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Kate Dewhirst, interim chief pharmacist and medication safety officer, tells us how the pharmacy team and safe medicines practice group have worked together with wards and teams to improve how we dispense and administer medication on inpatient wards by reducing the amount of medications that are missed.

Our pharmacy team have been aware of an issue with medications being missed for some time. It's been a common theme in Datix reports of medication incidents, it became a 'sign up to safety' campaign topic a few years ago, and it's a regular category in the Mental Health Safety Thermometer monthly report. So, the pharmacy team and the safe medicines practice group started reviewing different medicine incidents, looking at the reasons for missed medications and thinking about possible solutions to resolve this issue. Nursing and medical staff were also consulted.

> "Reducing the number of missed medications improves the treatment we provide to our service users."

How does it happen?

They found that there are lots of reasons why a medicine might be missed, and these are often linked to behaviours, systems, culture or environment. For example, prescriptions may be incomplete, administration rounds might be disrupted, or a service user may not want to take the medication.

Why is it important?

Missed medications can have a long term effect on a service user's care. If they miss their medication they will not be getting the treatment they need, their overall treatment may fail and their stay may be extended. Types of missed medication include mental health medication as well as antibiotics, contraceptives, inhalers and more. Missing just one dose of some critical medicines can have an immediate effect on a service user's health and wellbeing.

In a nutshell

To improve how we dispense medication on inpatient wards, we've looked at the causes of missed medications and introduced new ways of working to prevent this from happening.

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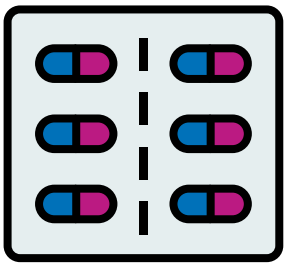


What are we doing to improve?

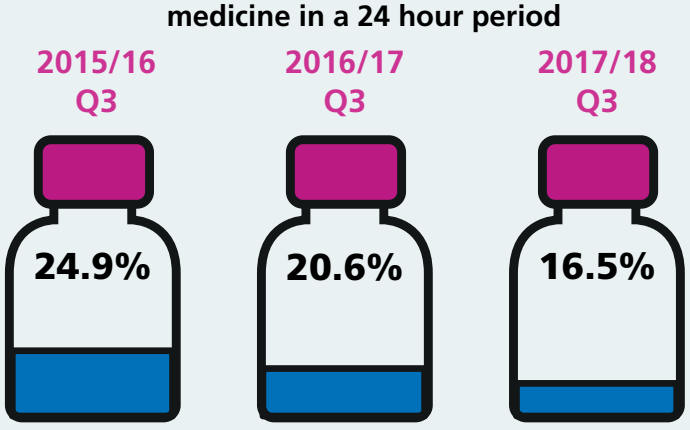
Our teams have made lots of changes to how they dispense medication and work with ward staff to reduce the number of missed medications. These new working practices were first shared with staff in a medications safety alert a couple of years ago, as part of raising awareness of this issue, and the teams have continued to embed them since. Here are a few examples…

- If a service user refused to take their medication, staff have been encouraged to try and take the time to work with the service user and understand what's driving this. It might be that the service user is unhappy with the side effects, the taste or formulation of the medication, or the time of day they're being asked to take it. All of these reasons can be adapted to by our pharmacy team, in order to avoid further missed medication.
- The presence of a pharmacy team member at ward ward team meetings has been increased, so they can work closely with clinicians to discuss any missed medicines, reasons why and advice for next time.
- System approaches have been considered. Now, pharmacy technicians visit wards more often to capture medication changes or additions in a more timely way rather than relying on charts being delivered to the pharmacy.

What results have we seen?

Since implementing these new working practices, the team have seen a reduction in the number of missed medications. There's also more awareness of this issue amongst ward staff, and there are closer working relationships between the pharmacy team and inpatient teams. More improvements will be possible in the future. For example, the new clinical record system, SystmOne, has the potential to improve how we work together as clinicians, and may include e-prescribing.

Percentage of service users missing at least one medicine in a 24 hour period



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