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Deputy ward manager Laura Ramsey explains how Stanley ward have been working to manage medicine omissions with the help of a handy chart.

Medication is an important part of service user recovery and we dispense many different medications on Stanley ward in Wakefield. When we do this, we sign a card to say that we have given the service user their prescribed dose. However, we noticed that occasionally, medication omission would happen.

Medication omission means that the appropriate medication is not provided to a service user, either because the medication has not been prescribed or has not been administered. Sometimes, it may be that the member of staff has given the medication but hasn't signed the card to say they'd done it. These events are rare but due to the busy ward environment, they do sometimes happen. When they do, we make sure to support and guide our staff in their regular supervision meetings.

Uncertainty around medication has an impact on patient safety, so we knew we had to do something about it to make sure that it's never an issue. We decided to introduce a 'safety cross', which is a chart of dates displayed on our ward wall filled in using a traffic light system to show the number of medication omissions each day. Every evening a member of staff will count the number of medication omissions in a day and mark it up on our safety cross as either a green, amber or red day. If there are just two or more medication omissions in a day we class this as a red incident.

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Staff found having the cross really motivating, especially as it's up on the wall near where they dispense medications. They really took it on board as it's a good visual reminder.

We started the safety cross in November 2018 and in that month we had six red incidents, reducing to four incidents in both December and January. We are now proud to be celebrating two months of continuous green results meaning that there have been no issues with medicines administration recording for over 60 days.

Staff on the ward think the safety cross is a really good idea. They've really engaged well with it and it's clearly had a huge impact. Some of the recording we do sometimes feels like we are just ticking a box but with this staff can see that they are making a big difference.

We've decided to start using the safety cross for other things after seeing how successful it has been for medication omissions. We use it to record whether we've had a safety huddle – daily 5-10 minute discussions where team members gather to focus on keeping patients safe and reducing harms such as incidents of violence or falls. It's helped us to make sure that no matter how busy we are, we prioritise getting together to help keep our ward environment as safe as possible.

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