ROYAL COLLEGE OF PSYCHIATRISTS ANNUAL REHABILITATION CONFERENCE NOVEMBER 2021

AUDIT CYCLE TO REDUCE AND IMPROVE MEDICATION AND PRESCRIBING ERRORS FOR IN-PATIENTS BY INCORPORATING SMALL QI BASED PROJECTS BETWEEN BASELINE AUDIT AND RE-AUDIT ALONGSIDE PHARMACIST VISITS TO A MALE REHABILITATION UNIT.

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Introduction

It is reported that an excess of 237 million medication errors are made every year. The avoidable ramifications of this cost the NHS upwards of £98 million and upwards of 1700 lives every year. The harm caused by medication errors have been recognised as a global issue, amid increasingly complex healthcare needs and the introduction of many new pharmacological interventions. The World Health Organization (WHO) aims to halve the level of severe avoidable harm associated with medication error at any point in the process---prescribing, dispensing, administration, and monitoring--between 2017 and 2022. It is important to minimise the risk of medication and prescribing related issues by way of appropriate medication management, training and regular audits.

Aim

To conduct a routine audit cycle to reduce and improve medication and prescribing errors for in-patients by incorporating small QI based projects between baseline audit and re-audit alongside pharmacist visits to a male rehabilitation unit.

Method

An external pharmacist visited a male rehabilitation unit weekly to complete checks within clinical area as per Speeds pharmacy checklist. Guidelines from Nursing & Midwifery Council (NMC) and Cygnet Health Care's Medication Management policy were gathered and referred to. An audit tool with simple checklist was created from key areas of Cygnet's medication management policy. Medication Files of 28 patients from male Rehabilitation Ward were audited in the initial audit cycle. Checklist included: patient information on medication cards, prescribing information (was clear and unambiguous), 5 Rights - (right patient, right drug, right dose, right route and right time), maximum dosing in 24 hours, correct indication of prescribed medication, checking missing administration signatures, checking the amount of stock of medication left prior to the end of the monthly cycle, drug errors with PRN medications and raising highlighted issues with legal paperwork.
After the initial baseline audit for the period of Feb - June 2021, some of the Quality Improvements were used before conducting the re-audit in Oct 2021.

Change Ideas following initial Audit

Nursing
Designated nurse as clinic auditor.
Weekly audits completed.
Weekly reminders sent to nurses.
Depot Board completed with reminders in clinic.

Management
Working Audit tool created; amending and added to as required.
Calendar reminders for depots set up on electronic system.
Results discussed within clinical governance.

Pharmacy
Nurse present with Pharmacist during weekly visit.
Pharmacist inclusion within email trails.
Regular face to face meetings with Pharmacist and Doctor.

Doctors
Regular reminders sent to Doctors with follow up actions.
Updates within morning MDT meetings.
Regular nurse meetings with doctor.

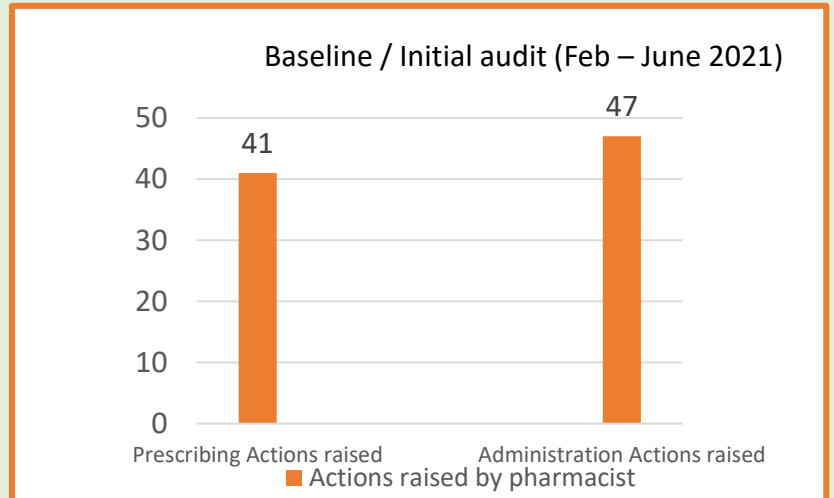
Patients
Liaising with patients.
Providing psycho-education.
Providing patient information leaflets.
Incorporating the need for medication within 1:1 nurse sessions.

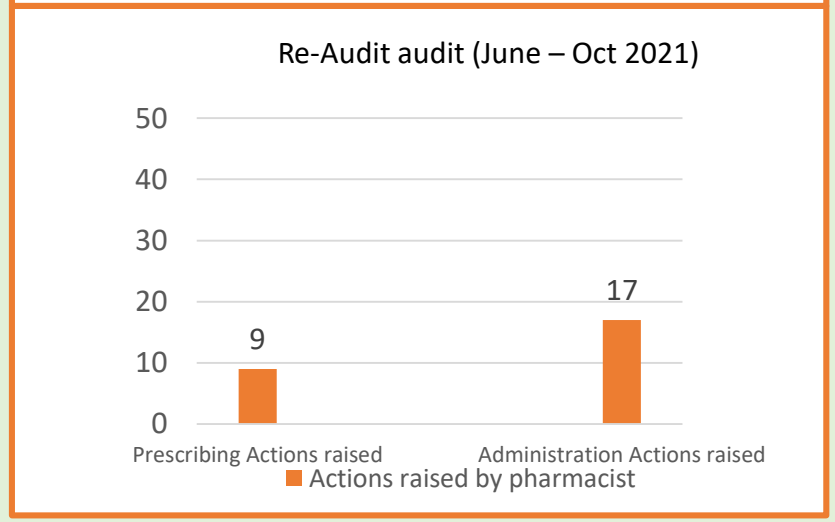
Result

The baseline audit for the period of Feb –June 2021 showed 41 raised actions within the Insight pharmacy system relating to prescribing and medication errors or issues, with record compliance being 96.3% and 8 minor interventions. Prescribing technical compliance was 98.4%, with 17 actions noted.
The re-audit for period of June – Oct 2021, showed an overall improvement: weekly pharmacy actions were reduced to 21 and record compliance increased to 98.5%, with 4 minor interventions. Prescribing Technical compliance increased to 99.5% with a reduction of actions, to 9.

Conclusion

Interventions, using QI approaches, between baseline and re-audit, included clinical governance discussion around strategies to improve medication management strategies. One consistent member of the nursing team was identified to conduct the weekly clinic audit, timescales and reminders sent via emails to doctors, liaison with pharmacy team and maintenance of patient medication files. This helped in providing a framework to monitor and evolve design based on repeated data collection between cycles. The QI Interventions helped in implementation of a more streamlined approach towards management of medication charts and medications. From this, the re-audit demonstrated a sustained improvement in regards to a reduction in number of actions raised. Feedback from the visiting pharmacist also highlights a noted improvement in the clinic standards.





References

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