Using a campaign to promote safer medicines practice among healthcare professionals

Safer medicines month was launched to alert nurses to essential aspects of medicines administration policy. This article discusses the campaign’s impact.

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The Chesterfield Royal Hospital Foundation Trust has a track record of initiatives to improve safety. This includes measures to raise nurses’ awareness of the risks associated with the administration of medicines, and initiatives to improve safety.

Last year, two focus groups were held with qualified nurses from across the hospital to find out how they felt that practice could be made safer and more effective for patients. The nurses suggested that an educational campaign be organised to highlight best practice and to encourage nurses to think differently about medicines administration. This paper summarises the content and outcome of the campaign.

INTRODUCTION

In recent years, attention has focused on the burden of risk generated in acute hospitals by the inaccurate administration of medicines.

The National Patient Safety Agency has drawn attention to specific problems that reoccur in acute hospitals involving medication (National Patient Safety Agency, 2009). These include:

- Patients receiving the incorrect medicine;
- The administration of oral liquid medicines using parenteral syringes;
- The omission of medicines without clinical rationale;
- Incidents involving poor communication or documentation.

The Chesterfield Royal Hospital Foundation Trust has a track record of effective clinical risk management, particularly in relation to medicines. This is reflected in the close working relationship that exists between nurses of all levels and the hospital pharmacy service. The trust has also developed innovative approaches to educating and assessing nurses’ knowledge of medicines using e-learning (Hare et al, 2006).

Over the past 18 months, the trust has developed a work plan to improve the safe administration of medicines throughout the hospital. The plan includes a range of measures to raise nurses’ awareness of the risks associated with the administration of medicines, and initiatives to improve safety.

In October 2009, two focus groups were held with nurses from across the hospital. The groups encouraged nurses to comment on a wide range of issues relating to medicines administration, and to determine what problems they faced and how they felt that practice could be made safer and more effective for patients.

One of the suggestions from these groups was organising an educational campaign to highlight best practice and to encourage nurses to think differently about medicines administration. A campaign was organised and took place during May 2010.

SAFER MEDICINES MONTH

The main objectives of this campaign were to increase understanding among nursing staff of the burden of risk generated by medicines as illustrated by incident reports, and to raise their awareness, and hence compliance, with key areas of medicines management policy.

The Safer Medicines Month campaign was underpinned by encouraging nurses to “change one thing” in their practice to improve the safety of medicines administration in the hospital. It was organised by the hospital pharmacy service, patient safety team and directorate senior matrons and matrons.

When organising the campaign, we were mindful of the practical constraints that existed in releasing large numbers of nurses to attend full or even half day educational events. With this in mind, we designed the campaign to limit the impact on clinical practice, to maximise attendance, and to focus on short, key messages.

The campaign consisted of three elements.

Lunchtime briefings

Twice weekly drop in sessions were arranged in the trust lecture theatre where a short, 20 minute presentation was undertaken to highlight key aspects of medicines management policy, in particular the five rights of safe medicines administration practice. These are: right patient; right drug; right dose; right time; and right route.

A list of “nevers” was also drawn up from incidents that were known to have occurred repeatedly in the hospital:

- Never administer a medicine without confirming the identity of the patient;
- Never administer an oral liquid using a parenteral syringe.

FIG 1. EXAMPLES OF PUBLICITY MATERIAL

<table>
<thead>
<tr>
<th>Saying medicines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Think before you</td>
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<tr>
<td>giveyorhoodyou</td>
</tr>
<tr>
<td>rights.</td>
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</tbody>
</table>

PRACTICE POINTS

When running a safer medicines campaign:

1. Design the campaign to limit the impact on clinical practice, to maximise attendance and to focus on short, key messages.
2. Give short, 20 minute presentations to highlight key aspects of medicines management policy, in particular the five rights of safe medicines administration practice.
3. Use a list of “nevers” drawn from incidents that are known to have occurred repeatedly in your hospital.

practice | Changing practice
Awareness raising sessions at handover
Pharmacists and ward pharmacy technicians attended handover sessions two to three times a week on each ward to highlight key learning points from medicines administration incidents that had taken place on the ward. Where possible, these were linked to aspects of policy and good practice.

Newsletters
Each week, a newsletter was issued highlighting a different key message derived from the “five rights” of drug administration practice. It was distributed in both paper and electronic form.

In addition, key messages from the campaign were emphasised through the distribution of publicity material, including sticky notes, pens and calculators, which carried the key campaign message (Fig 1).

EVALUATION
During the four-week campaign, 231 nurses attended the lunchtime briefing sessions.

TABLE 1. ATTENDANCE

<table>
<thead>
<tr>
<th>By band</th>
<th>By specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student nurse</td>
<td>Medical</td>
</tr>
<tr>
<td>Ward practitioner</td>
<td>Surgical</td>
</tr>
<tr>
<td>Band 5</td>
<td>Orthopaedic</td>
</tr>
<tr>
<td>Band 6</td>
<td>Emergency</td>
</tr>
<tr>
<td>Band 7</td>
<td>Paediatrics</td>
</tr>
<tr>
<td>Band 8</td>
<td>Gynaecology</td>
</tr>
<tr>
<td>Maternity</td>
<td>8</td>
</tr>
<tr>
<td>Critical care</td>
<td>22</td>
</tr>
<tr>
<td>Imaging</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>231</td>
</tr>
</tbody>
</table>

FIG 2. USEFULNESS AND APPROPRIATENESS OF SESSIONS

The number of nurses who attended ward based briefings by ward pharmacists were: week 1, 106; week 2, 103; week 3, 78 and week 4, 73. Attendance by specialty and by band is illustrated in Table 1. The evaluation sought to gain information on the following:

- Specialty and experience of nurses attending;
- Value of the sessions;
- Whether or not the sessions were pitched at the right level;
- Which areas nurses would change their practice as a result of the sessions.

CHANGING PRACTICE
Some 102 nurses indicated that they would change practice as a consequence of the sessions. Of the staff who said they did learn something to make them want to change their practice (116), the vast majority (86%) still found the session useful, often citing it as a helpful refresher.

Of the staff who said they did not learn anything that made them want to change their practice (116), the vast majority (80%) changed their practice as a result of the sessions.

CONCLUSION AND RECOMMENDATIONS
The campaign appears to have had considerable success in attracting large numbers of nurses to attend briefing sessions, and in alerting them to aspects of practice where shortcomings are common.

Many nurses have clearly been engaged by the campaign and have indicated they will change their practice as a result.

It can be argued that the impact of the campaign might be reflected in a reduction in medicines-related incidents. However, this presupposes that incident reporting is an accurate reflection of incident rate, which cannot be assumed to be the case. We also suspect the campaign may lead to an increase in incident reporting as a consequence of nurses being more aware of medication safety issues.

Given the apparent achievements of the initiative, the trust has recommended that the campaign be repeated on an annual basis. It is also considering using a similar campaign method to raise awareness of other aspects of care, such as nutrition.

The pharmacy service is to make arrangements for the key messages from the campaign – the “five rights” – to feature in all aspects of future medicines management training and education. This will be encouraged by the continued use of promotional materials.

REFERENCES

Nursing Times 16 November 2010 Vol 106 No 45 www.nursingtimes.net