Healthcare Improvement Scotland | ihub

Omitted Medicines

Using a quality improvement approach to reduce medicine administration omissions – in collaboration with Excellence in Care

May 2019

NHS SCOTLAND

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Contents

Introduction

Healthcare Improvement Scotland is the national healthcare improvement organisation for Scotland and part of NHSScotland. Healthcare Improvement Scotland's ihub was established in April 2016 in response to the integration of health and social care services across Scotland. The ihub supports Health and Social Care Partnerships and NHS boards to improve the quality of health and social care services by:

- supporting the development of cultures of continuous quality improvement, and
- supporting the work to design systems, services and processes which enable people to receive the right support and care, in the right place, at the right time whilst also reducing harm, waste, duplication, fragmentation and inappropriate variation.

The Scottish Patient Safety Programme (SPSP) sits within the ihub and the SPSP Medicines team aims to support the safer use of medicines for patients across all healthcare settings in NHSScotland.

The Excellence in Care (EiC) framework is being developed for the purposes of assuring and improving nursing and midwifery care in Scotland. Within the framework will sit a number of measures over nine key areas. The framework builds upon the findings in the Vale of Leven inquiry and also aligns with the principles set out in the Healthcare Quality Strategy for NHSScotland (providing person-centred, safe and effective care).

SPSP Medicines and EiC partnered with three NHS boards to form a mini collaborative to undertake tests of improvement work to reduce medicines administration omissions (omitted medicines). This work has also informed the development of a measure for omitted medicines in the EiC framework.

This report summarises the activities of the mini collaborative and the key findings and learnings from this improvement work. Resources which may support other local improvement initiatives are also identified.

The SPSP Medicines team was led by David Maxwell, Improvement Advisor, with the support of project officers Janet Heritage and Lorraine Donaldson, and Kirsty Allan, Administrative Officer. The SPSP Medicines Clinical Advisory Group (MCAG) provided clinical direction support to the team. SPSP Medicines also wishes to acknowledge the significant contribution of the EiC leads, namely Judy Sinclair (NHS Orkney), Margaret Connolly (NHS Greater Glasgow and Clyde) and Noreen MacDonald (NHS Western Isles), and their respective teams.

Background

Omitted doses of medicines are one of the most commonly reported category of medication incidents on incident reporting systems. A proportion of omitted doses can have significant impact on the patient as highlighted by Graudin et al[1] who found that there was a negative impact on patient experience due to omitted medicines, including increased pain (oxycodone omitted), exacerbation of psoriasis (topical steroids omitted), atrial fibrillation or increased blood pressure (beta blockers), exacerbation of airways disease/pneumonia/asthma (beta agonist inhalers), hypokalaemia (oral potassium) and aggressive behaviour in patients (olanzapine).

Between September 2006 and June 2009, the National Patient Safety Agency received reports of 27 deaths, 68 severe harms and 21,383 other patient safety incidents relating to omitted or delayed medicines[2]. 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[2].

Economic data on the financial cost of omitted medicines is limited. However, an article published by East London NHS Foundation Trust reported the implementation of their project eliminated an estimated 2,690 omitted doses over the course of a year, which would have been expected to give rise to 25 ‘adverse drug events’ (ADEs) and they estimated this to have the potential to save more than £34,000 per year across six wards[3].

The underlying causes of omitted doses are often multi-factorial and include poor medicines reconciliation, incomplete prescriptions, medicines being unavailable, error on the medicines round and failure to explore alternative routes when patients are nil by mouth. Measuring omitted doses is a good indicator of the quality and reliability of broader medicines management processes in a given area.

When considering the role of nurses in the administration of medicines, while it was agreed there were many types of omissions, including those that rely on clinical interpretation, nurses have the opportunity to influence and improve the incidence of blank spaces and the recording of medicines not being available and so this formed the basis of the improvement work outlined in this report.

Aims

The mini collaborative had two aims:

1

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

2

To develop a measure or measures related to omitted medicines for consideration for inclusion in the EiC framework and to identify an appropriate recommended national aim for omitted medicines improvement work.

Electronic systems

Please note that hospital electronic prescribing and medication administration (HEPMA) systems were excluded from the mini collaborative. This was due to the forcing functions that all current HEPMA users in Scotland have opted to use within JAC v2014 that eliminates the potential of retrospective identification of blank medication administration episodes, making the proposed paper-based measure for omitted medicines non-transferrable to the electronic environment.

Our approach

This work relates to the use of paper medication charts and was tested in acute care settings.

Six omitted medicines measures were developed and made available for testing (Table A). Testing included the operational definitions with a focus on inclusion and exclusion criteria. Details of the operational definitions can be found in Appendix 1.

Local project leads were asked to share the results of all six measures with others locally to drive improvement, and seek feedback from staff to determine which of the measures were more effective in engaging and inspiring staff to become involved.

Table A: Range of omitted medicines measures tested

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

Data reporting templates, a data entry guide and a driver diagram describing the theory of change were provided for testing and were developed throughout the test period. Current versions can be found on the SPSP Medicines section of the ihub website. Quantitative and qualitative templates are also illustrated in this report as appendices 2 and 3 respectively and the driver diagram can be found in Appendix 4.

The three NHS boards identified to carry out local testing and improvement work were:

- NHS Greater Glasgow and Clyde
- NHS Orkney, and
- NHS Western Isles.

The SPSP Medicines team and the three EiC leads began preparatory work in August 2017, followed in September by the establishment of local teams and the SPSP Medicines team providing the required supporting documentation for the testing process. Testing began in October 2017 and concluded in October 2018.

Data was collected using a retrospective chart review of a random sample of five sets of patient medication charts each week (or 20 patients per month). The regular and once only sections of the medication charts, including specialist charts, were reviewed for the previous five days. If a patient was in the clinical area for less than five days the entire length of their stay within the clinical area was reviewed.

Each test site reported against the six measures every month, returning quantitative and qualitative data. Monthly data were visualised as time series data using run charts.

Using a quality improvement approach, ward teams were encouraged to test change ideas using Plan Do Study Act (PDSA) cycles to reduce omitted medicines.

Tests of change were annotated alongside the time series data. These data were shared with the teams for reflection and learning, and to identify those ideas that were having a positive impact. The teams were supported by a series of WebEx learning sessions every two months, providing an opportunity to share data, change ideas and qualitative reflections.

Towards the end of the testing period, tests sites were encouraged to reflect on their activities and identify key learning that could be shared with others who wish to undertake local improvement work. Improvement stories for each test site can be found as appendices 5, 6 and 7 of this report.

Feedback on the progress of this work was also regularly shared as part of the EiC governance and reporting procedures. The EiC leads presented this work as part of the SPSP Medicines WebEx series on 18 October 2018 and presented their findings and recommendations to the EiC Hub meeting on 2 November 2018.

An overview of the timeline and key activities of this work can be found in Appendix 8.

Outcomes

One of the three test sites, NHS Greater Glasgow and Clyde, has shown an improvement in both the '% of monthly omitted medicines' and the '% of patients with one or more omitted doses'. NHS Orkney has shown an improvement in 'the '% of monthly omitted medicines'. All of the tests sites reported useful tests of change, and reflected on key learning and how they will take the work forward in the future (see appendices 5, 6 and 7 for more detail).

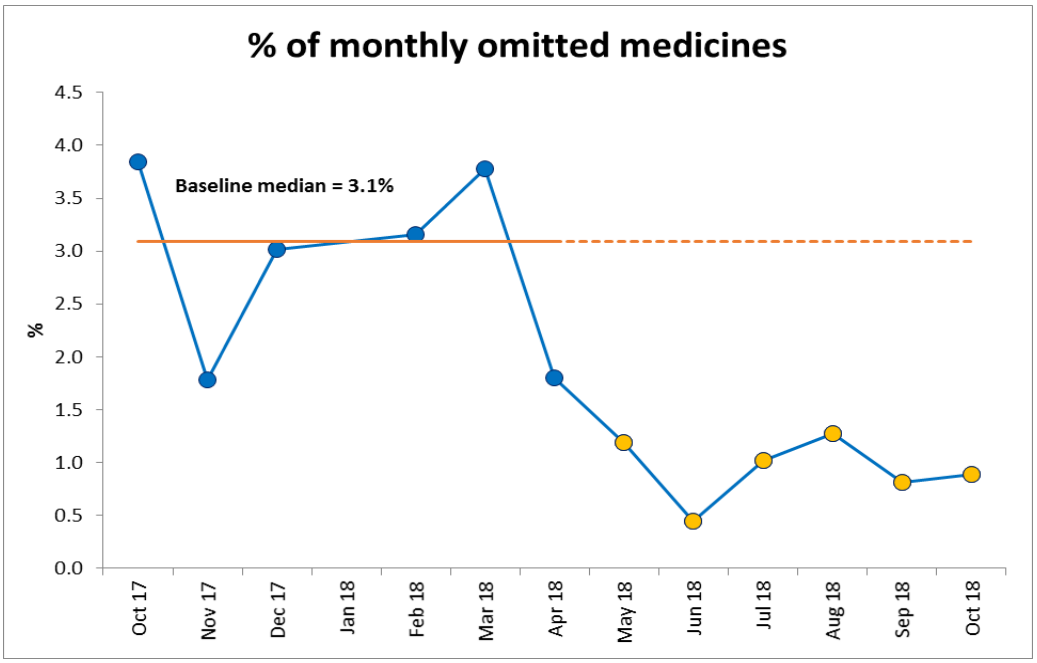
Of the six measures offered for testing, overall the two that were felt to be the most engaging were the '% of omitted medicines' and the '% of patients with one or more missed doses'. These two measures have been proposed for inclusion in the EiC framework.

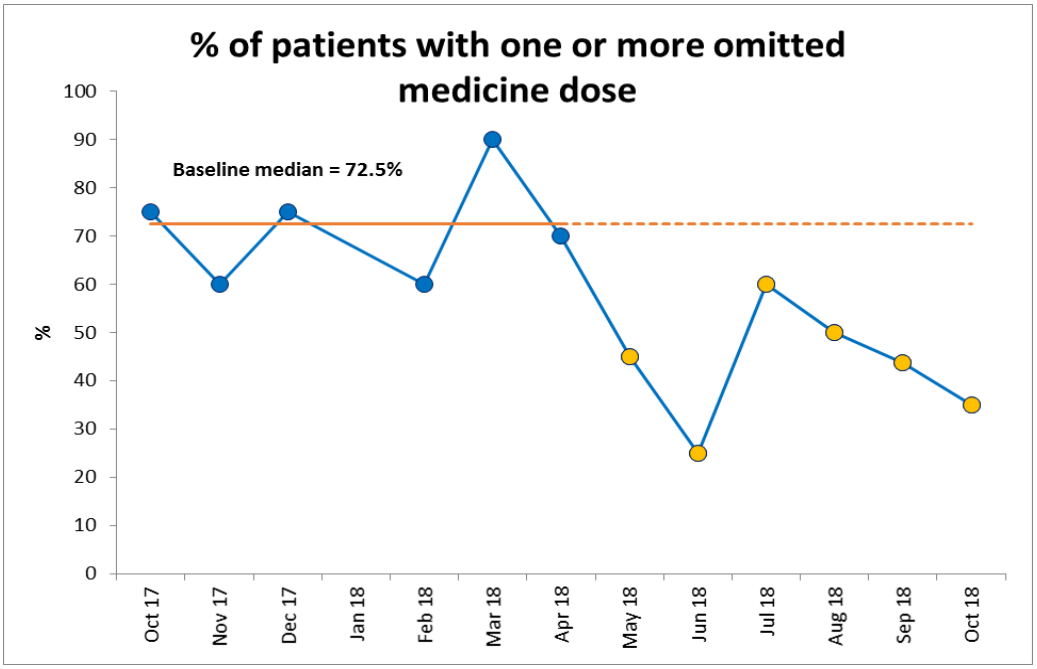
A national improvement aim of a 50% reduction in baseline of the % of omitted medicines is recommended. This aligns with the results and feedback received from the test sites together with the clinical guidance of the SPSP MCAG and similar improvement work in NHSScotland and NHS England.

The relevant run charts from all test sites are provided on pages 8–10 to illustrate their journeys.

NHS Greater Glasgow and Clyde

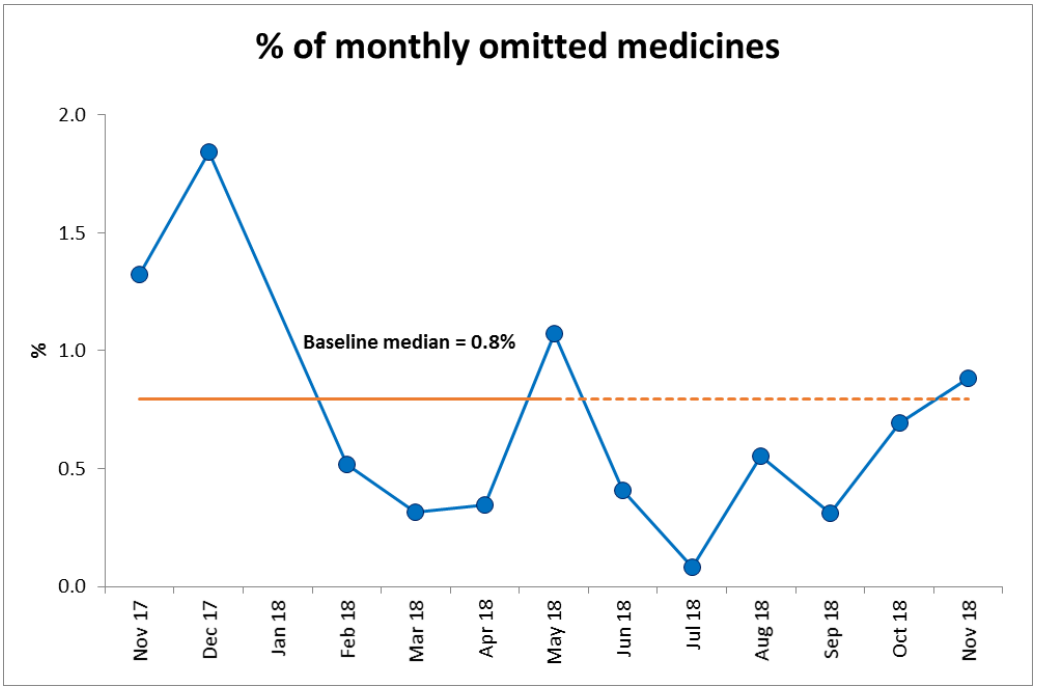
Mar 18	Ward clerk commenced data collection
Apr 18	Nightly medication chart audits (directorate intitiative)
May 18	End of shift medication chart sweep commenced
May 18	Need to test HSCW auditing as change in clerk led to difficulties
Jun 18	Medicine issues on safety brief
Jul 18	Data collection unsustainable due to absences/holidays. 10 patients sampled
Sep 18	Ward relocated for 2 weeks

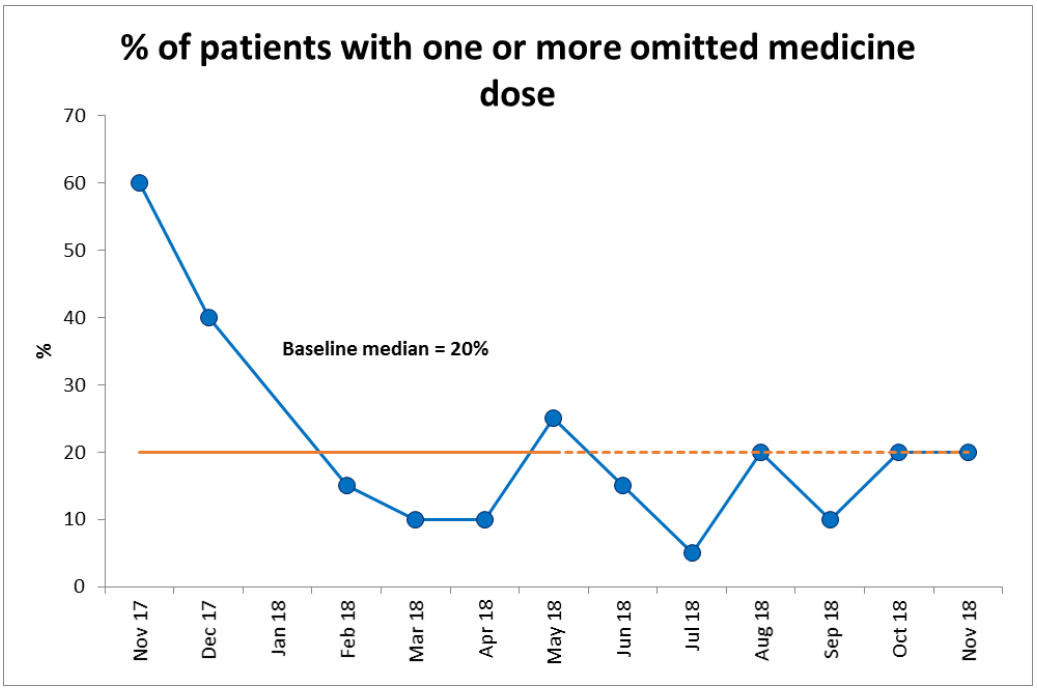




NHS Western Isles

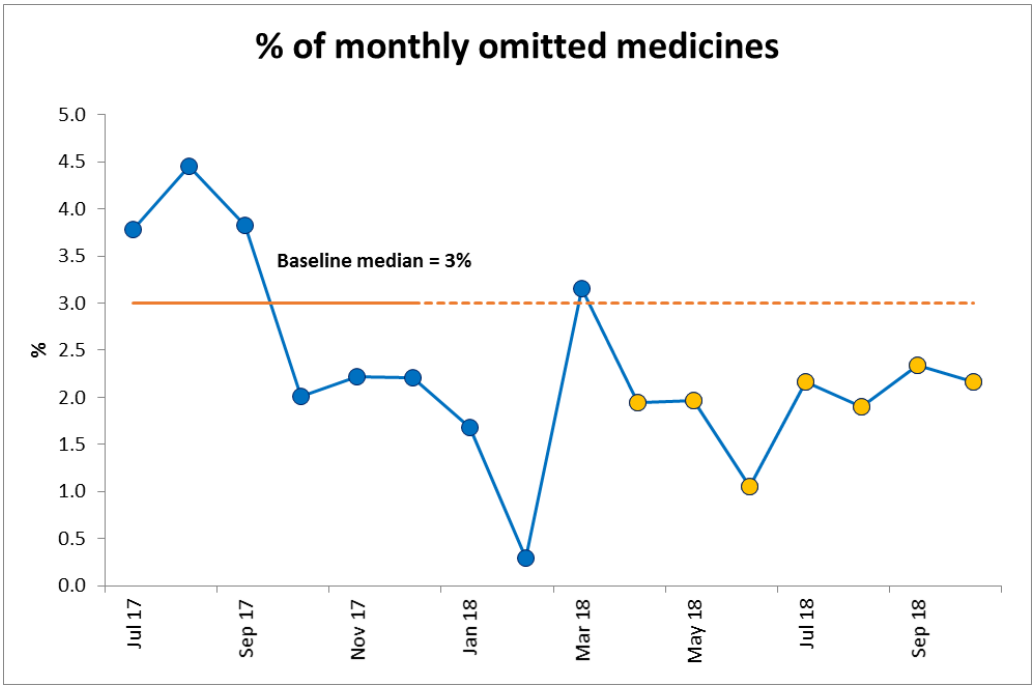
Dec 17	Started using red medicine tabbards
May 18	Conversation with dietician with better timing of nutritional supplements
Jun 18	Initiated 'sweeps'

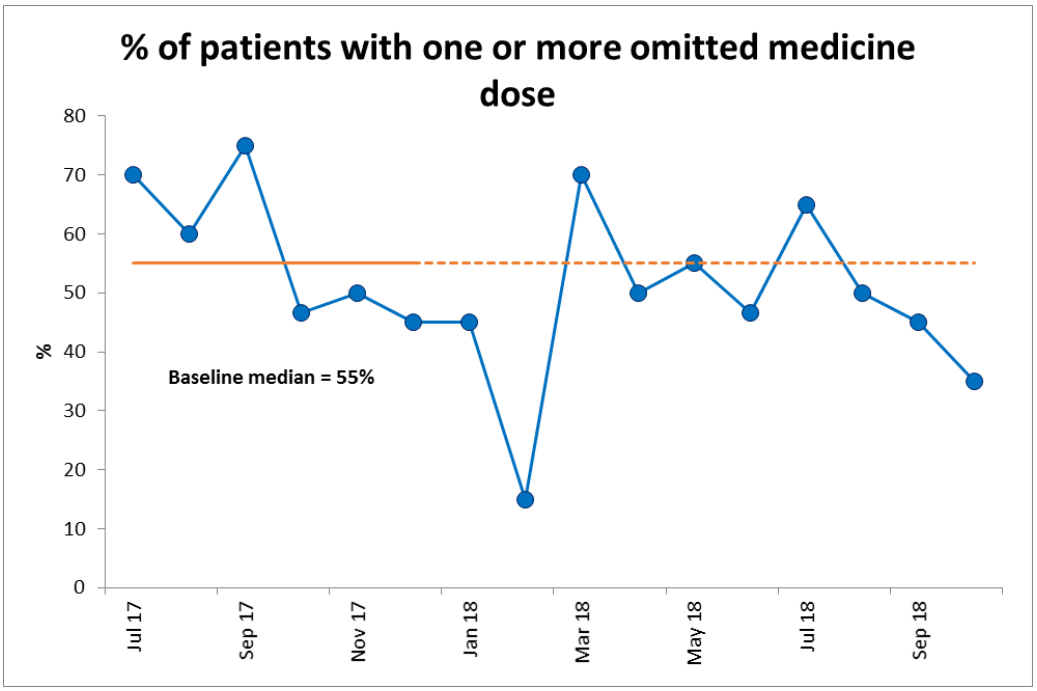




NHS Orkney

Oct 17	EiC started
Jan 18	Added to safety brief
Mar 19	Lead RN retired/discussion with RN highlighted change in reporting
Apr 18	Insulin charts inc.
Jun 18	Medication chart sweep started





Reflection and learning

Tests of change implemented included:

- displaying data (which was not previously available)
- post-ward round medication chart sweeps
- prompts to review the medication chart incorporated into patient/nursing notes
- omitted medicines added as a discussion point to daily safety brief
- tabards worn on nurse-led medication rounds
- engaging medical staff in the regular review of the administration section of the medication chart, and
- collection of data by ward clerk.

Test teams agreed that displaying audit results would enhance the awareness and engagement of staff in improvement work to reduce medicine omissions. All test sites provided qualitative feedback indicating staff were more engaged in medication administration safety and more likely to question or follow up on any identified omissions.

Staff in the test sites indicated that the improvement work had engaged colleagues beyond nursing. An example of this was feedback that consultants were highlighting blank/missed doses and that staff were reviewing the medication chart from left to right as well as vertically, indicating an increased awareness of medicine administration omissions.

Despite the variation in their size and operational nature, test sites reported some common challenges in implementing this work, including time pressures and continuity of staff involvement.

Next steps and recommendations

The measures of % of omitted medicines and % of patients with one or more omitted doses have been submitted to EiC for consideration.

This work applies across all care settings where medication is administered and is required to be recorded using a paper-based system and SPSP Medicines would encourage the spread of tools, resources and knowledge to facilitate local improvement work to reduce the incidence of preventable medicines administration omissions. Relevant resources are listed in the Resources section of this report.

It is recognised that local priorities will vary and these tools can be used and adapted to suit, for example if a particular care setting wished to focus on a specific high risk medicine. A high risk medicines discussion framework is available on the SPSP Medicines section of the ihub website to support local teams to discuss and prioritise improvement activities relating to high risk medicines. Included in this framework are relevant examples of harms due to omission.

Whilst outwith the remit of this report, it is noted that further economic analysis of medication omissions may be helpful in developing further understanding and to drive improvement.

As this work relates to paper medication charts only, it is also recognised, with the likely move to electronic prescribing, that through time this work will change focus and further improvement opportunities may be identified.

Resources

SPSP Medicines offers a number of useful online resources, including a guide to undertaking local improvement work and associated data templates. Resources developed by NHS boards for local improvement are also available such as the NHS Lothian SEED workflow (Search, Evaluate, Escalate, Document) for ensuring the availability of medicines and NHS Greater Glasgow and Clyde's "Chance to Check" which is a local initiative highlighting the importance of medicine administration.

Please visit the SPSP Medicines section of the ihub website at ihub.scot/spsp/medicines/ where you will find the resources listed below:

- SPSP Medicines omitted medicines guide
- omitted medicines driver diagram
- quantitative omitted medicines data template
- qualitative omitted medicines data template
- link to October 2018 SPSP Medicines Omitted Medicines WebEx, and
- local improvement resources.

References

1 Graudin LV, Ingram C, Smith BT, Ewing WJ, Vandeveede M. Multicentre study to develop a medication safety package for decreasing inpatient harm from omission of time-critical medications. Int J Qual Health Care. 2015;27(1):67–74.

2 National Patient Safety Agency. Rapid Response Report NPSA/2010/RRR009: Reducing harm from omitted and delayed medicines in hospital. 2010 [cited 2018 Oct 24]; Available from: http://webarchive.nationalarchives.gov.uk/20100721032155/http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=66780&type=full&servicetype=Attachment

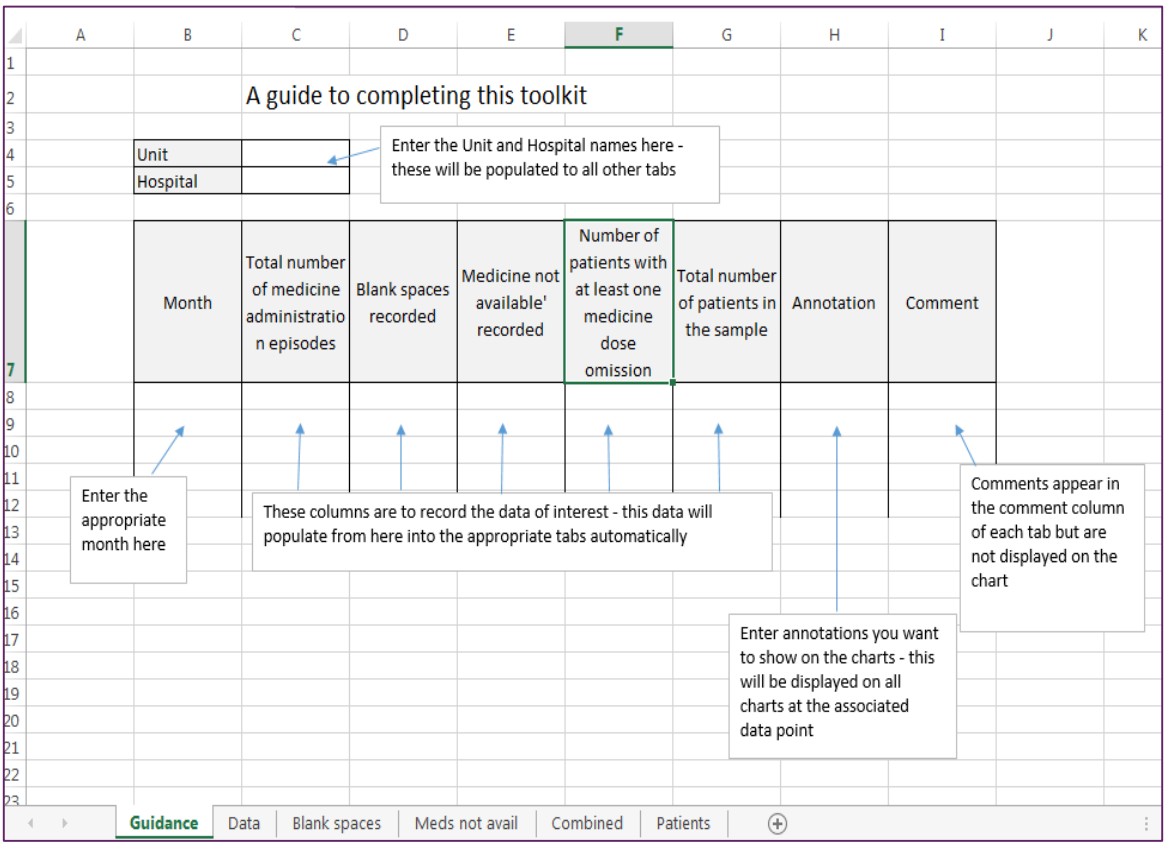
3 Cottney A. Using league tables to reduce missed dose medication errors on mental healthcare of older people wards. BMJ Open Qual. 2015;4:u204237.w3567.

Appendix 1: Operational definitions

Measure name	Percentage of omitted medicines
Goal	50% reduction from baseline
Operational definition	1. Determine the numerator: the total number of omitted medicine doses in the sample of medication charts. 'Omitted' has been defined as either a blank space OR where the medicine has been recorded as being unavailable. 2. Determine the denominator: the total number medicine doses intended to be administered in the sample of medication charts. 3. Calculate compliance by dividing the numerator by the denominator and then multiplying the resulting proportion by 100. **Inclusion criteria:** • Paper medication chart • Regularly prescribed medicines (medication chart and any supplemental charts); by any route: oral, parenteral, inhalers, eye drops, rectal and topical **Exclusion criteria:** • Electronic medication chart • Any as required medicines (PRN) • Nutritional supplements • Non-medicated creams • Patients who are self-medicating
Data collection guidance	This measure is reported monthly. A random sample of five sets of patient medication charts should be reviewed each week (or 20 patients per month). The regular and stat sections of the medication charts should be reviewed for the last five days to determine: - the total number medicine doses that were intend to be administered (denominator), and - the total number of dose omissions (a blank space OR where the medicine has been recorded as being unavailable). In the case where a regular medicine has more than one dose omission please include the total number of dose omissions in the numerator. If a patient was in the clinical area for less than five days the entire length of their stay within the clinical area should be reviewed.

Measure name	Percentage of patients with one or more omitted doses
Goal	50% reduction from baseline
Operational definition	1. Determine the numerator: the total number of patients with at least one omitted medicine doses. 'Omission' has been defined as either a blank space OR where the medicine has been recorded as being unavailable. 2. Determine the denominator: the total number of patients in the sample. 3. Calculate compliance by dividing the numerator by the denominator and then multiplying the resulting proportion by 100. **Inclusion criteria:** • Paper medication chart • Regularly prescribed medicines (medication chart and any supplemental charts); by any route: oral, parenteral, inhalers, eye drops, rectal and topical **Exclusion criteria:** • Electronic medication chart • Any as required medicines (PRN) • Nutritional supplements • Non-medicated creams • Patients who are self-medicating
Data collection guidance	This measure is reported monthly. A random sample of five sets of patient medication charts should be reviewed each week (or 20 patients per month). The regular and stat sections of the medication charts should be reviewed for the last five days to determine if any prescribed medicine doses were omitted, where the reason was either a blank space OR the medicine was recorded as being unavailable. If a patient was in the clinical area for less than five days the entire length of their stay within the clinical area should be reviewed. A patient is included in the numerator if one or more omitted medicine doses were identified as either a blank space OR the medicine was recorded as being unavailable.

Appendix 2: Screenshot of quantitative data template



Excel file available here: https://ihub.scot/spsp/medicines/

Appendix 3: Qualitative data template

Excellence in Care - Omitted Medicines
Test site monthly feedback

Test site: ……..

Reporting period: ……

1. Please note two things that worked well for your team this month.

2. Please note two things that should be improved for the following months.

3. Please note anything else that you would like to share with the national team.

Word file available here: https://ihub.scot/spsp/medicines/

Appendix 4: Driver diagram

Omitted Medicines Driver Diagram (August 2018)

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 reduce medication administration omissions by 50%. To reduce the proportion of patients with one or more omitted doses of medicines by 50%.	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 NHS 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) - MDT review of the medication chart, vertically and horizontally - Standardisation of medicines administration codes (NHS board level/ national) for paper and electronic systems - Prioritisation of the review of boarding patients - Ward round check list to include prompt to discuss newly prescribed medicines - 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 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) - Agree a local list of critical medicines (e.g. time critical, high risk). - Education of staff (supply chain, critical meds, communication processes etc.) - Post medicines administration round review of paper medication charts (e.g. double check between nursing staff) - Reminders for medicines due out with 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 pathway of medicines 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 - NHS Lothian)

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

Appendix 5: Improvement story – NHS Greater Glasgow and Clyde

Reducing omitted medicines: NHS Greater Glasgow and Clyde	Royal Alexandra Hospital, Paisley Ward 3

What did we do?

- Multi-disciplinary team meeting
- Elderly rehabilitation ward with 30 beds
- Initially led by group and then senior charge nurse (SCN) and ward pharmacist engaged with ward team
- Raising awareness around omitted & out of stock medicines
- Data was collected by a variety of staff, ward pharmacist, SCN, nurse and ward clerk
- Reviewed ward medication stock list
- Encourage where to look for medicines
- Post medicines round sweep
- Raise awareness around missed doses & re-advertised missed doses algorithm & copy beside the paper medication chart.
- If discovered a missed dose then investigate there and then

What went well?

- Testing different members of staff to data collect
- Awareness raising within the multi-disciplinary team
- Medical staff become involved in raising awareness – this has continued to be cascaded down to junior medical staff
- End of shift medicine paper medication chart sweep
- Staff realisation of the consequences of missed doses
- Identified reduction in over- ordering
- Identifying the need for a surge-use common stock pharmacy store – not just a need for non-stock pharmacy items
- Improvement was maintained despite temporary ward re-location

What could we improve?

- Finding a data collection method that is sustainable and non - person dependent (remains a challenge)
- Easy access to medicines out of hours pan NHSGGC wide remains difficult
- Knowledge around consequences of medicines that cannot wait 24hrs until it is administered.
- More work required around safe medicines administration
- Ongoing work regarding Critical Medications list – not finalised
- “Zero tolerance” of blanks pan NHS GGC

Top tips for others:

- NHSGGC programme Chance to Check
- Post-medicines round sweep
- Whole team approach involving everyone: clerk, nursing, medical and pharmacy staff etc
- Involve staff and patients
- No interruptions during medicine round (not cracked this nut within NHSGGC)
- Good compliance will improve Combined Care Assurance Audit results

Next steps:

- Local creation of an out of hours Surge–use common stock and Non-stock pharmacy store that staff can access as the demand arises- discussion how to facilitate this across other local sites
- Inclusion of the “Reducing Medicine Omissions” topic in junior medical staff audit education
- Discussion to ascertain if a re-launch of the “No Interruptions Policy” can be accommodated
- To increase awareness that a blank entry has zero tolerance – Medical and Nursing Induction programmes
- Evaluate “safe medicine administration” tests of change e.g. use of a modified drug trolley with eBNF app access

Appendix 6: Improvement story – NHS Orkney

Reducing omitted medicines: NHS Orkney	Balfour Hospital, Orkney Assessment & Rehabilitation

What did we do?

As part of the Excellence in Care testing of core measures, the EiC Leads were asked to choose projects to work on. After discussion with the then SCN and A&R Team, we commenced in October 2017:

- **Team members:** 3 Ward Nurses, Pharmacist, Doctor, E-health Lead, EIC Lead (band 6 Nurse retired in March 2018, Interim SCN continued to provide leadership and support to the team)
- **Ward area:** Assessment & Rehabilitation – 14 bedded mixed speciality/age/sex ward
- **How you engaged with staff;** Staff were included at all steps in the process and having key individual to go to helped in ensuring consistency and communication – Regular WebEx's and visit from national team were really beneficial in keeping up momentum and sharing of learning with other Boards.
- **What tests of change were identified:** Adding to daily safety brief, discussion at ward meetings, having a written process to guide staff in completion of audit, written guidance on data entry, Whiteboard for displaying data and messages, paper medication chart sweep at end of shifts.
- **Who collected the data:** Registered Nurses in A&R
- **How you shared the data with the ward staff and others:** - Verbal feedback, ward meetings, White Board.

What went well?

What tests of change you think resulted in improvement?

- Adding to safety Brief, written process for completing audit as this ensured consistency of audit and paper medication chart sweep at end of shift

Additional ways of working that helped engage staff:

- discussion at ward meetings, Whiteboard for sharing data and messages

What could we improve?

What we would do differently if starting from scratch:

- Have the inclusion/exclusion criteria
- Spend more time as an improvement team

What did you learn from tests of change that didn't go as planned?

- Lack of detailed communication in regard to audit process resulted in high number of omissions for one month

Top tips for others:

- Have an 'improvement team' and make time to meet
- Leadership support from Team Leader/SCN
- Regular meetings/support from other areas- within own hospital or with others
- Have as much information as possible before you start – 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 help and at least one person in team should have this

Next steps after October 2018:

- Team would like to carry on with project to see sustained improvement now that consistent processes are in place.
- Move to New Health Care Facility planned for May 2019 – Meds Omission work already embedded so team will continue with data collection and improvement work which will provide additional assurance during the transition period.

Appendix 7: Improvement story – NHS Western Isles

Reducing omitted medicines: NHS Western Isles	Western Isles Hospital, Stornoway Erisort

What did we do?

- Our test ward has 15 beds, consisting of General Medicine, Orthopaedic Rehabilitation, Acute Stroke, Stroke Rehabilitation & Intermediate Care. Our small project team comprised the SCN, the Charge Nurse, Chief Pharmacist and EIC Lead.
- The project was communicated to staff via both email and ward team meetings. Responsibility for the data collection was with the Charge Nurse who undertook the weekly audits along with one of the staff nurses on duty.
- Improvement ideas included reintroducing the "Red Tabards" to reduce interruptions, raising medicines awareness among the team and informing staff of common omissions, Daily paper medication chart sweeps by senior staff and an awareness of a pharmacy stock locator on the Intranet.

What went well?

- The overall project has gone well with good buy in and support from the SCN and Charge Nurse.
- Raising awareness among staff has been the biggest factor in improving and sustaining low rates.
- Learning from others – other regular meetings and national team support via WebEx

What could we improve?

- Giving staff nurses the responsibility for the audits. Relying on one person can make data collection person dependant.
- Displaying improvement data in a meaningful way in order to maintain momentum and focus.

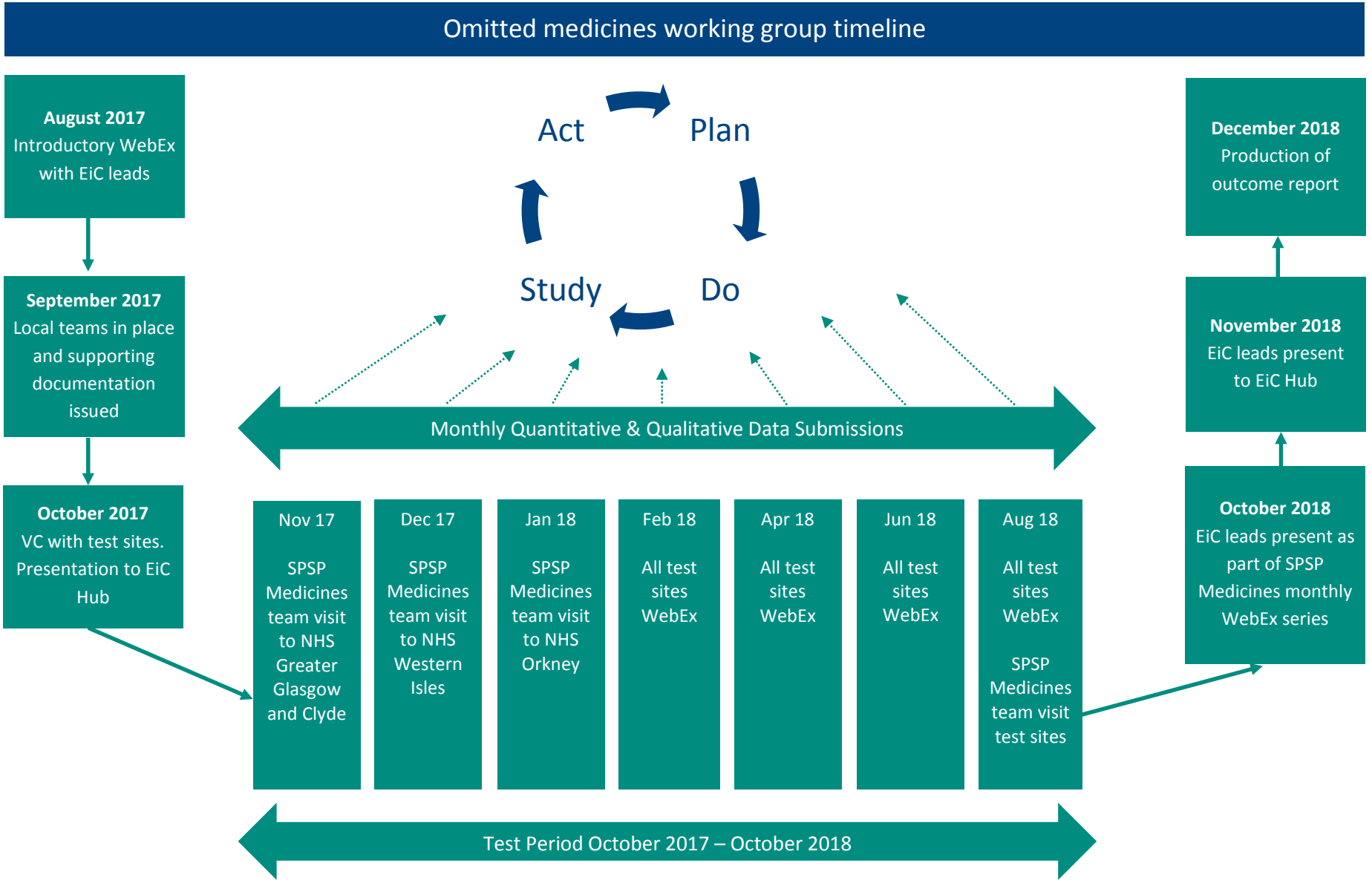
Top tips for others:

- Involve all staff and have a team approach from the outset.
- Rotate the audits among staff encouraging data ownership.
- A multi-professional approach with nurses, pharmacists and medical staff.
- Learn from other areas, particularly when struggling with new improvement ideas.
- Be clear with data collection definitions.

Next steps:

- Continue audits monitoring omission rates to sustain current rate.
- Discuss ideas for "improving result displays" within ward area for staff.
- Standardise process when identifying "Drug not available".

Appendix 8: Omitted medicines timeline



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