Pharmacy In-patient Orders

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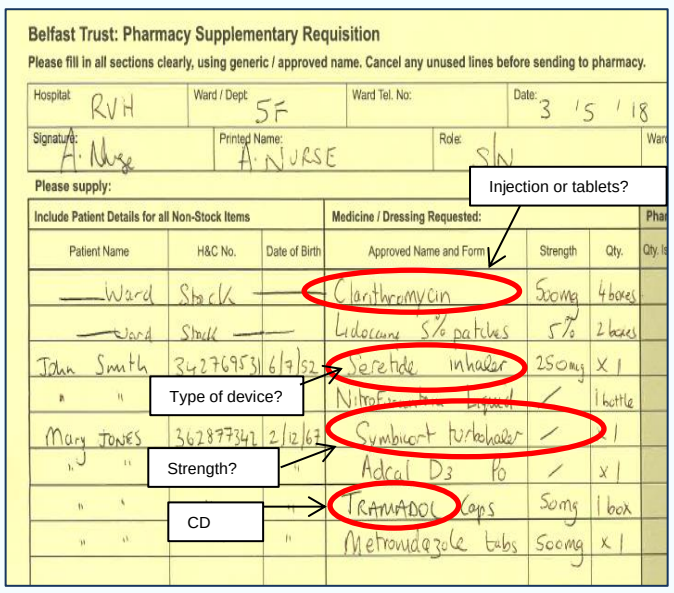
Background

Baseline data from the RVH Pharmacy in November 2017 showed 10% of orders for in-patient medicines could not be supplied despite stock being available. This was due to a range of issues including illegible writing, patient details missing/ incorrect, strength missing/ incorrect, and controlled drugs listed when they should have been ordered in the appropriate controlled drug order book (see example below).

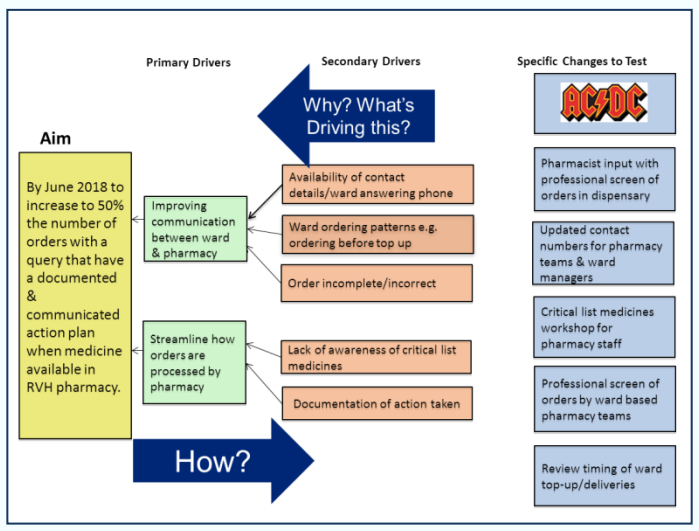


This could potentially result in delayed /omitted doses unless queries were resolved and communicated in a timely manner. Whilst pharmacy staff were actively resolving and communicating issues with ward staff, there was limited documentation to evidence this.

Aim Statement

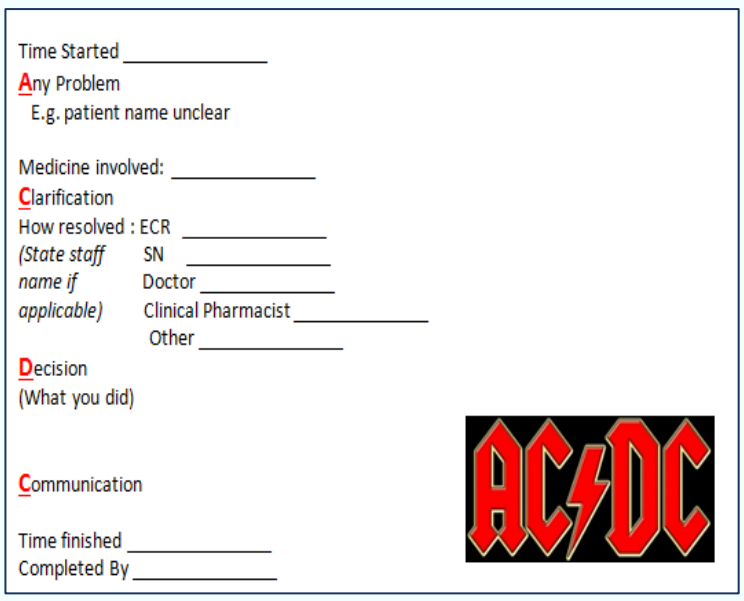
By June 2018 to increase to 50% the number of orders with a query that have a documented and communicated action plan

Driver Diagram



Change Ideas

- Brand project "ACDC" with aide memoire sticker attached to the back of orders with queries
- Update contact details for ward based pharmacy teams/ ward managers
- Dispensary pharmacist screen for in-patient orders
- Ensure ward based pharmacy teams screen orders for completeness at ward level where possible
- Interactive workshops for pharmacy staff to increase awareness of critical list medicines[1]



Results

CRITICAL LIST MEDICINES WORKSHOP

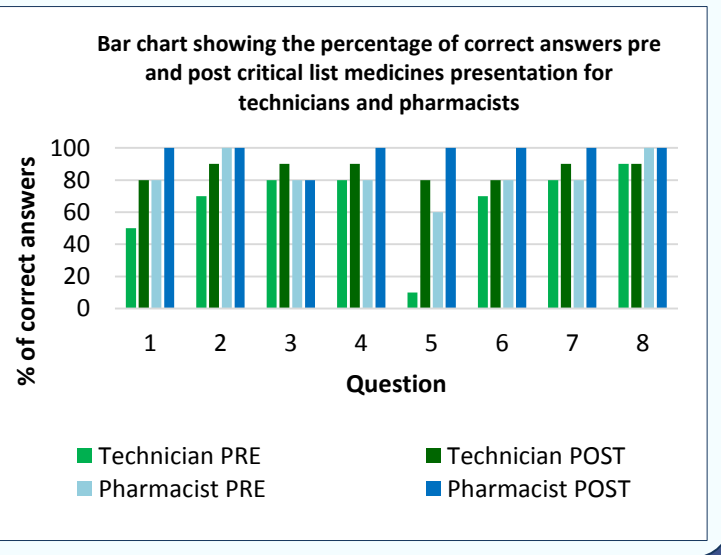
Plan-Interactive workshops for pharmacy staff to increase awareness of critical list medicines. Pre & post questionnaire.

Do-30 minute workshops for 2 groups of staff

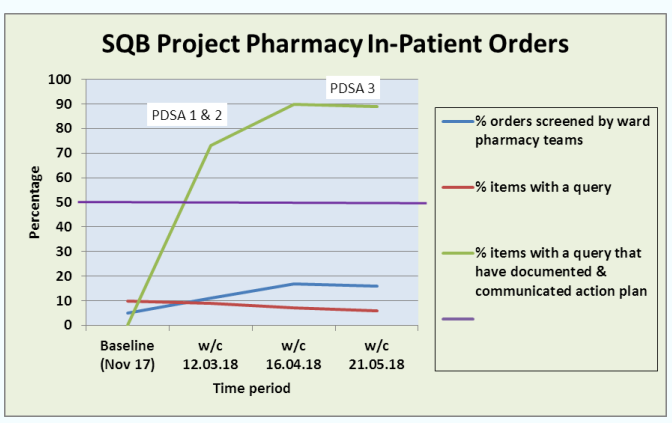
Study-Pre and post questionnaire showed significant improvements in knowledge

Act-plan to repeat workshop for other pharmacy staff with targeted learning

Pre & post questionnaire results for first round of workshops



Run chart



PDSA 1&2=aide memoire sticker and dispensary pharmacist screen

PDSA 3 = workshops

- 95 % of orders with a query had a documented and communicated action plan (well beyond target of 50%)
- Increased % of orders screened by ward based pharmacy teams
- Decrease in % of orders with queries through feedback to nursing staff
- Processing times remained constant despite concerns they would increase at the outset of the project

What next for the project

- Consider roll out to extended hours service. This would require re-engineering of service to ensure pharmacist support at in-patient orders
- Consider spreading to other BHSCT dispensaries
- Continue interactive workshops for critical list medicines and consider as part of core induction for new staff
- Consider interactive workshops on critical list medicines for nursing staff (resource dependent)
- Consolidate guidance for pharmacy staff processing/ checking in-patient orders.
- Ensure increased percentage of orders screened by ward based pharmacy teams where possible

Conclusions

Utilising an aide memoire sticker and introducing pharmacist support for in-patient orders has significantly improved the % of orders with a query that have a documented and communicated action plan. Interactive workshops on critical list medicines have increased knowledge and awareness of pharmacy staff.

References

(1) National Patient Safety Agency: Reducing harm from delayed and omitted doses in hospital. Rapid Response Report 2010 (NPSA/2010/RRR009).