The mission of measuring medication omissions: Qualitative insights into the associated challenges

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1. Background

- Medication omission rates range from 1.4% - 20%. [¹] Although most lead to little harm, some can cause severe harm. [²]
- To improve omissions, they must be measured. Recently, the Medication Safety Thermometer (MedsST) has been used as an improvement tool by over 100 NHS organisations to collect routine medication safety data, including omissions data (Fig. 1).
- Our earlier analysis highlighted omissions as one of the “biggest challenges” in terms of medication safety improvement.

2. Aim

- The aim of this phase of the study was to explore barriers and facilitators to measuring and improving medication omissions.

3. Methods

- 15 semi-structured in-depth interviews were conducted (face-to-face or via telephone) with MedsST leads (staff leading the implementation of the MedsST) and MedsST users (frontline users) from 10 organisations.
- Those recruited included pharmacists, nurses, pharmacy technicians, pre-registration pharmacists and audit clerks.
- Thematic analysis was grounded within the data.

4. Results

- All participants were aware of omission issues within their organisations, yet some were surprised by the high rate of them.
- Collection of omission data allowed identification of problematic areas, such as high rates of patient refusal omissions.
- Mixed views were expressed about patient refusal omissions; some staff felt they could not be improved, and others argued that they could cause serious preventable harm and can be improved.
- MedsST data had also been used to identify and learn from wards that had no omissions and displayed positive practice,

"Omissions were not something I used to think about during my ward round too much.” P11 (Pharmacist, MedsST lead)

"Our biggest issue is ‘patient refusal’, and then ‘not documented’ and then ‘medicine not available’. It has helped to define what our focus should be”. P1 (Pharmacist, MedsST lead)

"It was a 100% perfect score in the 20 patients we looked at…(and) I was like, ‘Woohoo, it’s a green’ (i.e. no omissions or harms).” P13 (Nurse, MedsST user)

"We looked at NPSA alerts and MedsST data, to say ‘our next project is going to be called ‘make it our mission to stop drug omissions’”. P6 (Pharmacist, MedsST lead)

"We decided to do an omission awareness week. We had badges made and a ‘find the drug’ flowchart that was laminated and distributed.” PS (Pharmacy Technician, MedsST user)

"If patients don’t get anticoagulated…they’ll get a clot. That’s a serious harm. If you’re withholding an anticoagulant because the patient is refusing, there’s a fundamental issue.” P12 (Pharmacist, MedsST lead)

5. Conclusions

- Routine measurement of omissions is possible.
- Data can be used for improvement but this is not happening in many organisations.
- Data can also be used to celebrate positive practice.
- Clearer communication about standardised definitions is required to ensure valid data and consistent interpretation.
- A multi-disciplinary approach may help improve awareness.
- Solutions for improving omissions can be transferable between organisations.

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References: