Omitted Medicines Driver Diagram (June 2017)

Ambition and Aims	Primary Drivers	Secondary Drivers	Change Ideas
Ambition: Patients in healthcare across Scotland will receive all appropriately prescribed medicines as intended. **Aims:** To be determined locally.	Person-Centred Care / Involvement	- A good history of previous medication use is obtained from patients and families - Patients are involved in managing their medicines - Inpatients are supported in asking questions about their medicines	- Facilitate patient and family oversight of medicines reconciliation documents - Share the prescription chart with patients/carers - Advertise and support “Not sure? Just Ask”, “Will my medicines make me better”, and other patient resources - Patients self-administer their own medicines, where appropriate (in accordance with local guidelines)
	Leadership and Culture	- Omitted medicines is a named priority in the board/ partnership quality and safety agenda - Reliable administration of medicines to patients is everybody's business	- Strengthen policy on accessing medicines within an institution, especially for out of hours - Data related to medicine omissions are routinely reported at all levels, including safety boards in ward / clinical areas - Utilise campaigns to improve medicines administration, e.g. zero tolerance week - Use of simple communication tools, e.g. CUSS (Concerned, Unsure, Safe, Stop) where medicines are omitted
	Teamwork, Communication and Collaboration	- Reliable documentation on medications charts - Regular, standardised communication regarding omitted medicines - Interruption-free medicine rounds - Recognition of patients on critical medicines	- Omitted medicines and patients on critical medicines highlighted at hand over and safety briefs. Prioritisation may be given to locally agreed critical medicines - Highlighter used on paper medication charts to highlight blank spaces and other omission codes of interest post medication rounds/shift change - Chance to check campaign (NHS GG&C) - Standardisation of codes related to medicines administration / omission (board level/ national) for both paper and electronic systems - Ward round check list to include prompt for newly prescribed medicines to be discussed - Medication safety visits to ward / clinical areas by MDT. - Share medicine omissions with prescribers for individual patients - Ensure timely correction of prescribing errors (e.g. highlight at ward rounds, white boards, handovers etc) - Documentation in patients’ records regarding medicine omissions (avoid - 'meds as charted')
	Safe, Effective and Reliable Care	- Healthcare team understands of roles and responsibilities - Awareness of locally agreed critical medicines - Medicines are part of discussions at transitions between care settings, including admission and discharge	- Improve knowledge and application of the relevant professional codes of conduct (e.g. NMC) - Develop locally agreed list of critical medicines - Education of staff (supply chain, critical meds, communication processes etc.) - Post medicines administration round review of paper medication charts (double check between nursing staff) - Change once daily morning doses to midday - Reminders for medicines due outwith standard administration times (e.g. timer, book/diary) - Use of electronic and other tools to facilitate communication about newly prescribed medicines/patients prescribed critical medicines - Learning and responding to adverse events / DATIX reports related to omitted medicines
	Supply Systems	- The supply system supports timely access to medicines - Staff are aware of how the supply system works - Use of patients own medicines	- Regular review of the stock list of ward medicines - Process map the supply of medicines to the ward/clinical areas (from the point of prescription to reaching the patient) - Named person/role responsible for stock management (e.g. pharmacy technician, ward nurse) - Escalation flow diagram when a medicine is not on the ward (e.g. SEED in NHS Lothian)

Please email the SPSP Medicines Team with additional change ideas and any comments on the driver diagram: spsp-medicines.hcis@nhs.net