A QIP to reduce drug errors during an acute surgical admission.
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Aim

- Reduce the need to re-prescribe medications from patients admitted under surgery.
- Reduce delays to medications being given.

Background

- Drug charts for acute surgical admissions were not being carried forward from ED to the ward.
- Evaluation showed that as many as 15 out of 32 (46.8%) electronic drug charts needed recharting due drug charts 'dropping off' the notes.
- This occurred when patients came from ED to the emergency surgical centre as this was a dual-purpose location both for ambulatory assessment and admission.
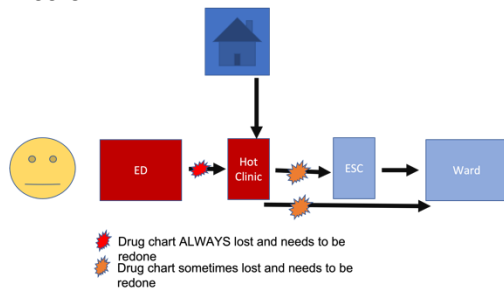
- This resulted in:
  - Delayed acute medication administration.
  - Increased clinicians' workloads
  - Increased risk of medications being duplicated or administered without adequate intervals.
- The audit identified errors in staff processing transfers of the hospital encounters and multiple encounters not being carried over.
- Additional confusion came from the shared purpose of the emergency surgical centre location; hosting both ambulatory assessment and an inpatient ward in the same space under the same name.
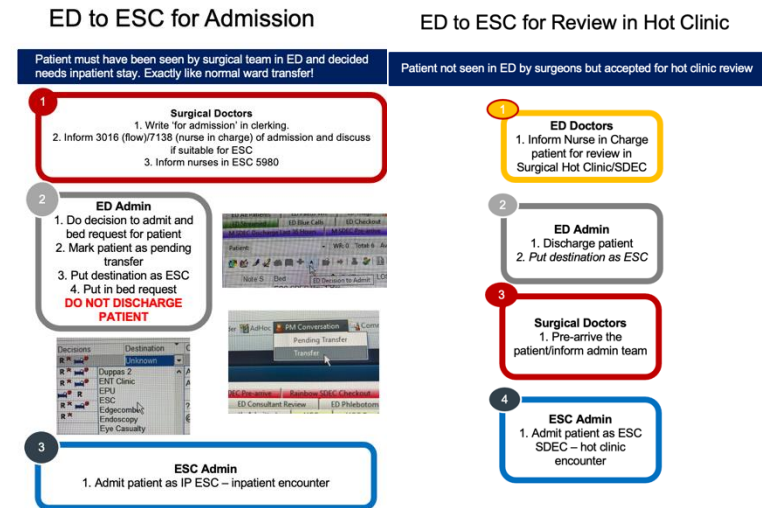
Methods

1: Audit of existing problem and identification of issue

2: Stakeholder engagement meetings
(Service managers, doctors, nurses, pharmacists, IT, administrators)

3: PDSA Cycle 1 – workflow design and implementation including briefing on this

4: Feedback and analysis

Example of workflow poster

Example workflows with steps for each role to ensure safe transfer of drug chart when a patient moved location from ED to the emergency surgical centre for either andmission or ambulatory 'hot clinic' review.

Results

After implementation, re-assessment of an acute surgical on-call period showed:

- 1 drug chart not being transferred out of 15 (6.6% error vs. 47%)
- No missed or delayed medications

Comparison of drug charts 'dropping off' and medication missed incidents before and after introducing workflows during two on call surgical periods.

Conclusions/Recommendations

- Fragmented IT processes can result in planned care not being delivered with delayed medications.
- There is currently not a perfect IT solution (a long-term goal), but a workaround process enables safe care.
- Continued training for new staff on qhe need to transfer the drug charts as well as record on admission.
- Future plans to rename the locations to differentiate ambulatory versus inpatient.

South West London Integrated Care System