Time critical medications in the acute setting; are we on time?
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Introduction
In February 2010 the National Patient Safety Agency (NPSA) published a rapid response report on reducing harm from omitted and delayed medicines in hospital. Between September 2006 and June 2009 the NPSA received reports of 27 deaths, 68 severe harms and 21,383 other patient safety incidents relating to omitted or delayed medicines.

It was recommended trusts identify a list of critical medications and carry out an annual audit of omitted and delayed critical medicines.

The University of Wales Health Board identified antimicrobials, anticoagulants, diabetic, epileptic and Parkinson’s disease medications as time critical medicines (TCMs).

Aims
• To assess the awareness of TCMs amongst nursing and medical staff in University Hospital Llandough
• To determine the incidence of omitted and delayed medicines, and in particular TCMs in the Medical Emergency Assessment Unit (MEAU)
• To ascertain the reasons why any delay may have occurred by analysing a sample of medication charts

Methods
1. Questionnaire
• 30 healthcare professionals were asked to complete a short questionnaire to assess previous training on and awareness of TCMs.

2. Audit
• The MEAU has been selected as the area to audit as it is an area where both existing and new prescriptions of TCMs are frequently encountered.
• Over a 6 day period in March 2013 all medication charts of patients admitted to MEAU for >24 hours were reviewed.
• The questionnaire highlighted issues with training on TCMs, as a result an education programme was delivered consisting of:
  – a short training session at the end of scheduled junior doctor teaching on consecutive weeks.
  – educational poster displays throughout the department
  – distribution of educational leaflets via email to all healthcare professionals
• The audit was repeated in July 2013 to complete the audit cycle.

Results
• 232 medication charts were reviewed in total
• 61% of all patients were prescribed a TCM
• There was a reduced time to administration of antibiotics if a time was documented on the medication chart
• Following the intervention there was a statistically significant reduction in delays/omissions

Limitations/ Future work
• Accuracy of timings are limited by lack of documentation on the ‘All Wales medication chart’
• Repeating the audit shortly after the teaching may have resulted in bias
• An on-going teaching programme and system of continuous audit is now required

Conclusions
• Awareness and understanding of TCMs is poor amongst health care professionals
• Documentation of administration time on medication chart reduces time to administration
• Improving awareness through various methods can reduce the incidence of delays/omissions in medication administration

Bibliography