East London NHS Foundation Trust

Missed Doses Project
Butterfield Ward, Forensic Low Secure Service

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Aim

Reduce missed doses of medication to meet the Trust standard of less than 4% for non-critical medicines and 0% for critical medicines by April 2015

Project Background

Butterfield Ward is a 19-bedded ward providing recovery services to individuals who have a long history of requiring inpatient care, who have proved difficult to engage. Individuals with severe and enduring mental health problems have a reduced life span of 15 years compared to the general population; ensuring they receive the right treatment could aid in bridging health inequalities.

A systematic literature review reported dose omissions are a common administration error (Keers 2013) and omitted and delayed doses are one of the most frequent causes of medication incidents reported to the National Patient Safety Agency (NPSA) (Cousins et al, 2011) The NPSA proposes a staged approach to defining locally agreed critical medicines and developing systems to improve and audit the timeliness of administration (NPSA 2010.)

Many patients on Butterfield Ward have chronic physical health conditions as well as severe and enduring mental health problems. In order to improve the patients' opportunity for recovery and improve physical health we need to ensure that the treatment plan is followed and can be robustly evaluated.

An audit of missed doses in Wolfson house found that Butterfield Ward had one of the highest missed doses rates and so it was decided that a project would be run in this ward to reduce this.

Figure 2: Test of change using PDSA ramp

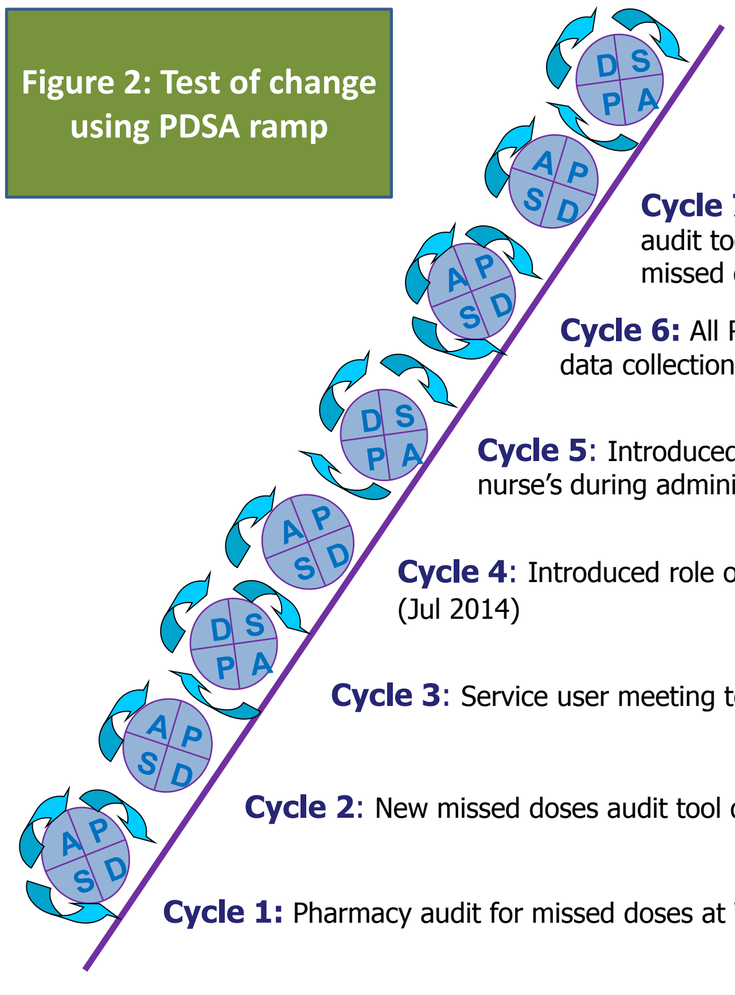


Figure 1: Driver Diagram

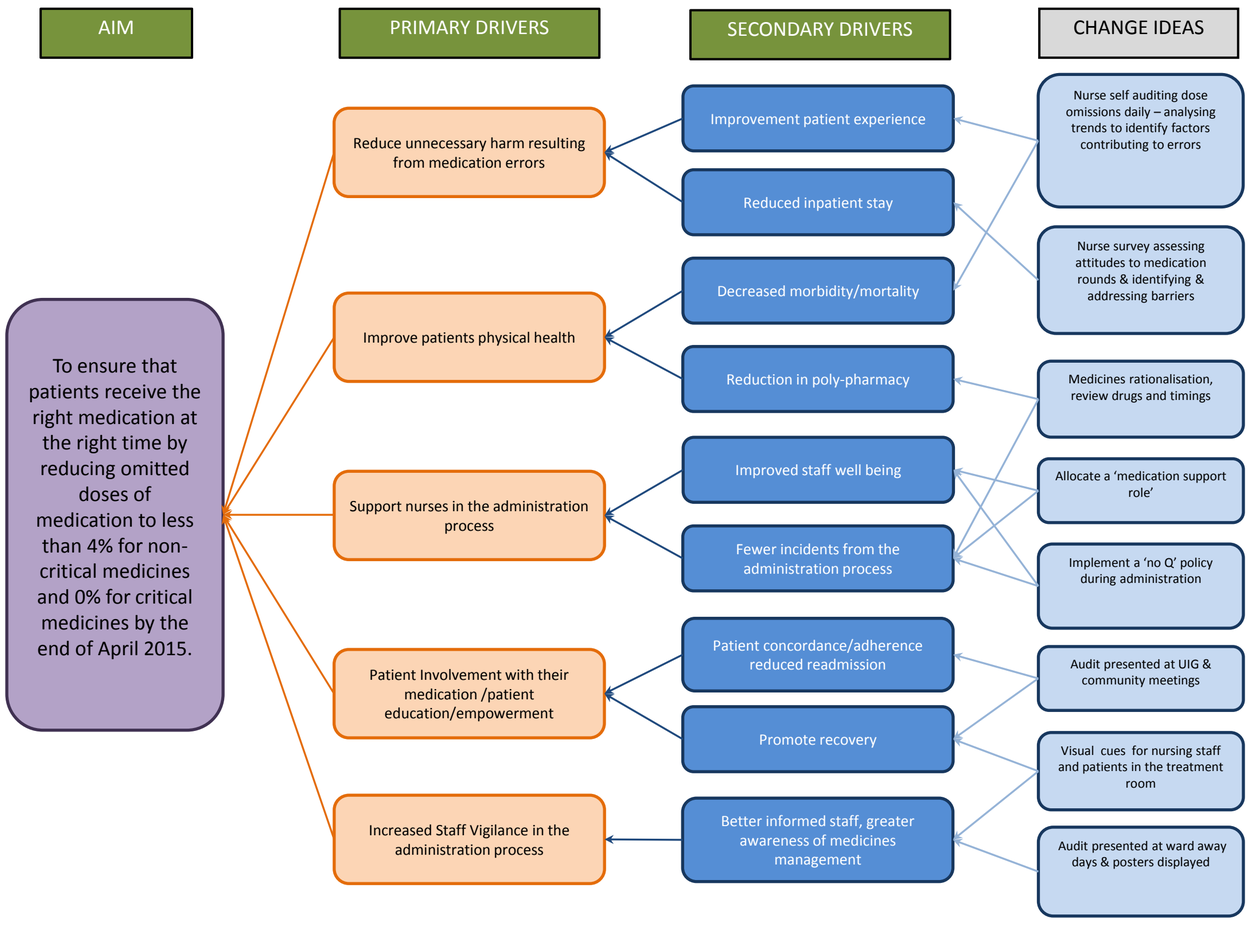
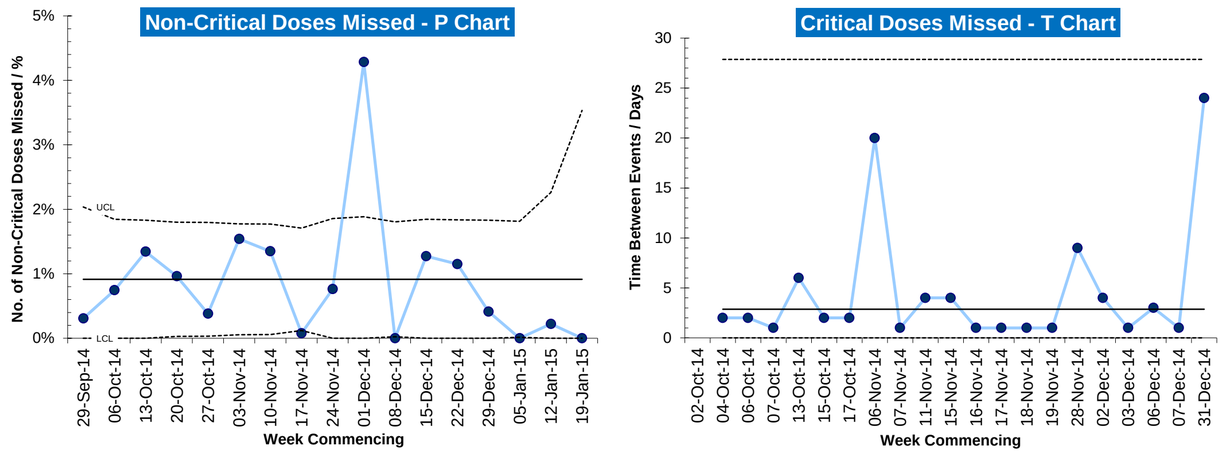
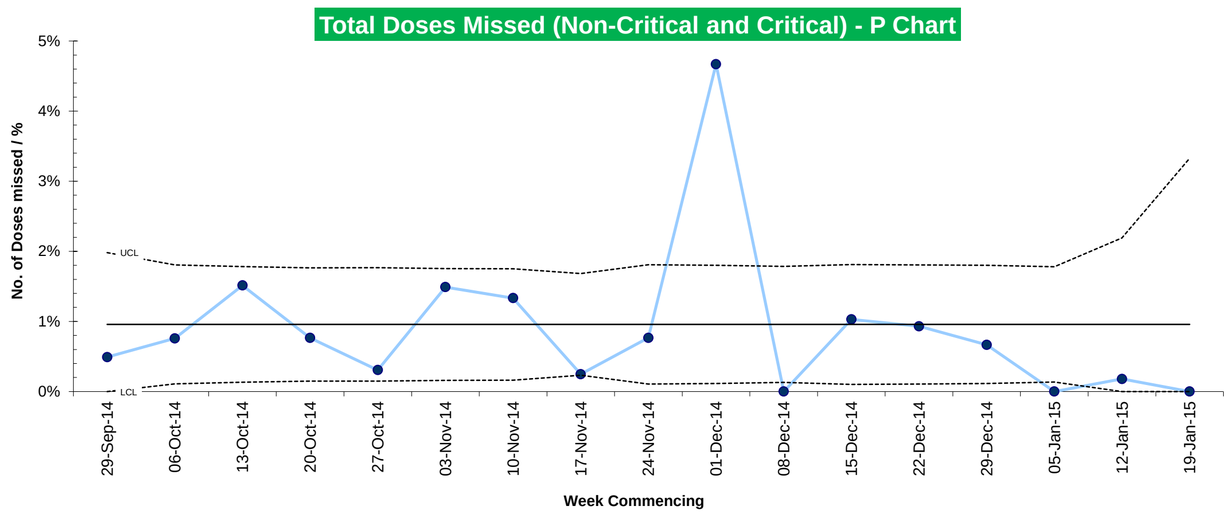


Figure 3: Control charts on data





Prior to this initiative, a monthly statutory audit of missed doses was undertaken by the Pharmacy Team, for all wards in Forensics services. This was the only process in place to monitor missed doses for Butterfield Ward, which was shown to have the highest percentage of missed doses in the directorate.

Frontline staff were concerned about this clinical issue and decided it was a priority area for quality improvement work. Moving to a culture of daily monitoring has been very ambitious but proved an important intervention that has positively influenced patient care. The following measures were agreed upon by the project team to help address the issue of missed doses within our ward.

Measures

% of non-critical doses missed
% of critical doses missed
% of doses missed in total

Learning

This project has raised the profile of medication errors (missed doses) among staff and service users on the ward. This has resulted in improved quality of care, through reduced error rates as evidenced by the data we have collected over the past few months.

QI Tips from Butterfield Ward

- Planning – clinicians are keen to 'get doing' but careful planning of *how* is crucial to a successful project, as well as *what to measure* and **actually measuring it**.
- Change ideas – these are exciting but must be aligned with measures to establish if they result in real change
- Communication – the project team require regular meetings to ensure work is being co-ordinated, and data can be scrutinised so the team respond in real time
- Engagement – project work needs to become business as usual, so staff need to believe it is meaningful if it is going to be a priority in practice: QI ideas that come from frontline staff are the ones that will be embraced most easily
- Improvement – has been demonstrated easily, with very little financial investment from the service. Improving the quality of care provided and reducing harm has proved an extremely rewarding experience for ward staff – and patients!

QUALITY IMPROVEMENT PROGRAMME