Reducing missed doses across Specialist Oncology Services and Clinical Haematology inpatient areas within Regional Services

Hannah Scouller, Practice Development Facillitator, Nicky Donnelly, Clinical Educator. Beatson West of Scotland Cancer Centre.

Introduction

Medicine omissions are identified to be an area where improvement is required across the organisation. Inspired by a team within Glasgow Royal Infirmary who developed a medicine round template and reported a success with reducing missed medicine doses when using the tool. The Clinical Educator and Practice Development Facilitator based within the Beatson West of Scotland Cancer Centre developed a QI project that would include baseline data collection, utilising the Omission of Medicines tool, providing a training plan to deliver face to face teaching in each clinical area across 8 wards in 2 of the GG&C sites and thereafter follow up data collection to test for reliability of the tool.

Medicines Omission Tool **Ward:** **Date:**

Please complete during medicines administration rounds and reconcile any medicines omitted at the end of the round by discussing with medical staff and agreeing appropriate actions.

To be completed by nursing staff				To be completed by medical staff	
Date/Time	Patient's Name/CHI	Medicine Omitted	Reason for Omission	Outcome* (i.e. withhold/continue/stop)	Prescriber Signature

*The outcome and plan should be clearly communicated to nursing staff and documented on the drug administration chart.

Missed Medicines Project

Beatson Nursing Teams.

Following on from success experienced within the GRI hospital, we are testing a tool to reduce missed medicine doses.

Please help us by:

- Ensure you use the tool on each medication round
- Encourage our medical colleagues to engage with us, by discussing your findings after each medication round
- Tell us if you have any ideas for improvment

For further information contact nicky.donnelly@ggc.scot.nhs.uk / Hannah.Scouller@ggc.scot.nhs.uk

Implementation

- Posters delivered to each ward and discussion with all available nursing/prescribing staff on day 1 of implementing in each ward
- Daily education for nursing staff over 2 week period for each ward, using scenarios and discussing use of tool
- Staff encouraged to use the tool from the first education session
- Frequent re-audits were carried out to monitor for improvement
- Staff were encouraged to give feedback on their use of the tool

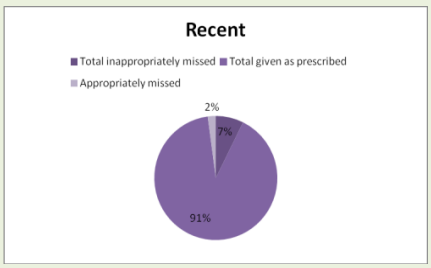
Conclusion

This project highlighted the complexity of missed doses and identified the need to define when a medicine omission is appropriate or inappropriate in order to establish a standard to adhere to. Use of the tool showed overall improvement however requires support from senior ward staff and sustained compliance from both those administering and those prescribing medications in order to achieve improvement. Improvements were noted both in reduction of inappropriate missed doses and overall missed doses. Sustained improvement would require ongoing education for new team members to ensure awareness of the process and rationale. This may be achieved by including this tool in the discussions around medicines safety that occur at the point of induction into the organisation. Other suggested teaching methods that have been considered by our team for future use is the development of a video blog that ensures consistent messages are provided for staff.

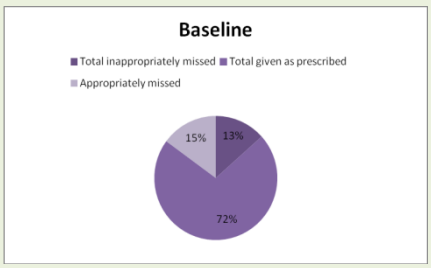
Continued support from key members of ward teams in ensuring compliance with the tool would also be required to ensure improvements were sustained allowing this document to become imbedded in the natural way of working.

Overall the findings from this quality improvement project where that it is a positive tool that has enabled teams to discuss the challenges faced around medication administration and could overall be adopted by clinical areas across the organisation with the support of our senior teams.

Overall baseline for all wards



Overall data collected after full implementation



Acknowledgements: Gemma Kaur and the Glasgow Royal Infirmary team for inspiring our improvement project across SOS & CH,and the nursing teams and managers of Specialist Oncology Services and Clinical Haematology in their continued support of the tool.