Junior Doctors Quality Improvement Journey

Quality Improvement Clinic
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NHS
Health Education East Midlands

Derby Hospitals NHS
NHS Foundation Trust

QUALITY IMPROVEMENT PROJECT:

Reducing the delay between patient admission and regular medications being prescribed for Surgical patients

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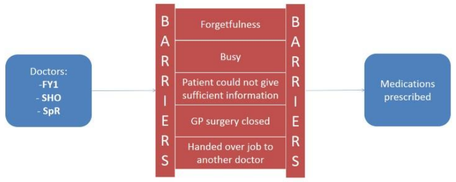
Process Map

Root Cause Analysis
BARRIERS TO PRESCRIBING WITHIN 24 HOURS



Change ideas

Survey of Surgical Junior doctors indicated:

- Lack of knowledge of hospital guidance about critical medications
- High work demands
- Poor handover from seniors
- Forgetfulness

PDSAs completed during study

- PDSA #1 Discuss with pharmacist availability of data
- PDSA #2 Junior surgical doctors survey
- PDSA #3 Produce posters and put up around SAU to alert doctors to problems
- PDSA #4 Send an email to all surgical doctors informing them of study.

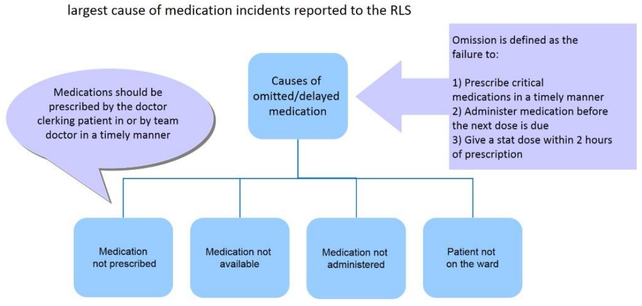
Recommendations by Doctors

"reminders to prescribe meds and greater awareness of what medications cant be omitted."

"...It's unrealistic to expect a F1 to manage both the ward and waiting room/ trolleys. It's a medication nightmare waiting to happen."

Initial Problem

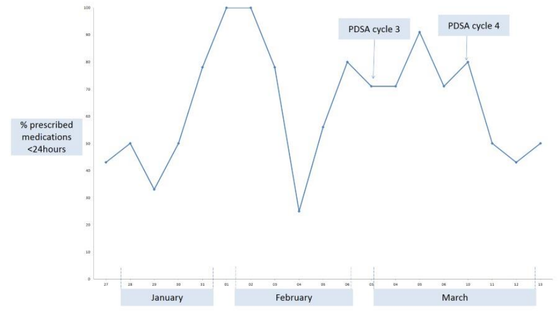
Findings from NPSA[1] study revealed that omitted and delayed medications were the second largest cause of medication incidents reported to the RLS



Improvement aim

High level Performance targets	**P**utting patients first **R**ight first time **I**nvesting our resources wisely **D**eveloping our people **E**nsuring value from partnerships
Our project aim	To reduce the time between patient admission and regular medications being prescribed for surgical patients admitted via SAU and remaining in hospital for greater than 24 hours
Measures	Survey – what factors do junior doctors feel are contributing to medications not being prescribed in less than 24 hours? Data collection – what is the baseline percentage of patients being prescribed their regular medications within 24 hours when admitted via SAU and remaining an inpatient for more than 24 hours.
Proposed changes	Improve knowledge of critical medications Educate regarding the importance of prescribing regular medications. Remind doctors to prescribe regular medications.

Results



Initial Audit: 61% → PDSA 3 → Re-audit: 78% → PDSA 4 → Re-audit 61%

Evidence Base

- The omission rate for prescription of medications during the first 48 hours affects 17% of patients.
- NPSA recommended actions to hospitals included

"making all staff aware of critical medications"

"identify a lead list of critical medications"

- Studies show that medical prescribing error is most likely at admission
- NPSA review highlighted that for some kinds of medicine an omitted or delayed dose can have serious and even fatal consequences

- *Royal Derby Guidance Critical List NPSA/2010/RRR09*
  - ❑ *Systemic antimicrobials*
  - ❑ *Anticoagulation*
  - ❑ *Insulin*
  - ❑ *Opioids px regularly for chronic pain*
  - ❑ *Antiepileptics*
  - ❑ *Anti-Parkinsonian drugs*
  - ❑ *Resus/anaphylaxis/reversal agentss*

Baseline measure

- Process Measures
  - Number of patients admitted to Surgical Assessment Unit during on-call (Monday to Thursday & Friday to Sunday)
  - Date and time of admission
  - Number of patients who stayed more than 24 hours in hospital
    - Date and time of when regular medication was prescribed
    - Was this within 24 hours?
- Outcome Measure
  - What percentage of patients staying in hospital >24 hours had their medications prescribed within 24 hours of admission?

Reflections

- Variable prescribing habits amongst doctors
- Raising awareness seems to improve prescribing habits, albeit on a short term basis
- Need structural teaching for doctors to raise awareness about critical medications to increase prescription rates
- Increased doctor number based at Surgical Assessment Unit to deal with issue of being busy
- Re-audit