East London NHS Foundation Trust

Reducing omitted doses of medication on the MHCOP wards

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Why are medication errors an important issue?

- Medication administration errors are preventable episodes that can result in unnecessary patient harm.
- Many people treated on the MHCOP wards have co-morbid illnesses; with resultant complex medication regimens.
- High burden of medication usage means errors are more likely to occur.

Why focus on omitted doses?

- Recent study in ELFT (Cottney & Innes, 2015) found that the most common medication administration error on inpatient wards is the unintentional omission of medication.
- Reduction in this type of error would give a large reduction in the overall medication error rate on the wards.
- In turn, this would mean that less patients would suffer harm through omitted doses.

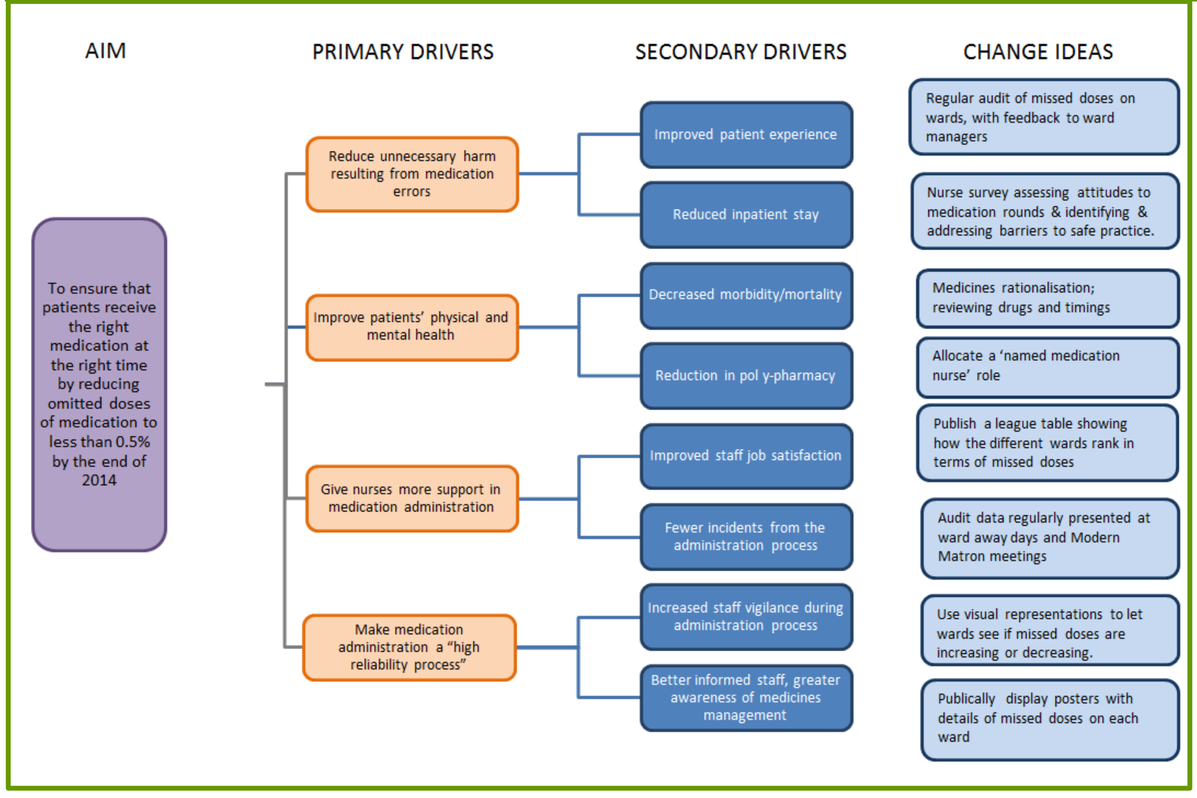
The Project

- To ensure that patients receive the right medication at the right time by reducing unintentionally omitted doses of medication on the MHCOP wards

Aim Statement

- To reduce omitted doses of medication to less than 0.5% of total doses due by the end of March 2015

Driver diagram



QUALITY IMPROVEMENT PROGRAMME

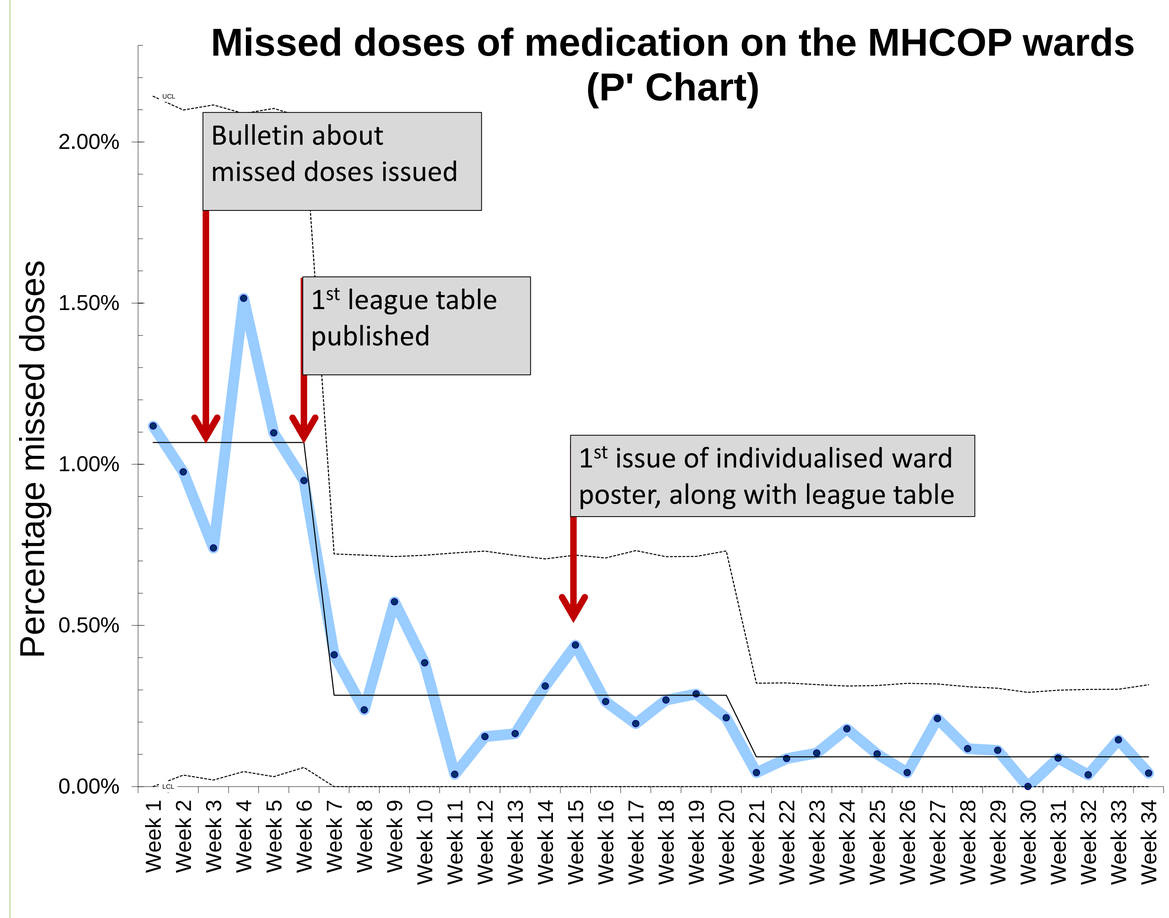
Change concepts & Ideas for PDSAs

Idea for Testing in a PDSA	Theory and prediction about what will happen when you test this idea
Issue bulletin to wards highlighting problem of missed doses	Raising awareness of problem may lead to reduction in missed doses
Issue a regular league table, ranking wards in terms of number of missed doses, and issuing prize for best ward	Encouraging competition between wards may reduce the number of omitted doses
Issue individualised poster for each ward, showing number of missed-dose-free weeks and trend in missed doses	Visual representation of data and public display should be an encouragement and reminder about missed doses

Measures

Name of Measure	Is this an Outcome, Process or Balancing Measure?	Operational Definition (e.g., numerator & denominator)
No. of medication doses *unintentionally* omitted/ No. of doses of medication due	Outcome	Data collected by weekly audit
Number of incident reports of omitted medication	Outcome	Incident reports on Datix classified as medication error
Number of doses prescribed for patients	Process	
Number of doses *intentionally* omitted	Balancing	

Results



Since the introduction of league tables and individualised ward posters, the missed dose rate on MHCOP wards has decreased markedly:

Time period	Average missed dose rate
6 weeks before project started	**1.07%**
The last 6 weeks	**0.07%**

The change idea has had a positive effect, and will continue to be used on all the MHCOP wards.