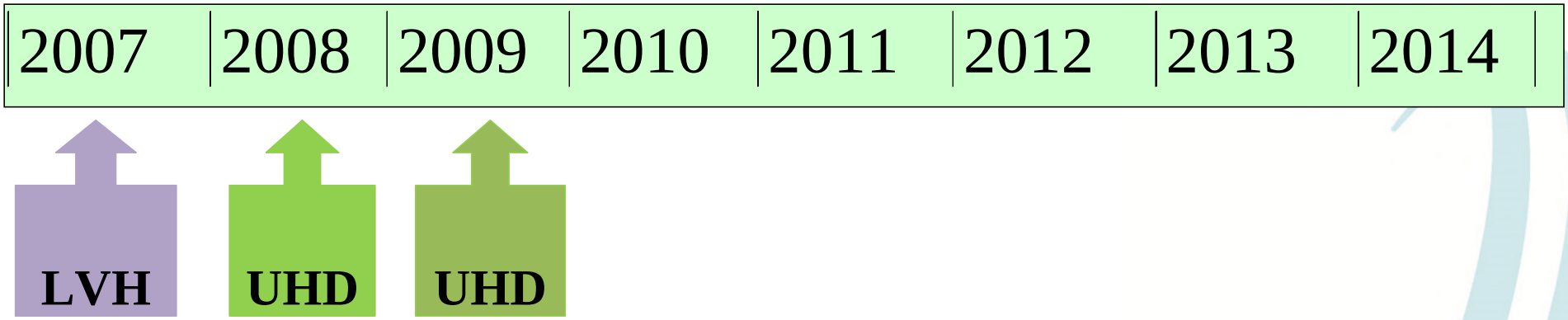
Further information

Supporting information including detailed evidence of harm and compliance checklists are available at www.nrls.npsa.nhs.uk/alerts. Further queries should be directed to the NPSA medication safety team at rrr@npsa.nhs.uk; telephone 020 7927 9690.

The NPSA has informed: NHS organisations, independent sector, commissioners, regulators and relevant professional bodies in England and Wales.

Gateway ref: 13614

Previous Audits:



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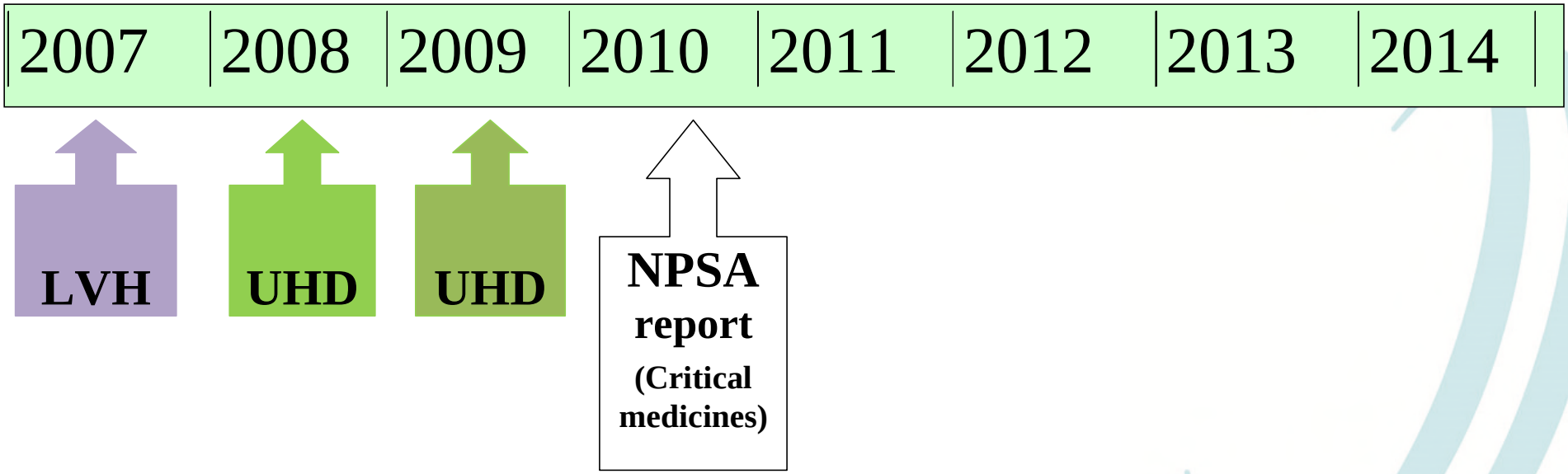
Previous Audits



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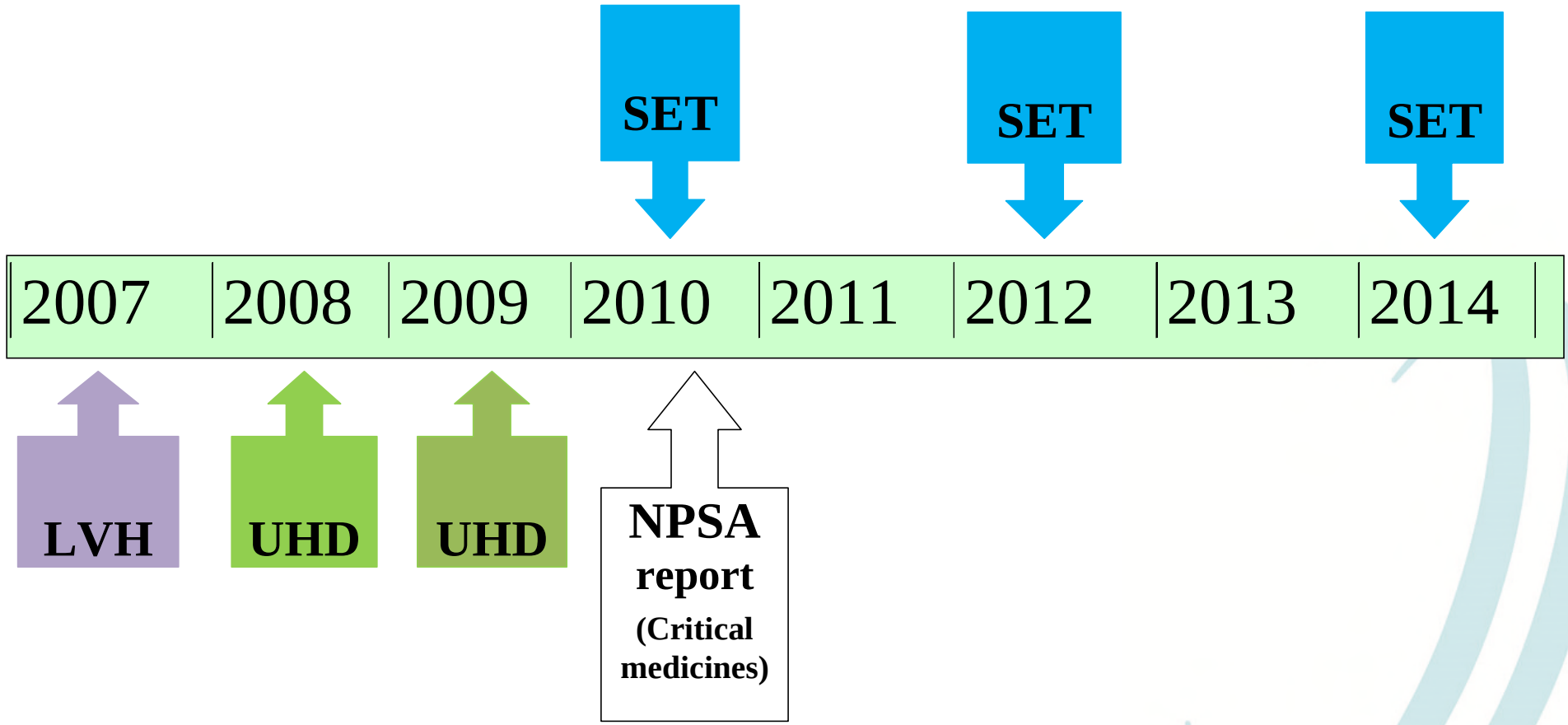

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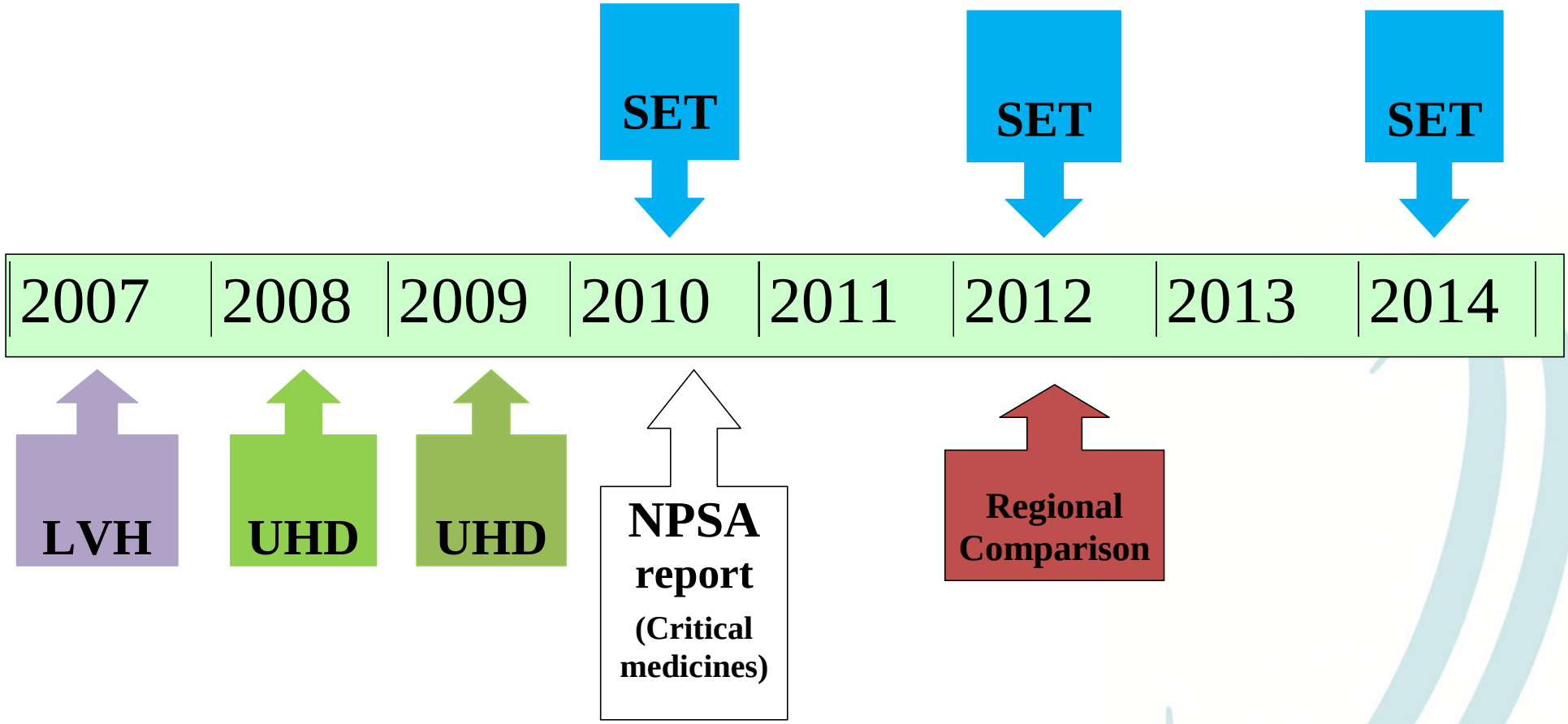

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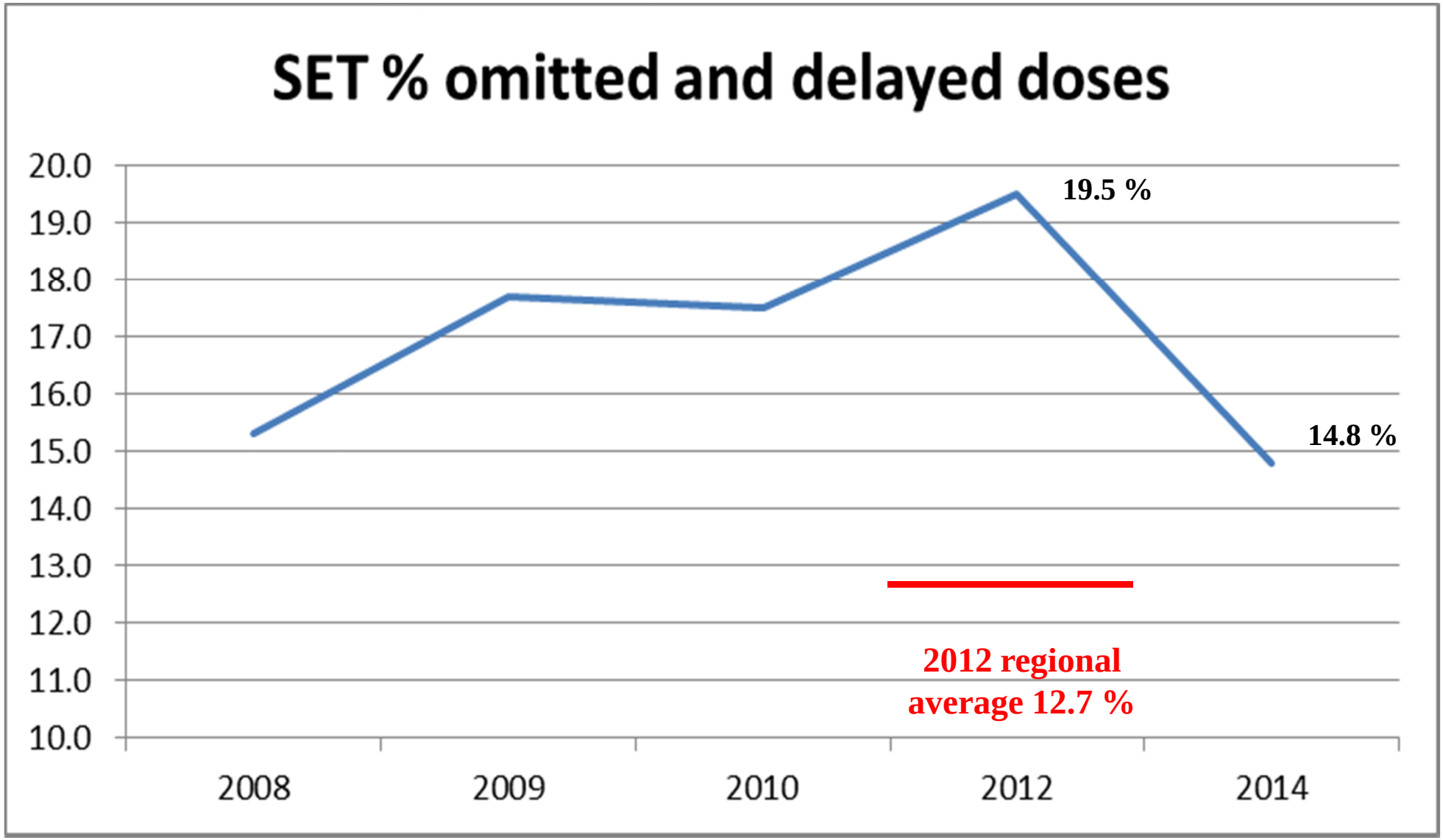
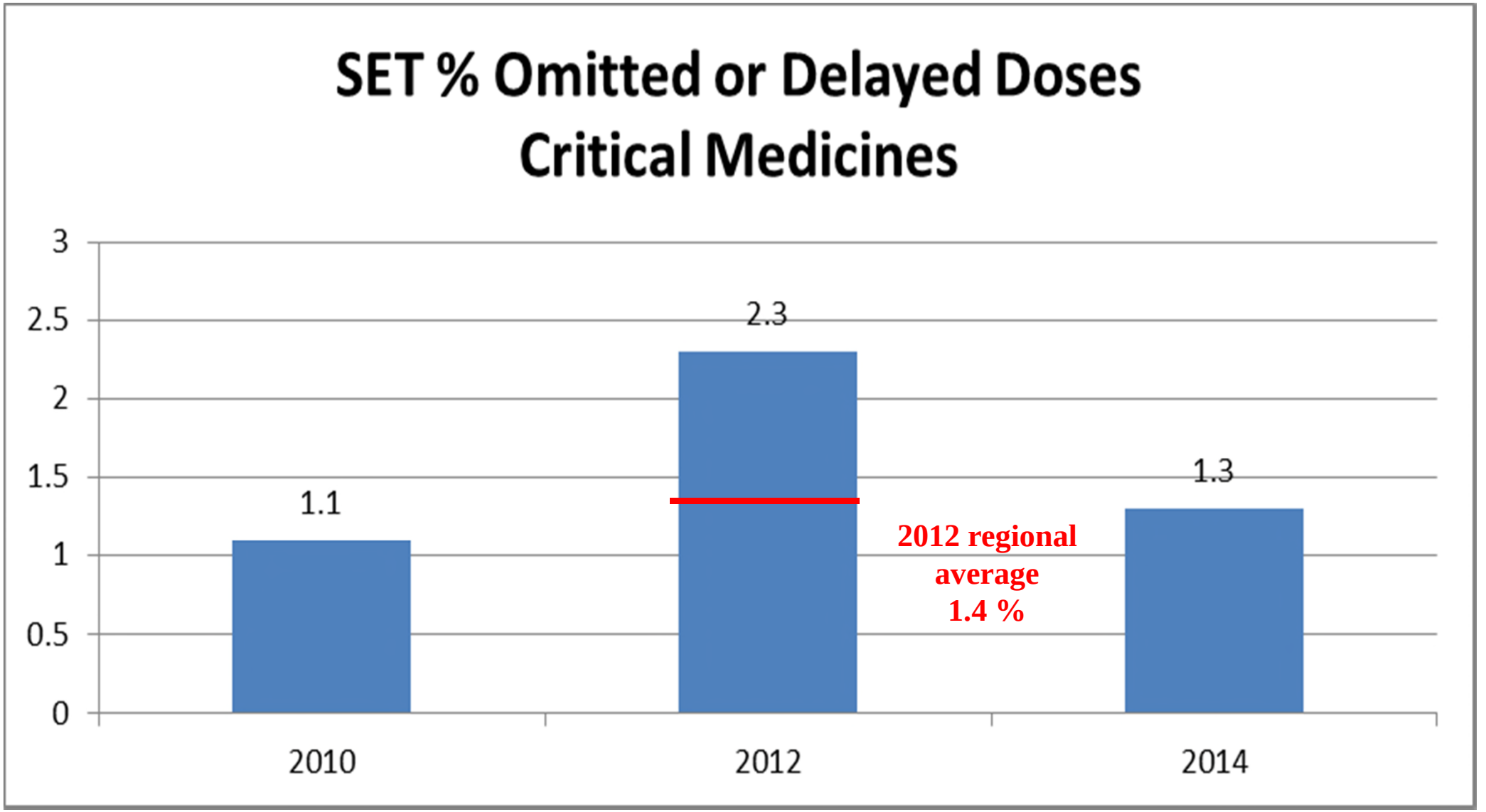
What did the data tell us ?

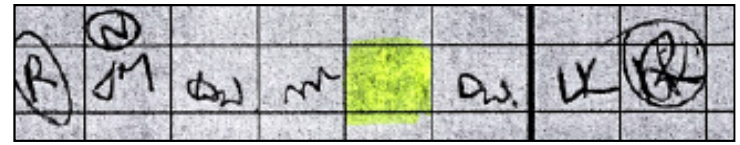


Critical Medicines …..

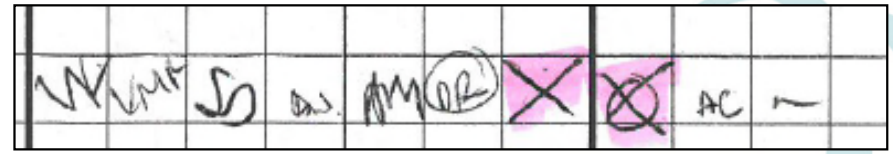


Other problems ....

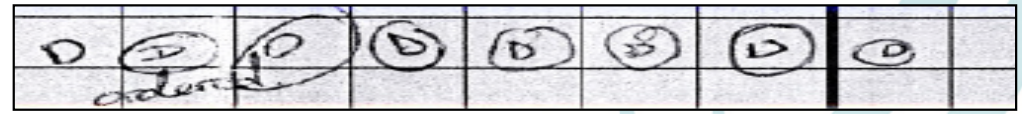
- Blank spaces (where a code should be)
  - TOO MANY !!



- Use of X
  - Not an authorised code



- Code ‘D’
  - medicines should be available in a timely manner



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Work to date …..

Communication of audit results at directorate meetings

Pharmacy LEAN project (supply of medicines)

Nursing KPI

Medicines Finder

Lunch and Learn

Omitted Doses Roadshow

Critical medicines Cupboard

Posters, Trolley Cards

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HARM FROM OMITTED
Omitted Doses Re-audit 2014
GET IT ON TIME
People with Parkinson's need their medication on time – every time.
THANK YOU


Pentasa

Accessing medicines out of hours : Searching for wards that stock a drug

UH WARD 8
UH WARD 9

CO-BENELDOPA 12.5/50 Capsules 100 Capsule Pack - MADOPAR	Stock Level
DH WARD 1	1
DH WARD 2	1
LVH REHABILITATION UNIT	1
LVH WARD A1 - GENERAL MEDICINE	1
LVH WARD B1 - GENERAL MEDICINE	1
UH ED AMBULATORY CARE	1
UH MAU	1
UH WARD 21	1
UH WARD 22	1
UH WARD 24	1
UH WARD 25	1

CO-BENELDOPA 12.5/50 Dispersible Tablets 100 Tablet Pack -	Stock Level
LVH MEDICAL ASSESSMENT UNIT 3	1
LVH REHABILITATION UNIT	1
UH ED AMBULATORY CARE	1
UH MAU	1
UH WARD 21	1

Aim of 2015 Audit

- To establish if the improvements noted in 2014 were maintained

- To identify areas where further improvement needed

Audit standards

Measures of Quality / Standards:

Evidence of Quality	%	Exception	Instructions and definitions for data collection
Approved drug non-administration codes are used whenever a prescribed dose on a kardex is not administered	100%		Examination of kardex
The code X is not used to record non-administration of a dose	100%		Examination of kardex
There is no blank space on the kardex where dose administration should be recorded	100%		Examination of kardex
Critical medicines should never be inappropriately omitted.	100%	Approved drug administration code	Examination of kardex

Method

- Data collection by Foundation year doctors and pharmacists
- All wards with a 2 week kardex
- Current kardex used
- 5 patients per ward
- All 3 main hospital sites
    - 40 wards

Results

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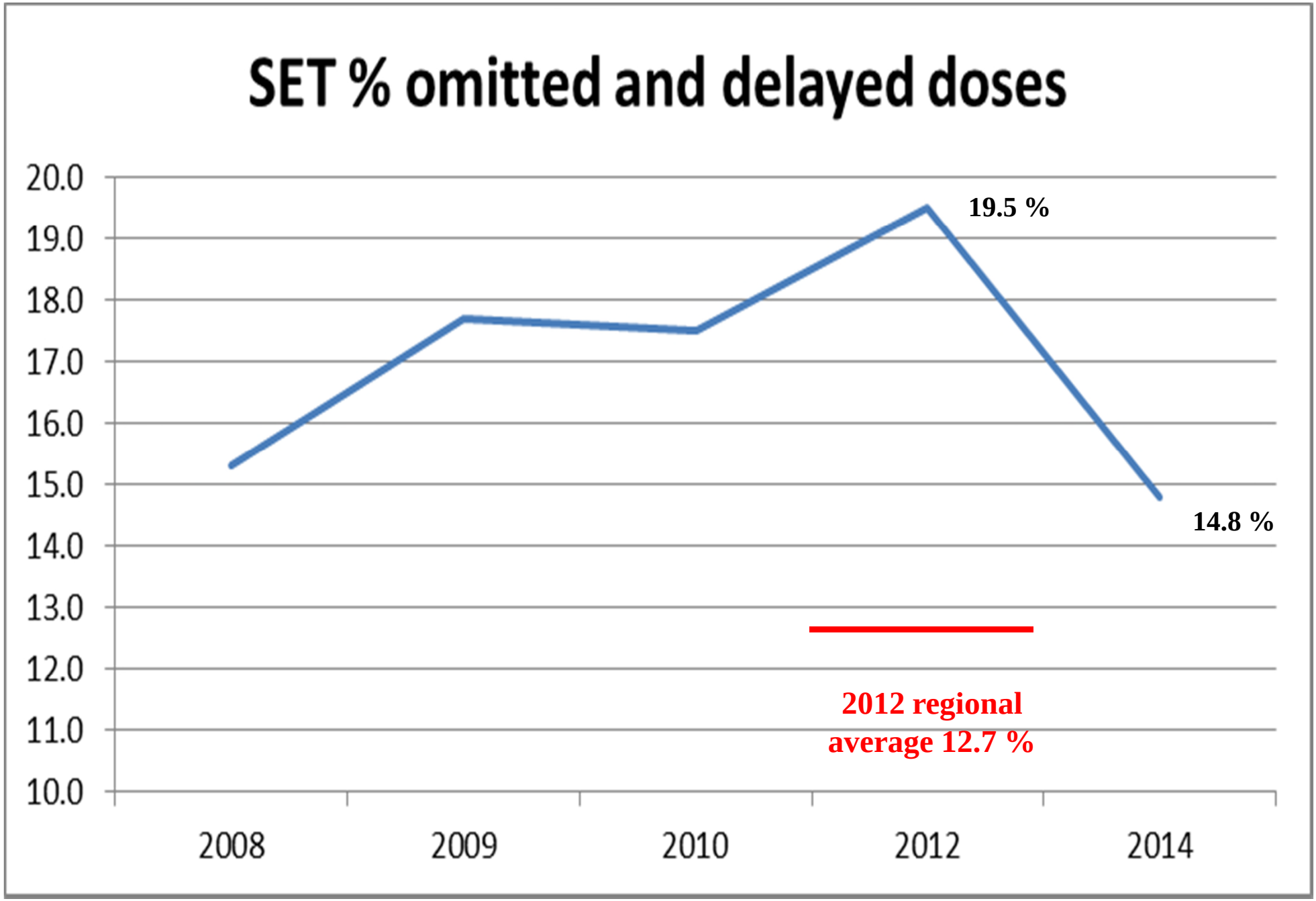
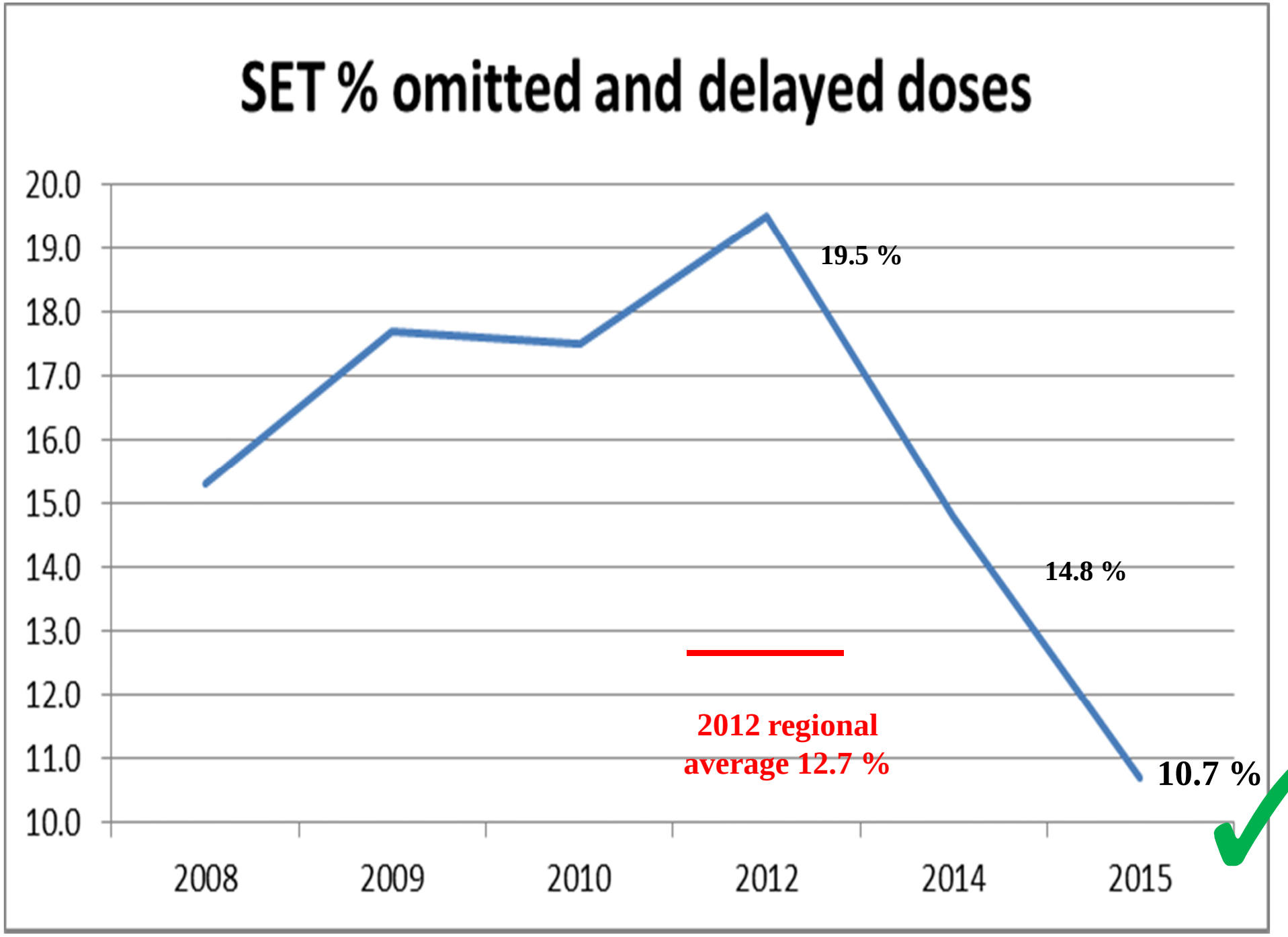
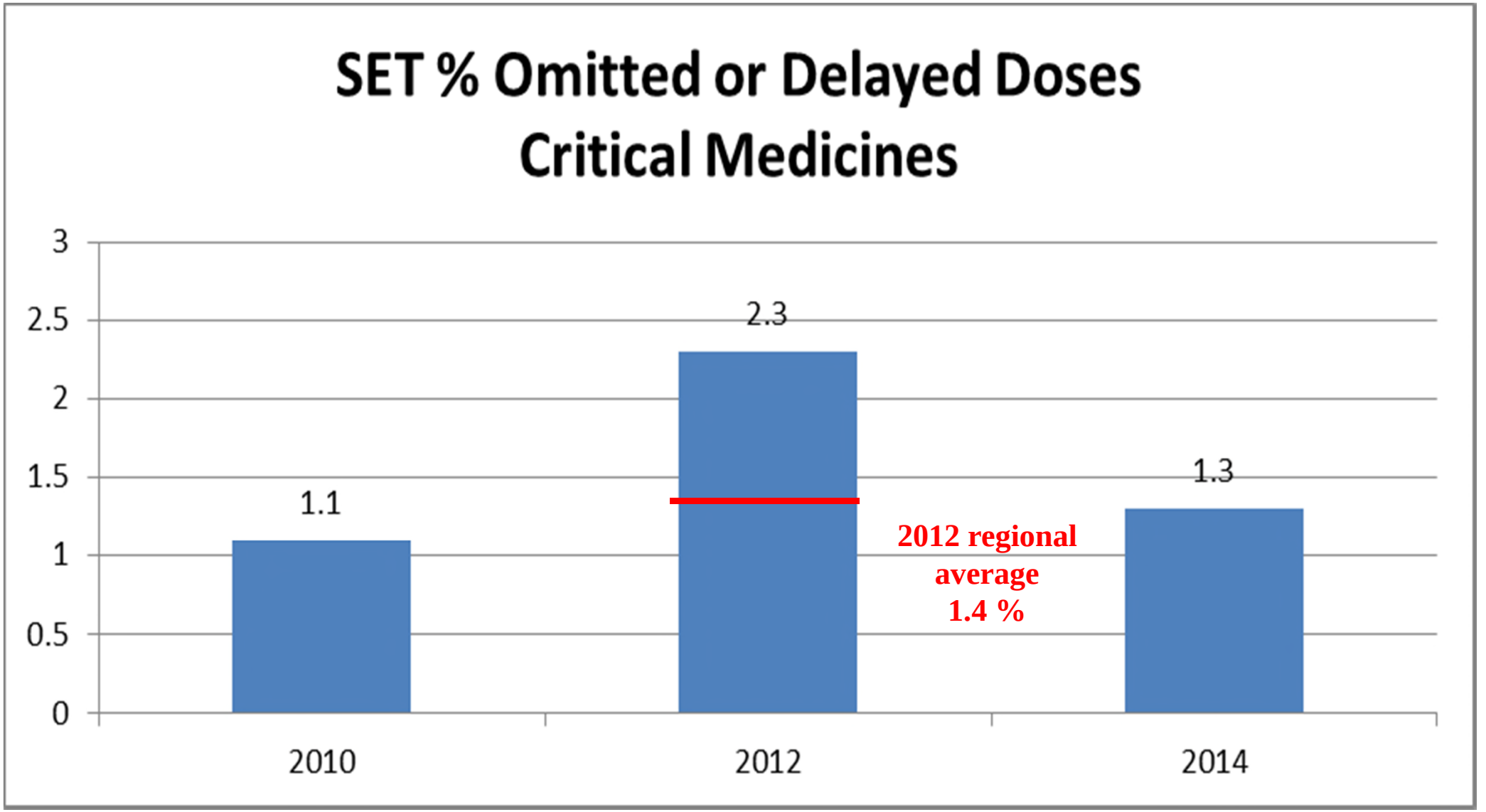
Omitted doses audit 2015

- 185 patients
- 12,266 doses audited
- 8% increase in doses prescribed

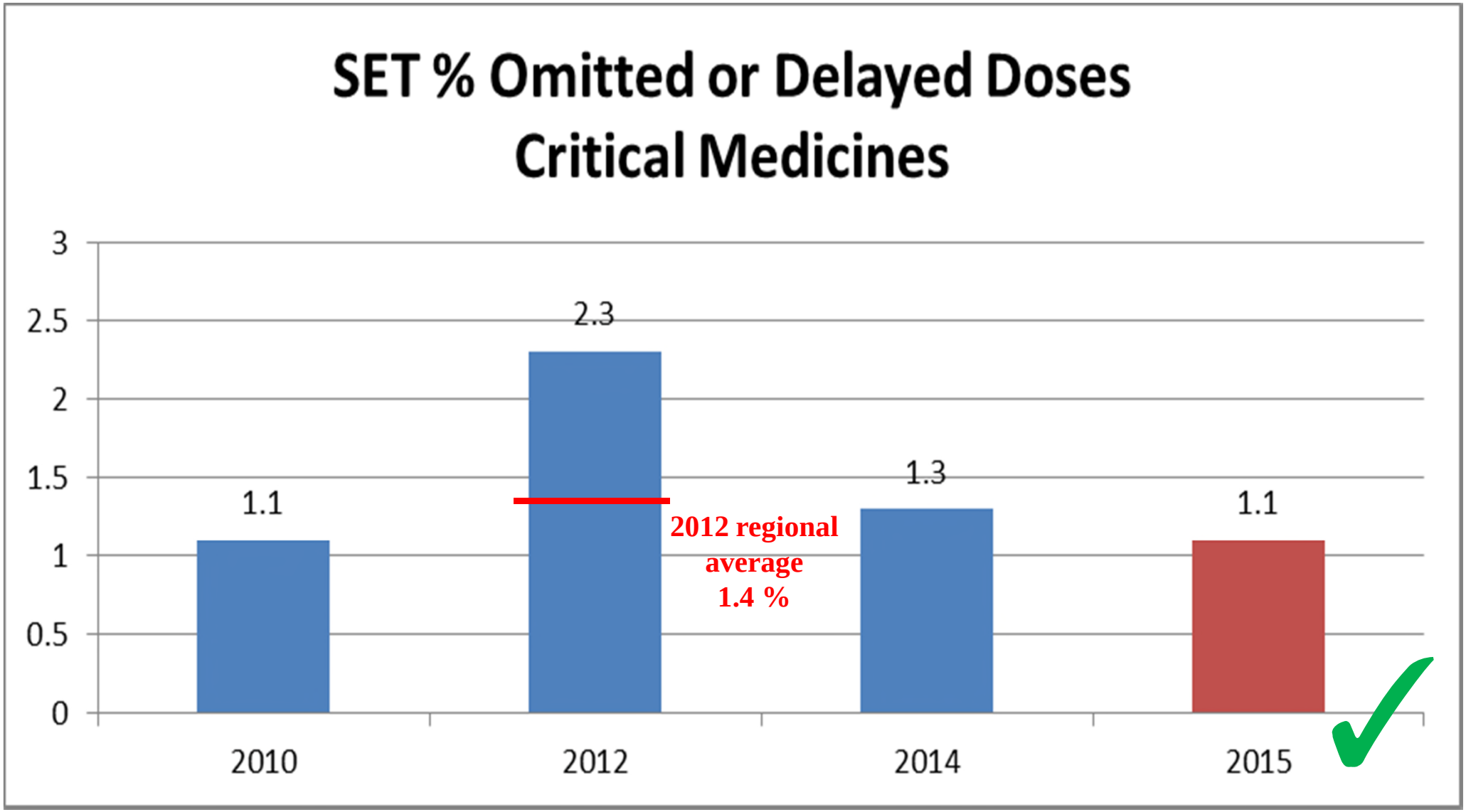

SET % omitted and delayed doses
20.0
19.0
18.0
17.0
16.0
15.0
14.0
13.0
12.0
11.0
10.0
19.5 %
14.8 %
2012 regional
average 12.7 %
2008
2009
2010
2012
2014


SET % omitted and delayed doses
20.0
19.0
18.0
17.0
16.0
15.0
14.0
13.0
12.0
11.0
10.0
19.5 %
14.8 %
10.7 %
2012 regional
average 12.7 %
2008
2009
2010
2012
2014
2015

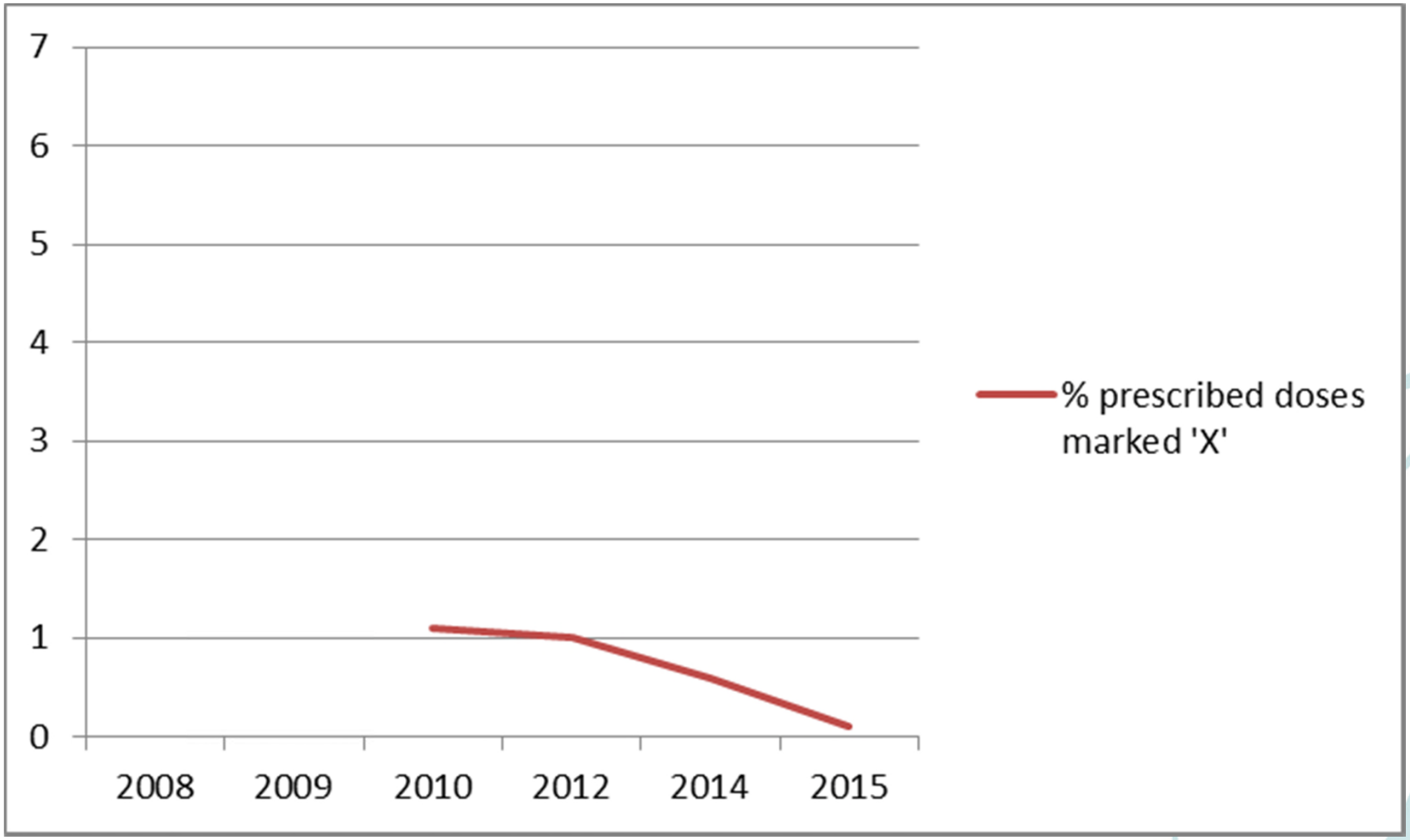
Critical Medicines …..



Critical Medicines .....



Inappropriate Omissions : ‘X’



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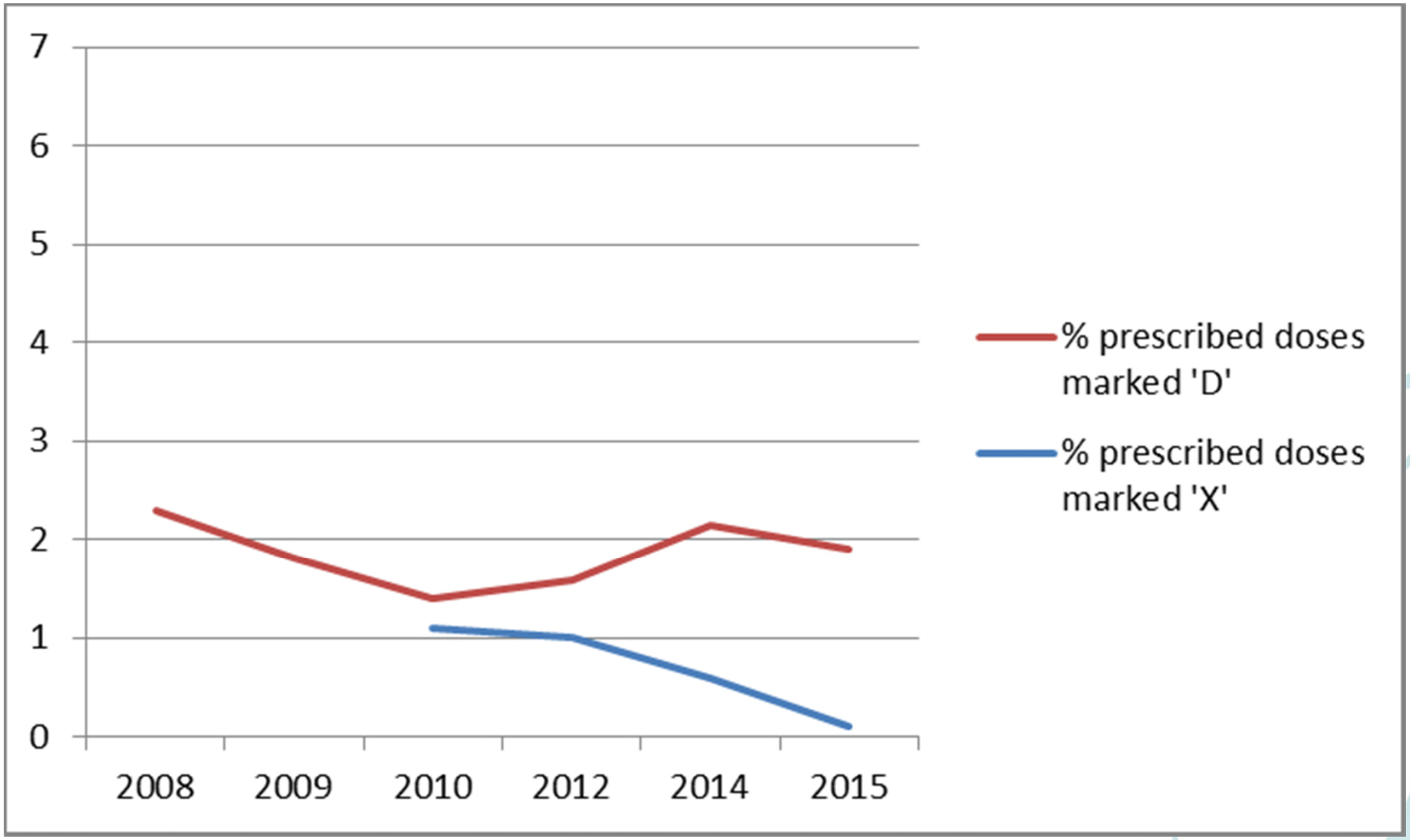
Inappropriate Omissions : ‘D’



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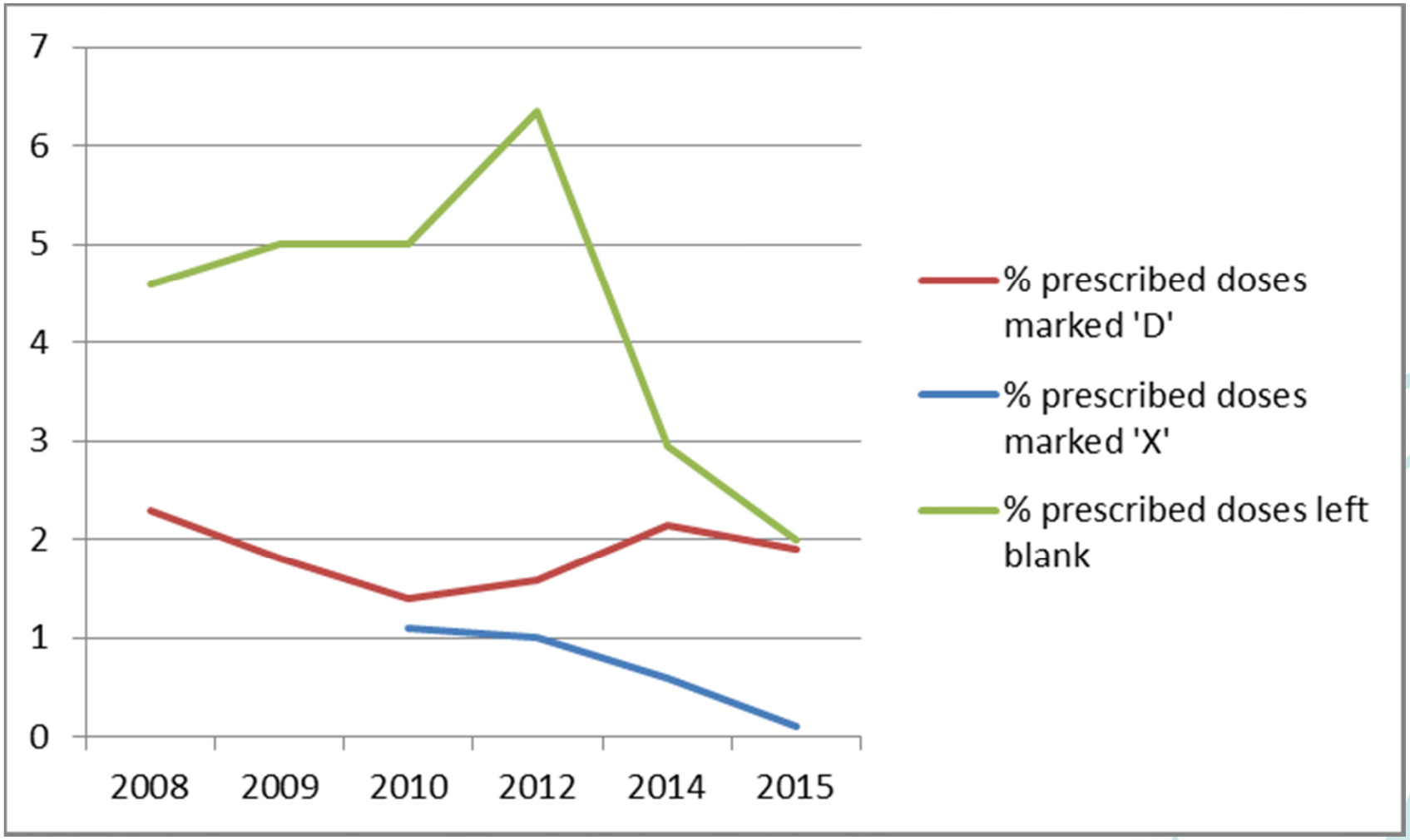
Inappropriate Omissions : ‘blank’



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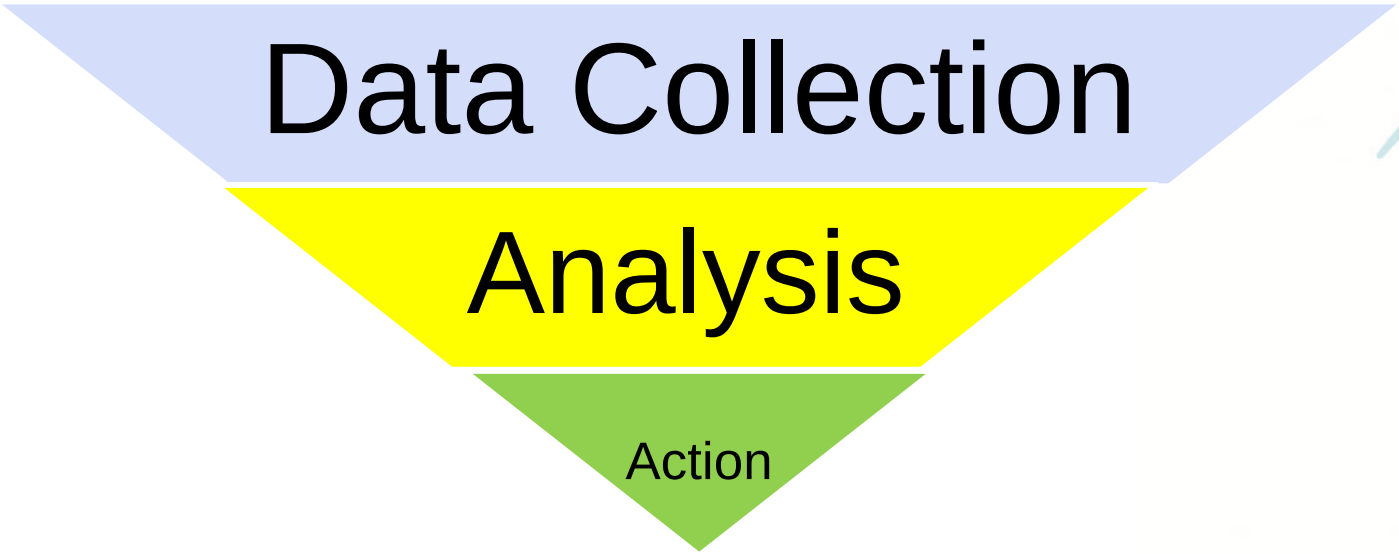
Aggregate Data …..

- May be misleading
- Can camouflage variation



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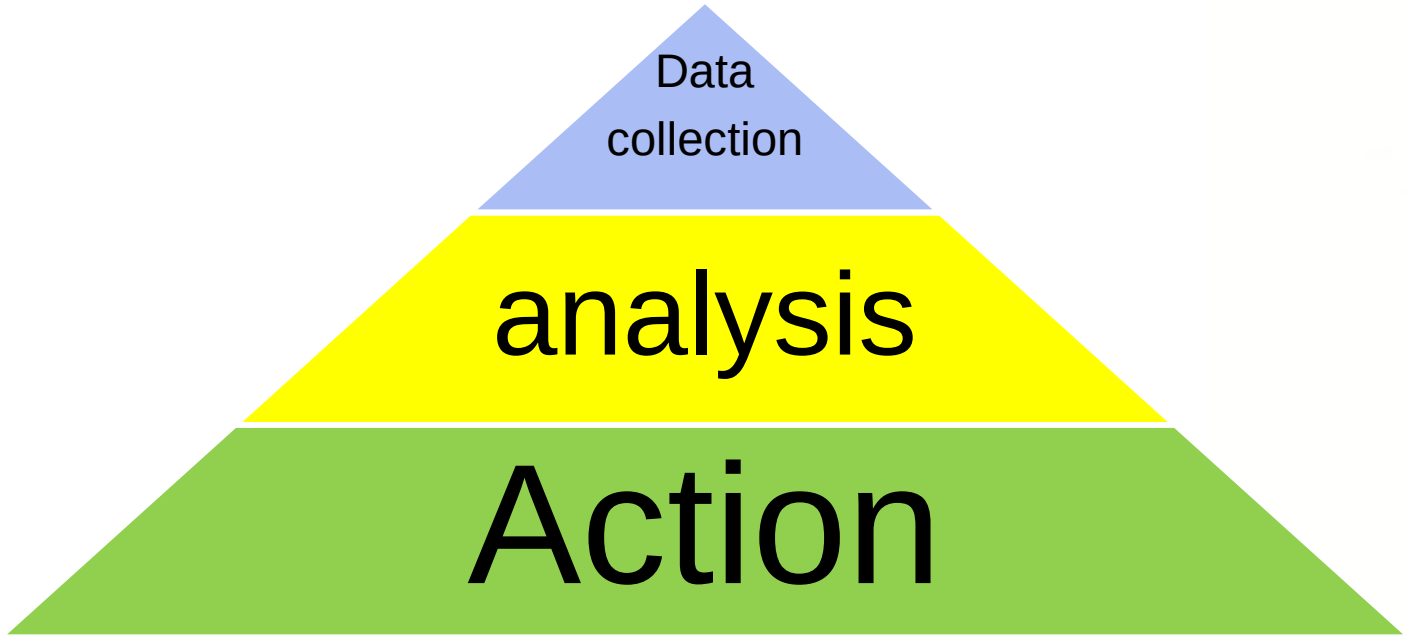

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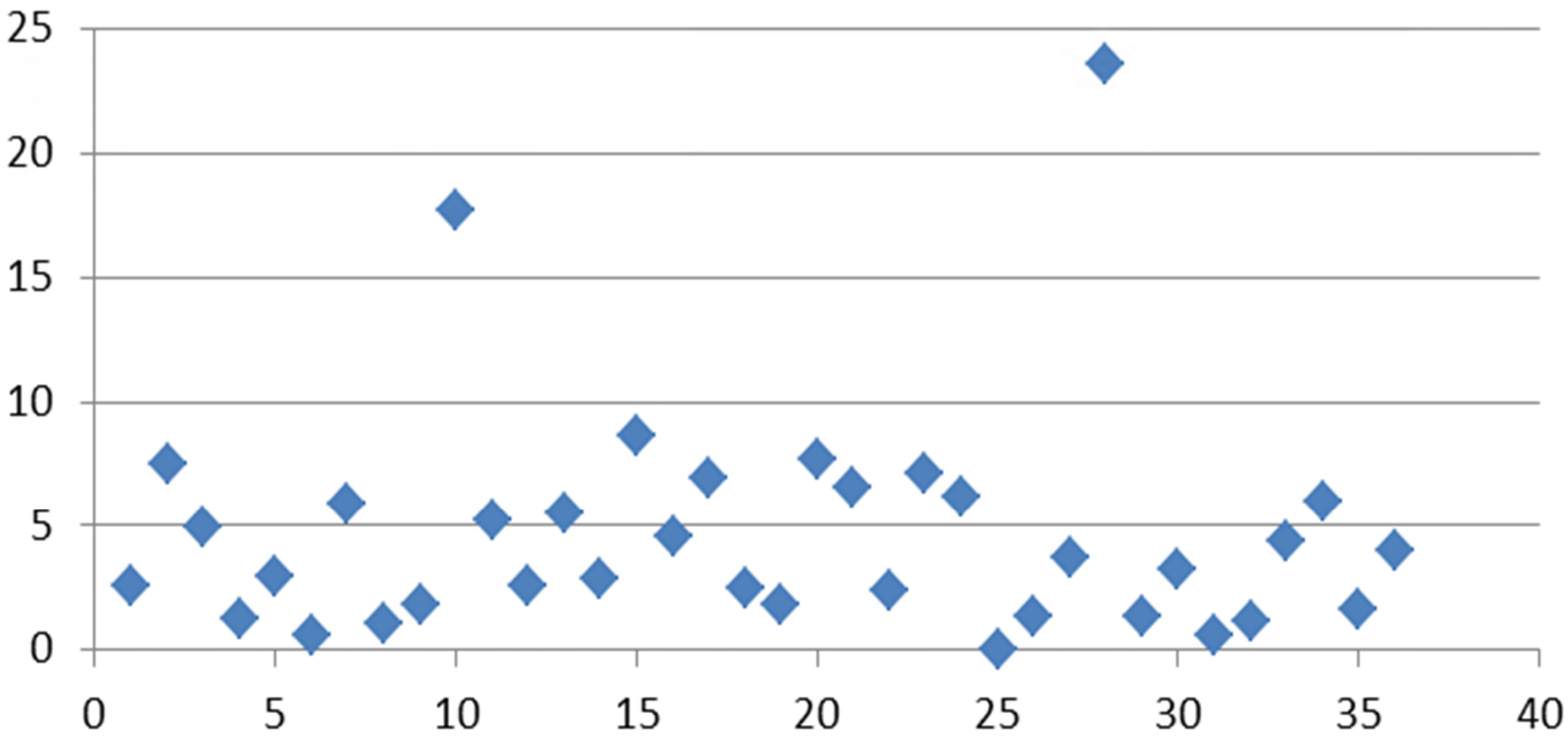
Distribution of % of precribed doses inappropriately omitted or delayed



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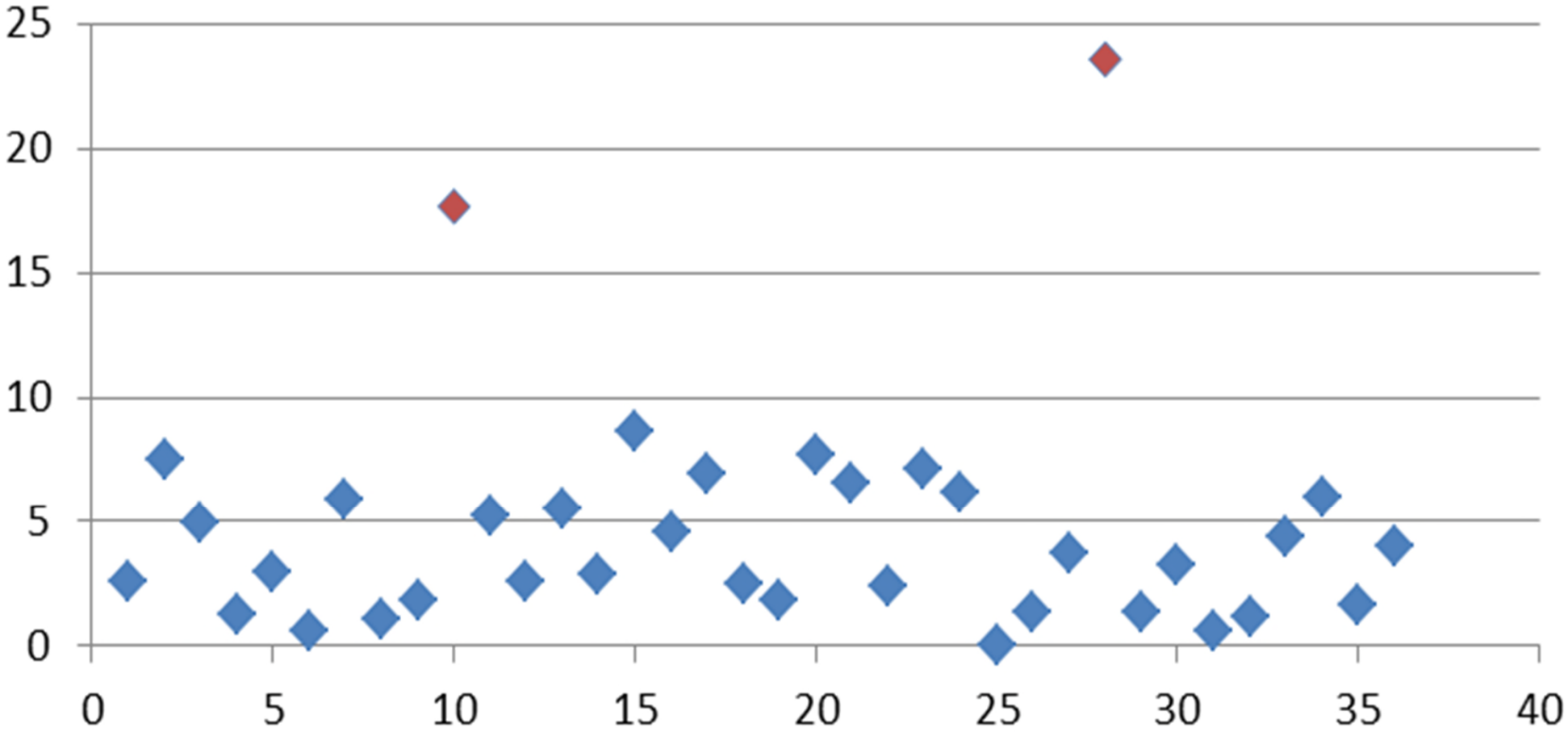

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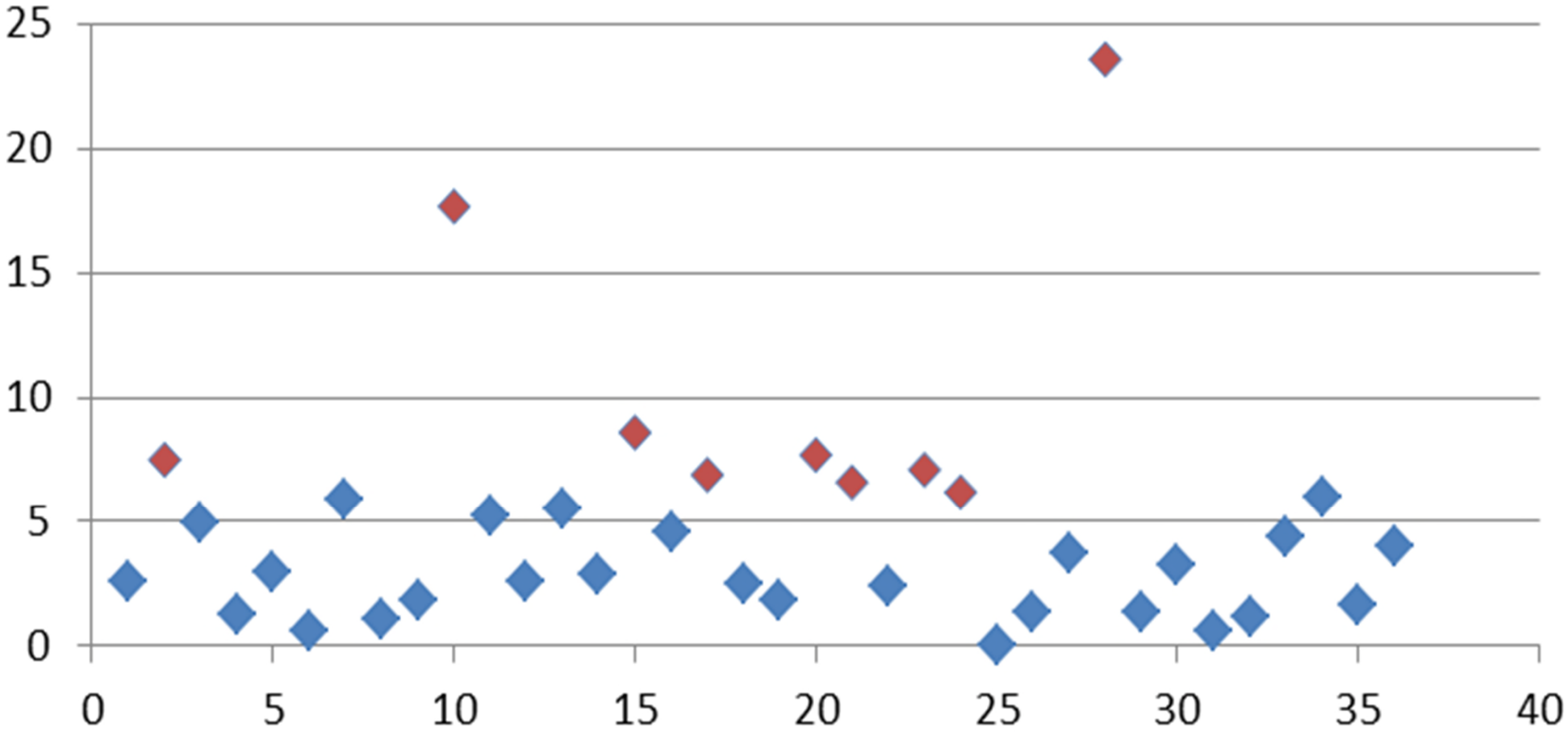

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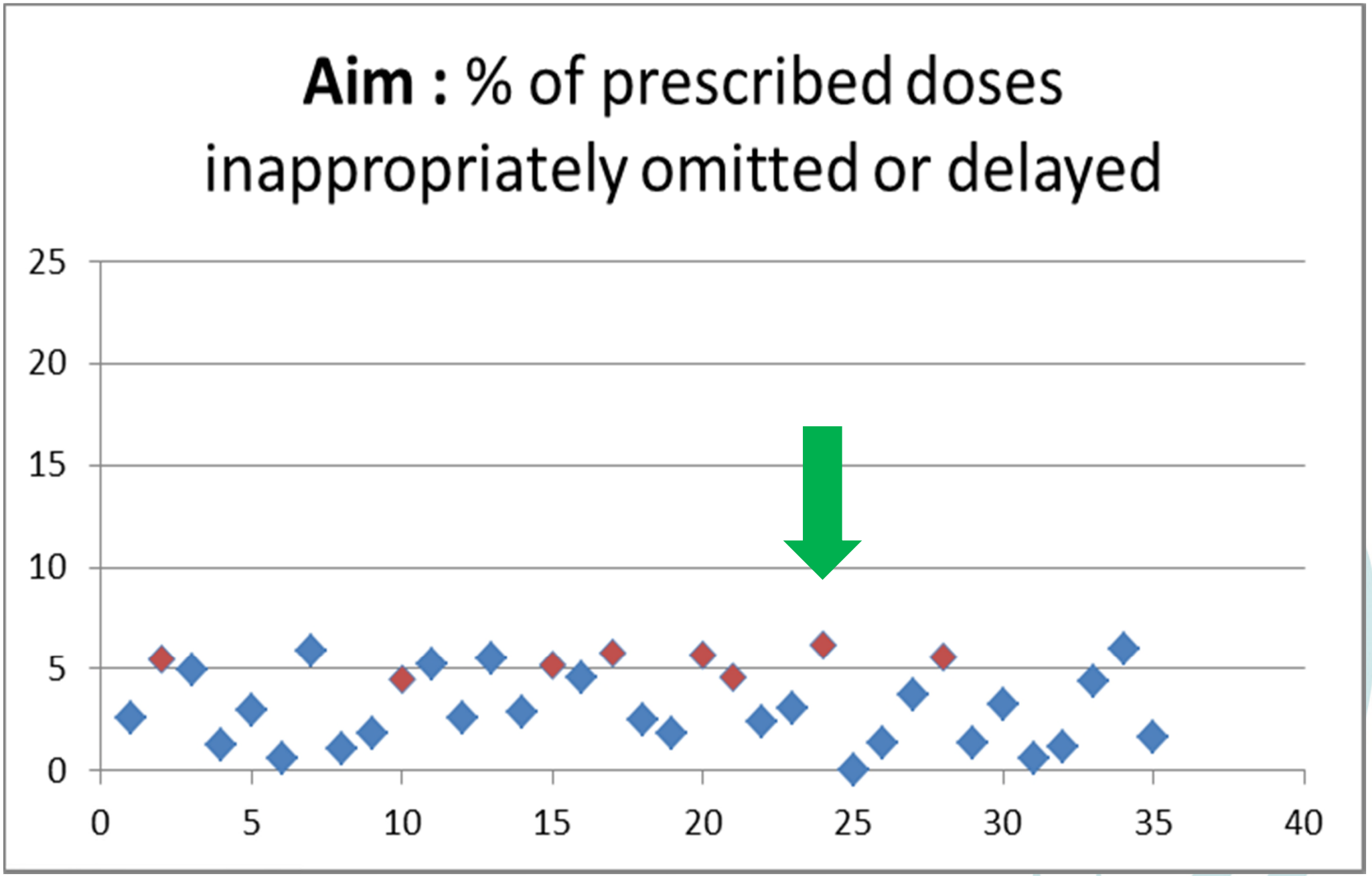

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Way forward…

- Multidisciplinary approach
  - Nursing, Pharmacy, Medical staff
- Targeted improvement :
  - identification of those wards that need support
  - learn from others
- Communication
  - Social media
  - Infographics

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Improvement …..

2011	2015
• Parkinson's patient in ED	• Parkinson's patient in ED
• NH resident	• NH resident
• Meds not stocked in ward	• Meds not stocked in ward
• PODs not available	• PODs not available
• No evidence of out of hours ordering	• Medicines finder used
• Swallow screen / modifed consistencies / med review	• Oncall pharmacist contacted /OOH ordering
• Patient missed 7 doses	• Patient missed 3 doses

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Questions ?

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Accessing medicines out of hours : Searching for wards that stock a drug

Out of Hours Information

TRUSTWIDE INFORMATION

Ward Medication Stocklist

DOWNE HOSPITAL

Flowchart - Use of Out of Hours Pharmacy Service

Procedure for Ordering Drugs Out of Hours

Controlled Drug Ordering Procedure

Emergency Drug Cupboard Stock List

LAGAN VALLEY HOSPITAL

Flowchart Procedure for Ordering Drugs Out of Hours

Controlled Drug Ordering Procedure

Emergency Drug Cupboard Stock List

Anti-Epileptic & Parkinson's Medication Ward Stock List

ULSTER HOSPITAL

Out of Hours Pharmacy Service Information

Related Information

About Us

Swine Flu Info

Non Medical Prescribing

Contact Details

COSHH

Wound Care

Calculators

IV Administration Info

Controlled Drugs

Out of Hours Info

Forms

Policies and Protocols

Medicines Information

Pharmacy Homepage

Nursing KPI

I

EVIDENCING CARE

Regional Nursing

Key Performance Indicators (KPIs)

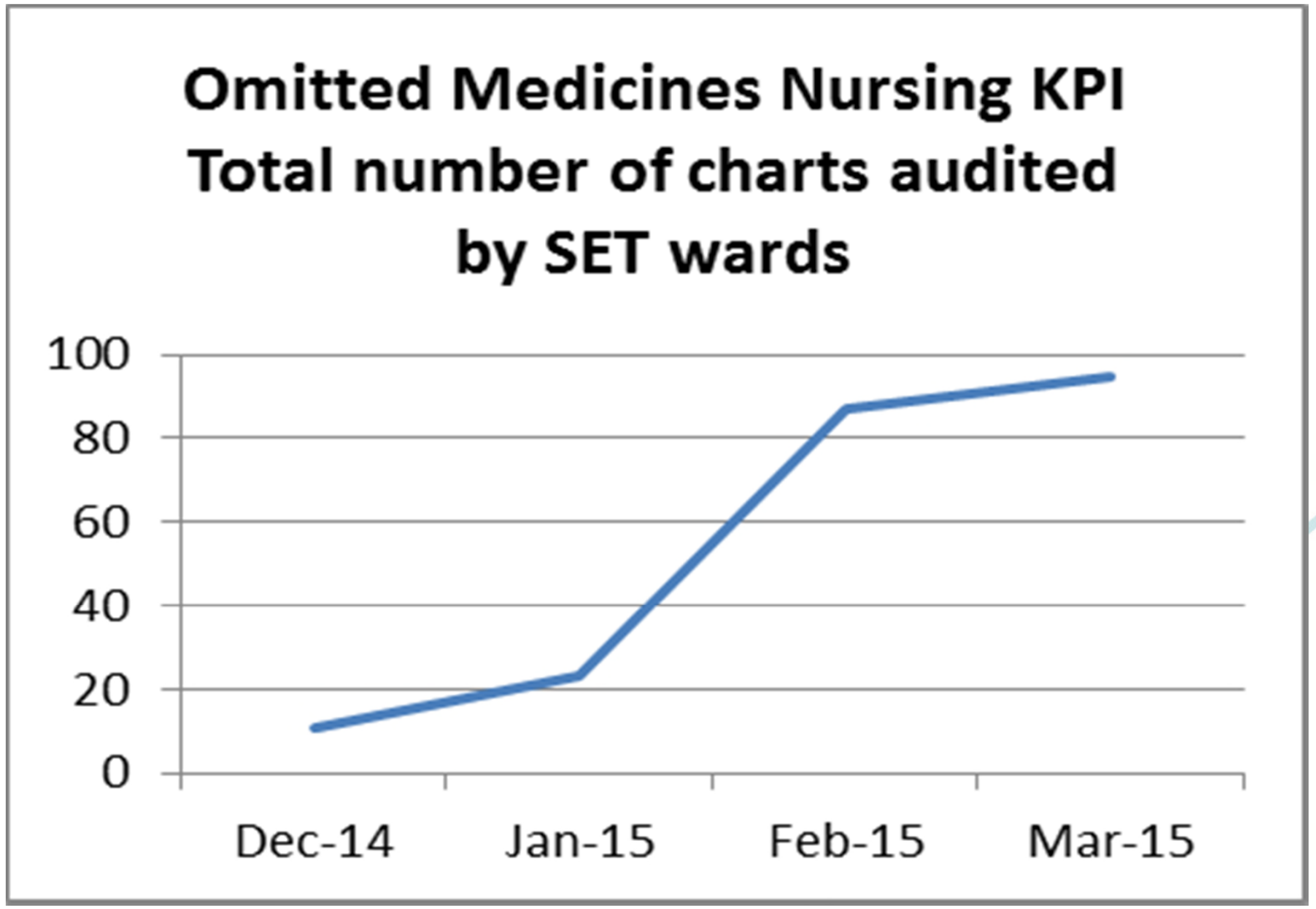
COMPLIANCE ASSESSMENT

&

2015/16 REPORTING ARRANGEMENTS

Revised Draft at 16th June 15

3.0	**OMITTED and DELAYED MEDICATION**
3.1	**Overview of indicator**
Key Performance Indicator	**Incidence of prescribed medication omitted or delayed to a patient in hospital**
Process measures	100% compliance in 80% of all adult in-patient wards by March 2016 ADs to consider
Outcome measure	50% reduction in the failure to record the reason for omitting or delaying the administration of a prescribed medication to a patient in a minimum of 5 acute adult in-patient wards. ADs to re-write and consider spread plan
Rationale for monitoring	A Rapid Response Report from the National Patient Safety Agency (NPSA; 2010) on 'Reducing harm from omitted and delayed medicines in hospital' highlighted that medicine doses are often omitted or delayed in hospital for a variety of reasons. However, sometimes the reason for the omission or delay is not recorded and it is therefore difficult to assess the impact of this failure to record on the health and recovery of the patient or whether any omission or delay caused actual harm to the patient. The Northern Ireland Medicines Governance Team Audit (2013) reported that the percentage of omitted and delayed doses across five HSC trusts in Northern Ireland was 12.7% (range 9.4-18.6%) while the percentage of omitted and delayed doses of critical medicines was 1.4% (range 1.0-2.0%). The most common reasons for doses to be omitted were 'No reason' where the administration record had been left blank and the dose overlooked, followed by the patient refusing a dose.
Frequency of reporting **Internal Trust Reporting** **Regional reporting to PHA**	**Process measures:** A minimum of **10** charts per month in a minimum of 5 acute **adult in-patient wards.** ADs to re-write **Outcome measure:** Monthly **Six Monthly** – number of charts audited, number of charts with no blanks, number of charts where blanks related to a critical medication
Method of data collection	**Process measures** will be measured by audit of nursing records.
Audit tool	Reporting to PHA use agreed tool at 3.2 below Regionally agreed tool at 3.3 below



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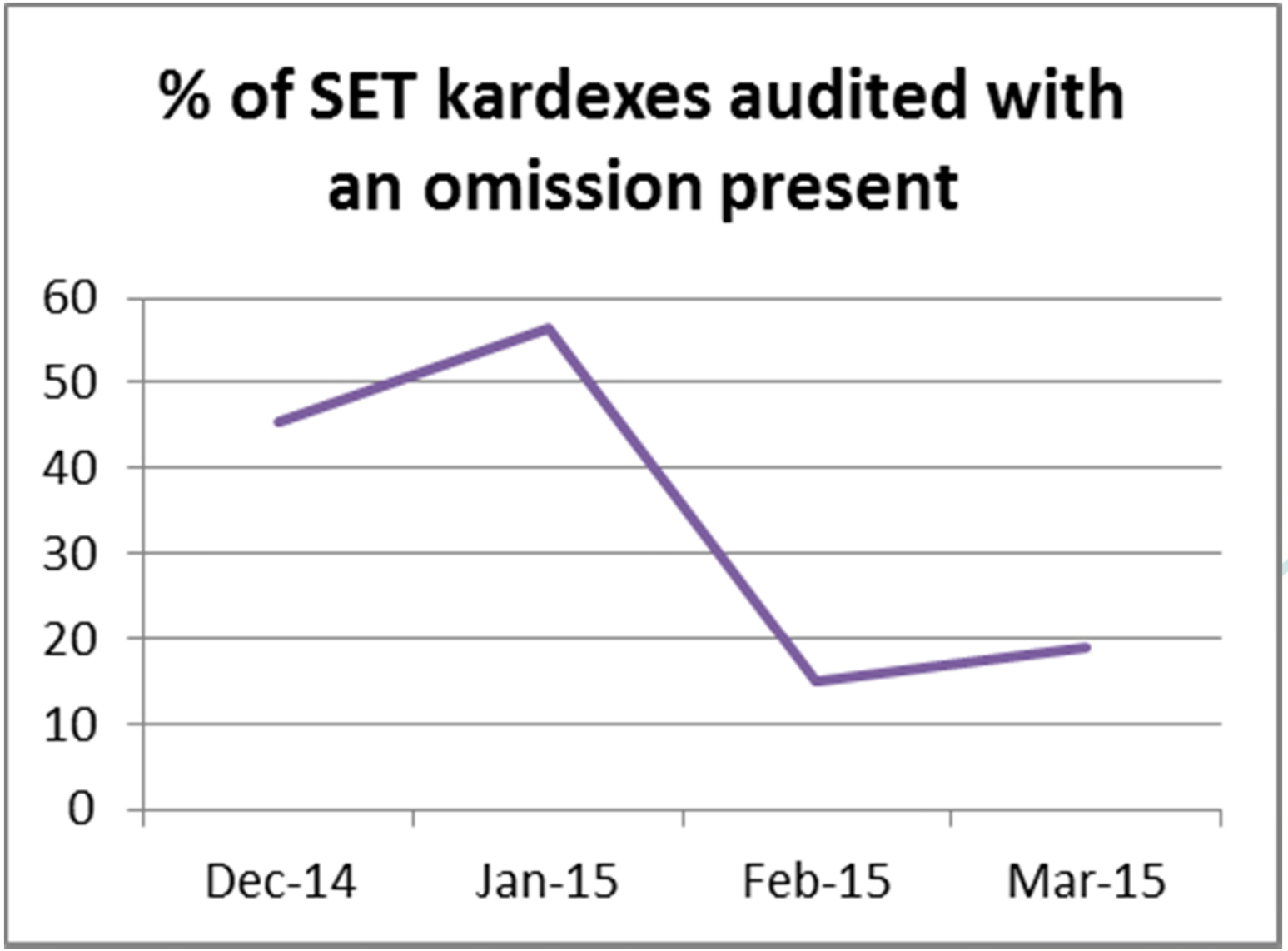

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