Missed or Late Medications within Paediatric settings

Lucy Manning

Abstract: The Trust has identified that there appears to be late or missed medications due to administration processes that require action within Paediatric inpatient areas. Understanding of staff issues related to this and development trial of new tools to increase administration compliance.

Plan

Through examination of data related to late or missed medications within the paediatric inpatient area, it has been highlighted there is a need to change practice.

The team wished to use CQI methodology and pursue use of 4 PDSA cycles to reduce missing or late medication administration by 100% by December 2020

1. Awareness raising with staff members
2. Door handle notices when patient leaves ward to have investigations/treatments during period medication should be administered as an aide memoire and visual prompt
3. Use of a notices/ marker in patients folder to highlight when patient leaves ward to have investigations during period medication should be administered as a visual reminder
4. Implementation of additional drug rounds during 24 hour period

Do

All 4 PDSA cycles were discussed and planned, staff survey was undertaken to ascertain why staff felt there were blockers to making change happen and issues related to processes that could be changed to create improvements. New visual cue tools were designed and used within Paediatric inpatient area. An increase to drug round frequency was agreed and implemented, data collection tools were agreed, and staff communication board was designed.

Study

Data was collected from variety of sources to aid discussions with team and make further improvements

Act

The Trust is now using the data to report issues to senior Paediatric team members and Trust medicines management team to inform quality improvement projects going forwards relating to patient safety. Satisfy this national requirement. For more information on the tool and project please contact lucy.manning@nhs.net or nicola.vanes@nhs.net

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