Learning from Incidents – A Quality Improvement Approach

Jackie Box, Associate Chief Pharmacist & Sheela Shah, Community Health Services Pharmacist
Introduction

• Aimed to look at different approach to addressing medicines incidents

• Across one of the CHS areas

• Community teams included
  • District nursing
  • Twilight
  • Rapid Access Team
  • Specialist teams e.g. diabetes team, heart failure
Background

• Medicines most frequently involved from quarterly analysis of datix incidents:
  • Anticoagulants
  • Insulin
  • CDs

• Incidents that occur included
  • Double dose
  • Missed doses
  • Incorrect dose given
  • Treatment (anticoag) given for longer than required
  • ‘Missing’ CDs in patients home
Background

• **Current approach**
  - Incidents regularly monitored & input into individual incidents
  - Quarterly report of medicines incidents highlighting trends & learning lessons
  - Shared at governance meetings internal & external

• Clinical Director keen to review incidents using a Quality Improvement approach
  - PDSA methodology
‘Deep dive’ Medicines Incidents

• Series of 3 meetings with various community teams. Aim:
  ✓ Elicit themes of medicines incidents
  ✓ Map out steps involved in medicines administration

Meetings involved:
  – Practitioners: Staff engagement
  – Head of Primary Care Services: Leadership community teams
  – Pharmacy: Leadership Medicines Optimisation
‘Deep Dive’ MDT Review

- Themes elicited included
  - Transcribing practices/errors
  - Insufficient information on referral about medicines
  - CD balance sheets
  - Information about medicines in care plans
  - Running out of medicines in home

- Mapping out pathway
  - Elicited how changes regarding medication are communicated
  - SystmOne notes not always checked prior to visit
  - Not all teams writing in home notes
  - Communication between teams to be improved
  - Specialist teams not making changes on MAR chart
Community Nursing Medicines Pathway

Aimed to capture issues identified from deep dive

Launched by Head of service

Training prior to implementation by pharmacy

Encouraged continued medicines incident reporting for further learning
Monitoring of adherence to pathway

• Shadowing with the nursing teams to measure adherence to pathway & identify any further issues:

• Key areas looked at:

A. **SystmOne observations** i.e. notes checked prior to visit
B. **Home notes** checked prior to attending patient’s care
C. **Transcribing practices & MAR chart documentation**
D. **CD balance sheets** completed correctly
E. **Adequate supplies of medication** available for this visit and next one?
F. **Anticoagulation** adequate information in notes, yellow book available etc.
Shadowing with DN Teams

- 3 DN bases
- 15 patients in total over the three teams
- Shadowed an allocated band 5 nurse
- Copy of scheduled visit list
  - Patient details
  - Brief description of the visit – each site had a different amount of information
  - Additional information if new patient referral
- Consent gained from patient
- Observed whilst relevant care was given
- Returned to base for handover and SystmOne update
Findings

Scheduled visit lists
Can be printed off in the afternoon day before the visit, other teams visit, their recommendations not reflected in visit plan e.g. changes in insulin dose, latest INR and warfarin dose

A. SystmOne

*Primary record for the patient*

- SystmOne notes not always checked prior to visits & sometimes not all relevant information from sys1 attached to visit list

- Notes not always updated immediately after a visit with all information required
B. HOME NOTES

- Some teams either provided insufficient information in home notes or sometimes no documentation at all.

- Home notes did not match S1 notes in one case

- Specialist teams were not yet writing in home notes

- Home note not checked prior to patient care – for “regulars”

- Time restraints to complete home notes mentioned by the team
C. Transcribing/ MAR Chart

- Some poor transcribing practices noted:
  - Not using 2 sources of recent information for transcribing
  - Medications stopped not crossed of charts
  - Old MAR not archived post admission
  - Allergy status not updated on chart

Case

- TTA attached to referral letter did not match TTA in patient’s home i.e. amitriptyline missed off
- Nurse used ‘old’ MAR to administer amitriptyline
- Day team transcribed new MAR chart
D. CD Stock balance sheet

- Crossings out
- No signatures
- Incorrect balances on receipt of new stock
- CD name missing on balance sheet.
- Blank CD balance sheets not carried
E. Adequate supplies of medication for the next visit
• Observed good systems in place & no issues notes

F. Anticoagulation
• Insufficient information from the acute on discharge
• Care plans did not always contain required information
• Delays in receiving INR (results sent in post). Yellow books kept by anticoag clinic & posted back.
• +++ time spent chasing results with anticoagulation clinics

Eg; LMWH admin: No documentation in notes/ care plan wrt length of treatment course, review date, or who was reviewing
Post Shadowing Actions

• Immediate actions resolved on day
• Feedback of all shadowing provided at the 3 DN bases
  – Key learning lessons
  – Photos used to illustrate points
• Pathway is being reviewed (feedback from teams)
• MAR chart being reviewed (to reduce risks)
• Poster presented at Trust Safety day & relevant Trust meetings
Next Steps

• Develop monitoring checklist
• Repeat shadowing visits by CHS pharmacist

Continuous Improvement

• Checklist to be embedded into team practice
  – By team leaders
  – As part of 121s; training etc.
• Annual shadowing by CHS pharmacist.
What we learnt?

• Shadowing – time consuming but invaluable

• Better understanding of medicines processes including some of the challenges

• Enhanced relationship with pharmacy & nursing teams

• Working progress but created a healthy dialogue about medicines within teams - ↑ engagement during process