NHS
Institute for Innovation and Improvement

Releasing Time to Care

The Productive Mental Health Ward

Medicines

Version 1

This document is for ward leaders, lead nurses, matrons, nursing directors and directors with responsibility for improvement

Releasing Time to Care: The Productive Mental Health Ward - Medicines is published by the NHS Institute for Innovation and Improvement, Coventry House, University of Warwick Campus, Coventry, CV4 7AL

ISBN: 978-1-906535-56-8

Introduction

Medicines administration is at the forefront of the safety agenda. Rarely a month goes by when medicines administration is not in the spotlight.

Safe and reliable medicines administration is reliant on much more than the administering nurse's, experience and vigilance. It is reliant on well-functioning ward teams, robust processes, clear communication, accurate and clear record-keeping, clear and simple organisational policy, and a well-developed safety culture.

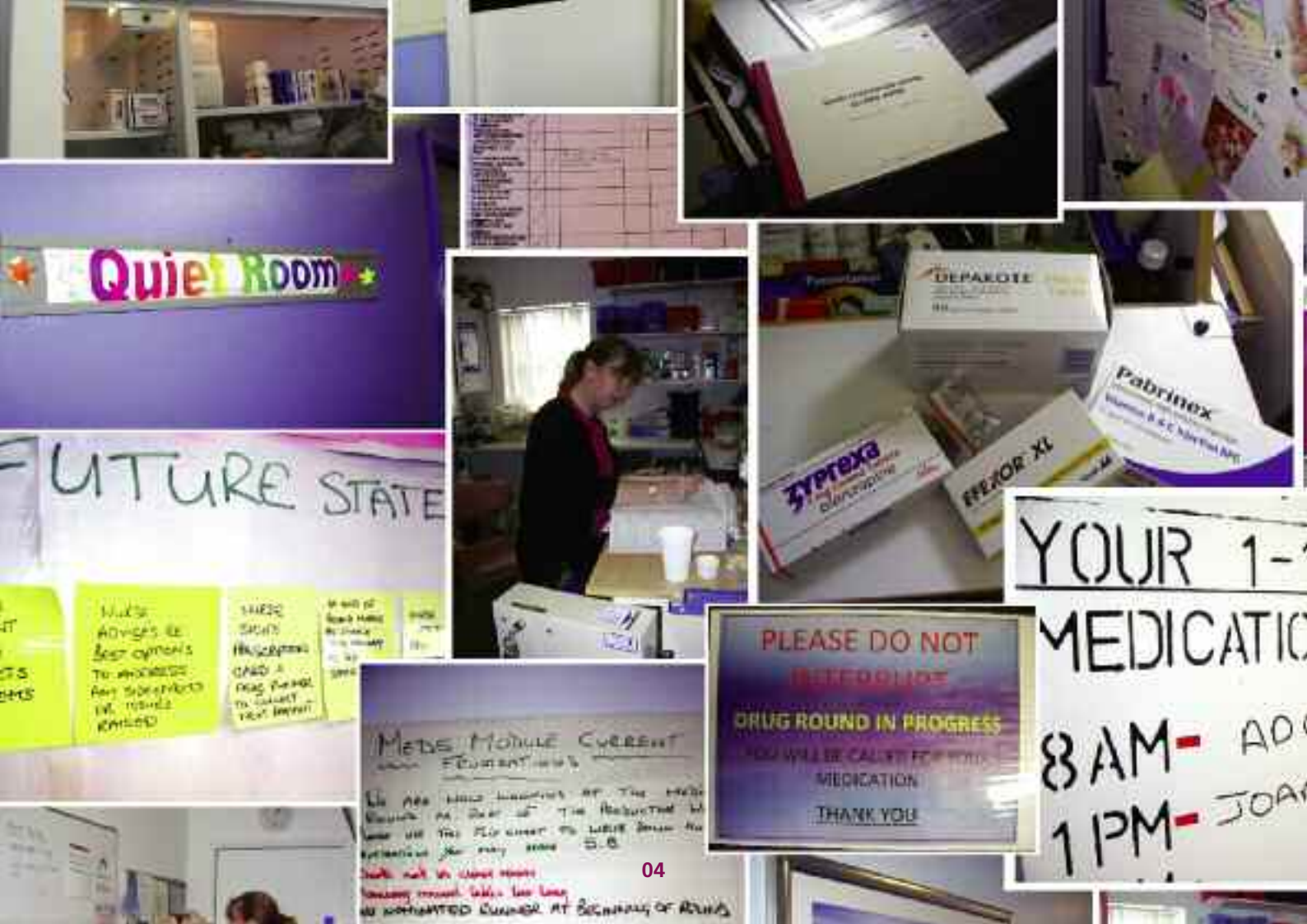
The patients in our care require the correct drug, in the correct dose at the required time. Delays of a few hours can lower the therapeutic levels of the drug beyond effective levels.

Finally, medicines administration affects the dignity of our patients. Not only in the requirement for a calm and orderly medicines process allowing time for communication with the patient, but also for those patients who require advice and management but do not want to 'bother' the busy nurse.

Typical ward medicines storage before Productive Mental Health Ward


Quiet Room
UTURE STATE
PLEASE DO NOT
DRUG ROUND IN PROGRESS
MEDICATION
THANK YOU
YOUR 1-1 NURSE
MEDICATION
8AM- ADELE
1PM- JOANNE
Pabrinex
Zyprexa
I.V.
& BLOOD
Equipmen

Contents


Quiet Room
FUTURE STATE
DEPAKOTE
Pabrinex
ZYPREXA
FLEXOR XL
PLEASE DO NOT
DISTURB
DRUG ROUND IN PROGRESS
MEDICATION
THANK YOU
YOUR 1-
MEDICATIO
8AM-
1PM-
Meds Module Current

These modules create a Productive Mental Health Ward

What is the Medicines module?

What is it?

- it is a way to improve the scheduled administration of medicines on your ward, resulting in fewer errors and less wasted time

Why do it?

To deliver safe, reliable, efficient and dignified care through:

- increasing patient safety by reducing errors
- ensuring timely administration of medicines
- improving patient experience - a calmer ward atmosphere
- reducing wasted time - medicines administration tends to occupy around 40%* of total nursing time during a day - reducing wasted time spent here means more time available for direct patient care, even on the medicines round itself
- reduce interruptions
- improve documentation in line with organisational policy

* The Productive Ward second phase testing

What it covers

This module will answer **5 key questions:**
- how can we ensure we are following organisational policy?
- who should administer medicines?
- how should the equipment be prepared?
- how should the environment be prepared for medicines administration?
- ensure all patients receive medication at the right time

What it does not cover

This module does not address:
- hospital medicines administration policy
- storage of medicines
- patient medicine chart
- intravenous or epidural administration of medicine
- medication administered outside of scheduled medicines round (ie, PRN medication)
- prescribing of medicines

Learning objectives

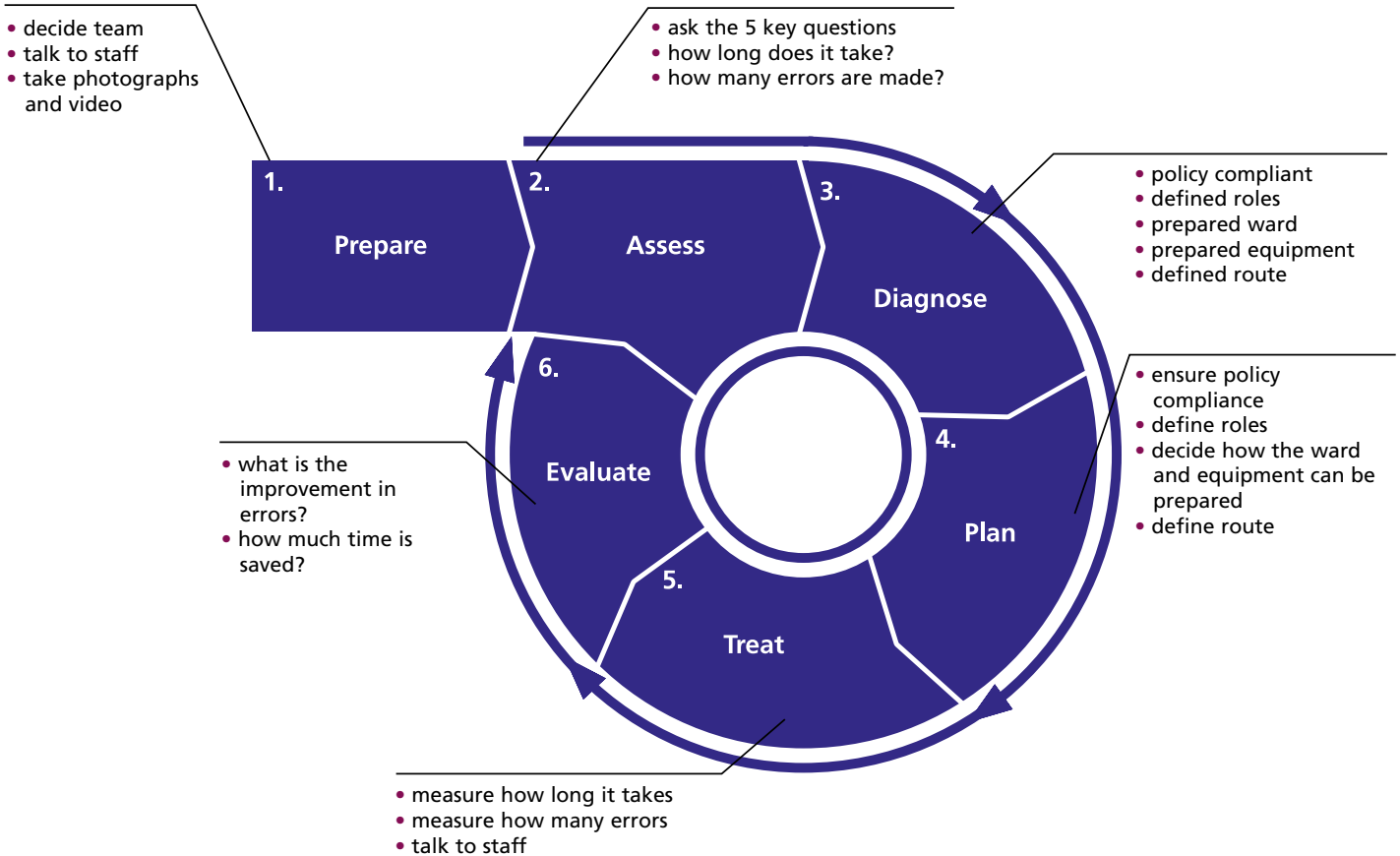
The team will:

- understand that The Productive Mental Health Ward methods are about the process, not individuals
- understand how this module links with clear, accessible organisational policy
- define the basic stages of Process Mapping
- understand the basics of Cost/Benefit Analysis
- understand that the preparation and coordination of tasks has a large impact
- define standardised work and understand how it increases quality
- develop audits as a positive activity that helps sustain the new medicine round

What tools will I need?

Tool	Toolkit reference number
Photographs	Tool no. 6
Video	Tool no. 7
Interviews	Tool no. 5
Timing Processes	Tool no. 8
Calculating Related Incidents	Tool no. 9
Process Mapping	Tool no. 10
Cost/Benefit Analysis	Tool no. 11
Module Action Planner	Tool no. 12
Spaghetti Diagrams	Tool no. 14

How will we do this on our ward? - the 6 phase process



Prepare

Prepare

Step 1: Decide who will be involved
- one ward manager
- one senior ward nurse
- as many staff who are involved in the medicine round as possible
- pharmacist/pharmacy technician
- clinical staff member

Step 2: Set ground rules
- this is about process, not individuals
- it is not about blame, or targeting individual team members

Step 3: Talk to staff
Use Toolkit tool no. 5 (Interviews)
- what is the general feeling towards the medicine round on the ward?
- which round causes the most issues?
- why does it take so long?
- what causes errors in dispensing medicines?

Step 4: Talk to patients
Use Toolkit tool no. 5 (Interviews)
- what is the patient's experience of the medicine round?
- talk directly to patients
- use patient survey results
- talk to your patient advice and liaison services (PALS) representatives
- ask patients if they received information regarding their prescribed medication

Different staff work at different paces due to things like experience. Take this into account in your process mapping

Step 5: Take photographs
Use Toolkit tool no. 6 (Photographs)
- medicines trolley and cupboards

Step 6: Take video
Use Toolkit tool no. 7 (Video)
- decide which medicine round causes the most issues on the ward
- film the entire medicines round from start to finish

Step 7: Gather information from incident reports
- look back over the last 50 incident reports and gather any relating to medicine rounds

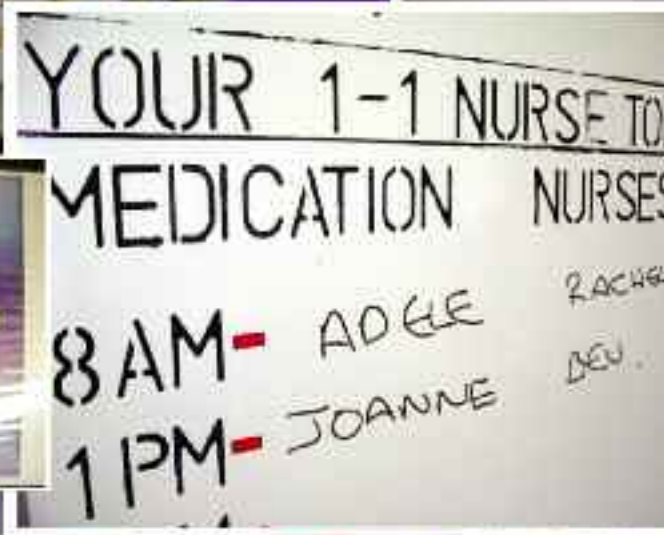
Step 8: Understand how long it takes
Use Toolkit tool no. 8 (Timing Processes)
- time every medicine round for a week and take a note of any interruptions

Step 9: Obtain organisational and national policy
- collect organisational policy on medicines administration at ward level
- collect up-to-date national guidance and policy

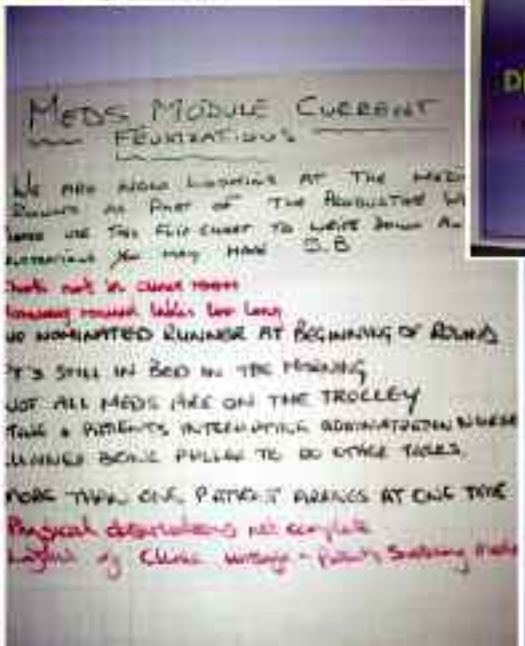

STATE


Pabrinex
EFEXOR XL


I.V. I.M.
& BLOOD
Equipment


YOUR 1-1 NURSE TO
MEDICATION NURSES
8AM- ADELE
1PM- JOANNE


PLEASE DO NOT
DRUG ROUND IN PROGRESS
MEDICATION
THANK YOU


MEDS MODULE CURRENT

Prepare - milestone checklist

Move on to 'Assess' only if you have completed ALL of the items on these checklists

Checklist	Completed ✓
1. Decide who will be involved.	☐
2. Talk to staff.	☐
3. Talk to patients.	☐
4. Take photographs.	☐
5. Take video.	☐
6. Gather information from incident reports.	☐
7. Understand how long it takes.	☐
8. Collect organisational policy.	☐

Make sure all shifts are aware of progress - discuss as a part of shift handover

Effective teamwork checklist	Tick if YES
1. Did all of the team participate?	☐
2. Was the discussion open?	☐
3. Were the hard questions discussed?	☐
4. Did the team remain focused on the task?	☐
5. Did the team focus on the area/process, not individuals?	☐

Assess

Assess

Information from your Activity Follow analysis (Toolkit Tool 3)

Releasing Time to Care

The Productive Mental Health Ward

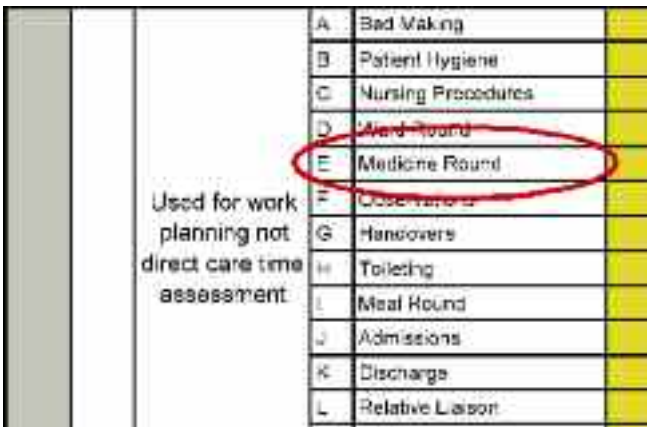
Populate orange sections only
Green areas will self populate

12

	Cat	Code & Reason	Hour 6-7am	7-8am	8-9am	9-10am	10-11am	11-12pm	1

Use the results from the intended task tally to find out how much time your staff spend on medicine rounds. The total is measured as a % of total time on the shift.

When analysing Activity Follow data and the data from timing the medicine round, you need to take into consideration junior staff; they may require more time to administer medicines.



Process

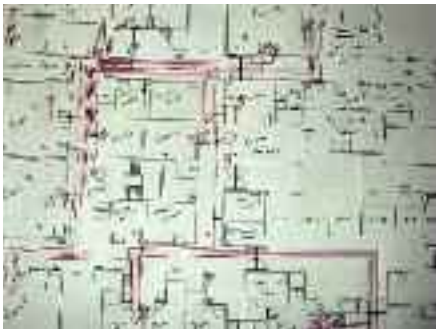
- watch the video and create your current state process map (Toolkit tools 7 and 10 - Video and Process Mapping)
  - also use any information gained from talking to staff

- on your map include the results you have from timing the medicine round
  - you should have at least 14 readings (two per day)
  - try to see if there are any which are too high or too low (these are referred to as special cause) - remove these
  - take the average of those that are left - this is the average time taken before the changes

When process mapping, take into account interaction with patients. Listen and watch for patient communication in the video

To ensure you have an honest and open dialogue about medicines and safety in general, you must keep the discussion on process, not people

- resist the urge to come up with solutions to problems and issues you have identified from examining the current way you do medicine rounds
  - stick to making an accurate map of what is currently happening and recording issues (not solutions) on sticky notes
- help staff to be non judgemental with any findings
- if the process takes two nurses use different coloured sticky notes to represent this



- use the Activity Follow data to help you construct a Spaghetti Diagram to see how staff move around the ward when conducting a medicine round

Accidents and errors

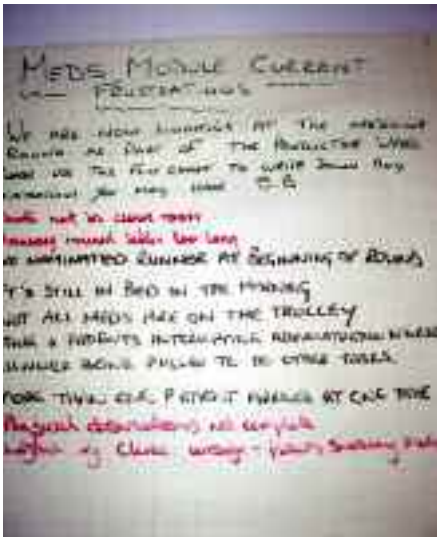
- from the last 50 incidents - draw out medicines administration related incidents
  - is there a pattern?
    - same drug?
    - same dosage?
    - same area of ward?
    - same time?
    - same person?
- understand the time concerned - if there were five medicine related incidents, and this period is over the last month, that is roughly one per week (use Toolkit tool no. 9)
- speak with staff to understand errors or near misses which may not be reported - try to estimate a number per week
  - it helps to ask 'what type of thing goes unreported?' rather than 'were there any unreported near misses?'
- add the two - that is your error rate before the changes
- be aware that discussion in this area can be uncomfortable for some
  - when facilitating ensure that a no blame culture is in place otherwise some staff, especially those who may have been involved in a safety incident in the past, may not contribute

Some staff have difficulty talking about errors. Lead by example. Noone is perfect and we have all had near misses. It helps to start by talking about a time when you were involved in medicines administration that was not up to the high standards you aim for, showing that you are willing to talk openly

Example of an incomplete incident report

Staff experience
From talking to your staff, summarise their experiences of the medicine round on a flipchart.

- are there any factors of the medicine round that frustrate staff?
- are they aware of the organisation's medicines administration policy?



Example of staff's frustrations

Patient experience
From talking to patients, summarise their experiences of the medicine round on a flipchart.

Speak to staff, other than nurses when process mapping. Staff like pharmacists can bring a valuable insight into the medicines process

Policy
Discuss your organisation's policy on ward level medicines administration with both your matron (or equivalent) and director of nursing.

Also spend time discussing the latest drug administration guidance from, among other sources:

- Nursing and Midwifery Council (NMC)
- National Institute for Clinical Excellence (NICE)
- Medicine and Healthcare Products Regulatory Authority (MHRA)
- organisational medical formulary
- manufacturers' guidelines

Break down your policy and the guidance onto a flipchart so you can work through it with your team.

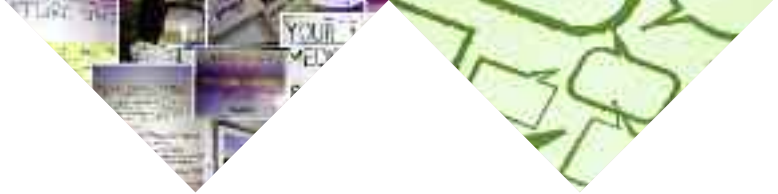
Documentation
Look at any nursing documentation which involves medication rounds:

- care plans
- prescription cards
- ordering books
- prescription charts for discharged tablets

Discuss with your ward team compliance in completion of the these documents, ask the question - 'are there potential risks or duplication?'

Ask the 5 key questions

Are we following organisational policy?	• what is your organisation's medicines management policy? • are all staff familiar with the policy? • is there a copy, or access, on the ward?
Who does the medicine round?	• how many people on your ward are competent and qualified? • how is the medicine round assigned? • do the people responsible know in advance when it is their turn?
How do we prepare the equipment?	• if there is a trolley, does it contain the right medicines and equipment to administer the medicines ○ are the medicines in date? • what is the procedure, and who is responsible, for restocking the trolley? • what other items do we need? • is there space to update drugs charts?



How do we prepare the environment?	• are all patients ready to receive medicines before the round, eg, do they have water/milk and are they informed that the round is occuring? • are the patient medicine charts easy to locate? • are all staff aware of their roles and responsibilities

How do we ensure that all patients receive the right medication at the right time?	• do different tasks overlap?
	• how do we ensure that all patients receive the required medication, and that they do so on time?
	• are there delays in administering the medicines?
	  ◦ if so, why?
	• is the medicine round organised by:
	  ◦ patient centred teams?
	  ◦ by ward routine?
	  ◦ geographically?
	  ◦ general custom and practice (always done it that way)?
	• how do we prioritise patients?

Assess - milestone checklist

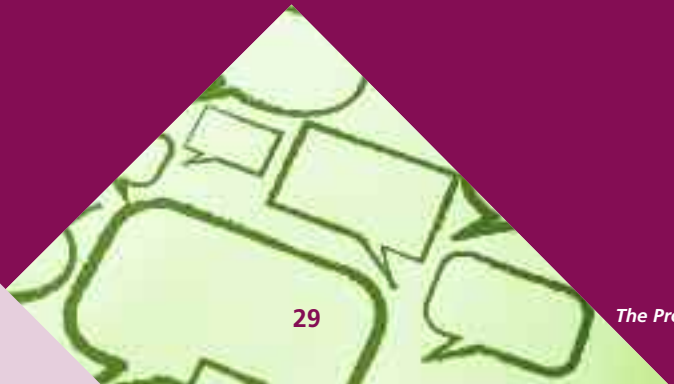
Move on to 'Diagnose' only if you have completed ALL of the items on these checklists

Checklist	Completed ✓
1. Create current state map of the medicine round.	☐
2. Analyse accidents and errors related to medicine rounds.	☐
3. Understand the staff experience of medicine rounds.	☐
4. Understand organisational policy related to medicines administration at ward level.	☐
5. Ask the 5 key questions.	☐

Make sure all shifts are aware of progress - discuss as a part of shift handover

Effective teamwork checklist	Tick if YES
1. Did all of the team participate?	☐
2. Was the discussion open?	☐
3. Were the hard questions discussed?	☐
4. Did the team remain focused on the task?	☐
5. Did the team focus on the area/process, not individuals?	☐

Diagnose



Diagnose - what does 'good' look like?

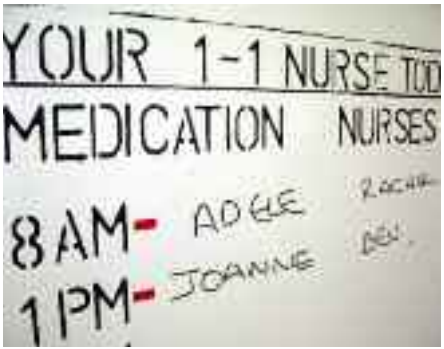
Before you move onto the 'Plan' stage, where you will discuss and agree the changes you want to make, think about what good would look like.

Go through the following examples with your team. They give snapshots of medicines improvements made by hospitals implementing The Productive Mental Health Ward and The Productive Ward.

You can use them to trigger discussions within your team.

Ideas that have worked - example 1

Clear responsibility
The team members who are responsible for the medicine round are defined in advance. A weekly roster can be used. Most importantly the responsibility for the medicine round is confirmed at shift handover and displayed visually.



Clear identification of the medication nurse will aid patients when requesting PRN. It also offers a consistent approach

Ideas that have worked - example 2

Senior nurse does not carry out medicine round
While medicines are administered the ward is still functioning. Other staff and visitors still need directing and advice. This is a source of interruptions.

By ensuring the senior nurse on shift is not included in the medicines administration team, the nurse can then be available to coordinate activity, answer queries from patients, relatives and staff and be on hand to answer queries from the trained staff administering medicines.

When considering this you should also think about the need to keep the skill level of the senior nurse up to its high standard. One way to do this would be to rotate this 'coordination' role between the senior nursing staff.

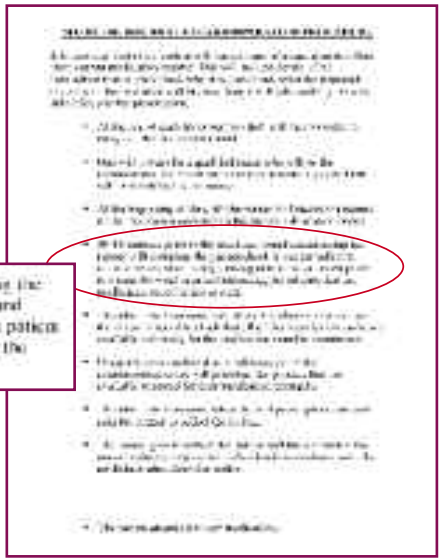
Ideas that have worked - example 3

Patients prepared
Patients are informed of the up-and-coming medicine round and are able to attend for their medication. This brief can also be helped by having a patient information leaflet.

Plenty of time is given to this activity. It is often delegated depending on the way the ward is organised.

- consider using the ward check-in process for this preparation (see Safe and Supportive Observation module, page 35 for example)

Finally, patient dignity should be considered. The patient should be prepared for their appropriate medication in a manner that maintains and respects their dignity.



Ideas that have worked - example 4

Visual management
The use of a red tabard gives a clear signal to other staff and visitors that the nurse is concentrating on medicines administration and should not be interrupted.

The visual signal is clear to see and easy to understand.

In place of red tabards, some organisations use different coloured, and more encompassing, aprons to the same effect during medicine rounds.

The use of red tabards could be considered as an effective temporary countermeasure to the interruptions nurses have during medicines administration.

You may find that as your implementation of the Well Organised Ward and Patient Status at a Glance module matures, interruptions may reduce to such a level that red tabards are not required, ie:

- visitors can find their way around the ward
- staff can find the equipment, information, people and guidance they require more easily and without interrupting someone

Example from The Productive Ward testing

Ideas that have worked - example 4 (continued)

Visual management
The use of a sign on the clinic door gives a clear signal to other staff and patients that a medicine round is in progress and should not be interrupted.

Ideas that have worked - example 5

Ward prepared
Consider that you need people, documentation and medicine prepared for successful administration of medicines.

Before medicines administration commences a check is made on the drug stocks in both central ward stocks and satellite stocks such as patient drug lockers and drugs trolleys.

Make sure, if you are installing patient medicine cabinets, you risk assess the position, including working height

To make this easier you can consider doing a 'mini' 5S (see Well Organised Ward module) on your drugs trolley.

Example of a standard created by the team following completion of the module

MEDICATION TROLLEY RE-STOCK STANDARD

- As medication is used the empty boxes will be kept to one side for re-stock at the end of the medicine round.

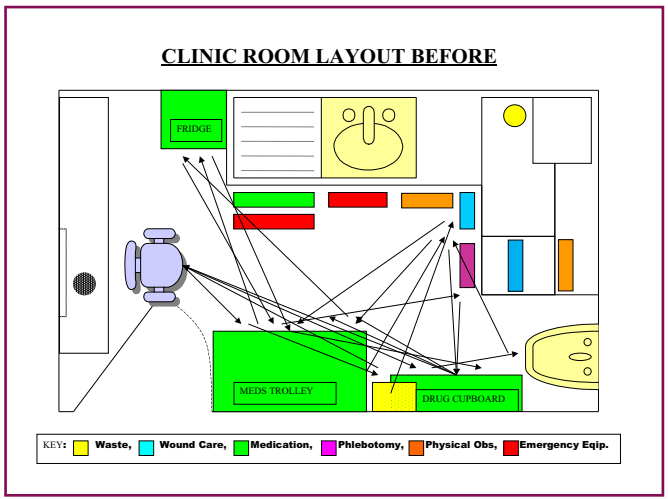
(NB – for high use medication restock will need to take place when half a strip of medication is left, a note can be made of these)

- At the end of the medication round the trolley will be restocked like foe like using the empty boxes and high use list as a guide from the stock cupboard.

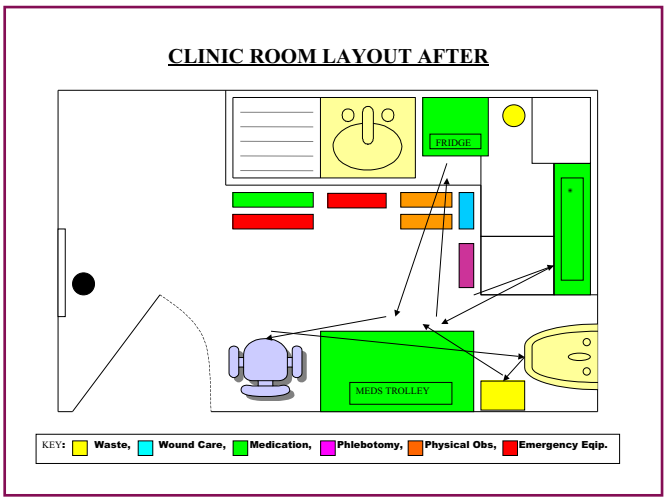
- The medication trolley will then be left clean and restocked ready for the next medication round.

Ideas that have worked - example 6

When working through the Well Organised Ward module your clinic room motion can be reduced and patient safety increased by improving the environment with respect to risk and accessibility of equipment



Spaghetti Diagram before



Spaghetti Diagram after

Ideas that have worked - example 7

How do we prioritise?
Patients on mental health wards do not stay in one place, therefore locating people for medicines administration will be problematic at times.

It is important to consider the balance between patient experience and efficiency.

Consider the order of patients, ie, a running order. Use the check-in example in the Safe and Supportive Observations module, page 35; this will give the nurse an idea of where the patient was last located.

Ideas that have worked - example 8

Prescription card audit
After looking at documentation used for medicine administration the team designed an audit for their prescription charts. This is used to monitor the nurse's documentation to improve patient safety and reliability of care.

The team released time on the medicine round and fed this back into improving documentation.


Quiet Room
FUTURE STATE
PLEASE DO NOT
DRUG ROUND IN PROGRESS
MEDICATION
THANK YOU
YOUR 1-1 NURSE
MEDICATION
8AM- AOIFE
1PM- JOANNE
Pabrinex
I.V.
& BLOOD
Equipme

Diagnose - milestone checklist

Move on to 'Plan' only if you have completed ALL of the items on these checklists

Checklist	Completed ✓
1. Carefully work through the examples with the team.	☐
2. Openly discuss each example.	☐
3. Consider the examples against your own environment.	☐
4. Ask staff for new ideas, possibly building on the examples shown.	☐

Make sure all shifts are aware of progress - discuss as a part of shift handover

Effective teamwork checklist	Tick if YES
1. Did all of the team participate?	☐
2. Was the discussion open?	☐
3. Were the hard questions discussed?	☐
4. Did the team remain focused on the task?	☐
5. Did the team focus on the area/process, not individuals?	☐

Plan

It's all about the preparation…

You will probably have noticed that the majority of the previous eight examples of medicines administration improvements are based on preparation before the medicine round starts.

Your emphasis when creating your new medicine round should be on clarity of roles, good time-keeping and well-prepared patients, staff, medicines and equipment.

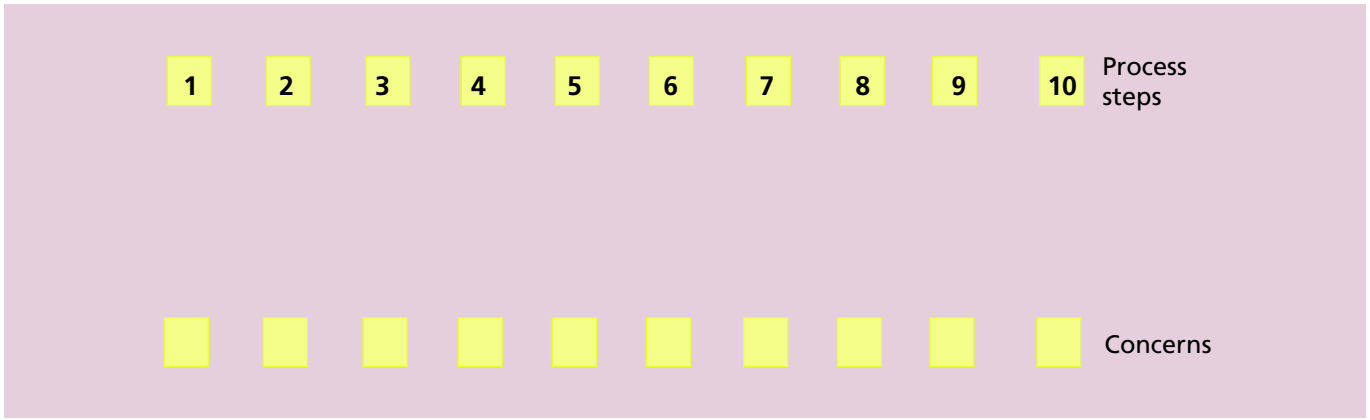
Plan

How can we ensure we are following organisational policy?	• ensure the policy is displayed near the medicines preparation and storage area • check staff qualifications are up-to-date, display a list of ward staff who are qualified to answer medication-related questions
Who should do the medicine round?	• list the people who are qualified to do the round • discuss who are the right people from each shift • create a monthly roster to cover rounds on all shifts
What equipment should we have?	• decide whether the right equipment is in place eg, prescription charts, medicines trolley • create an inventory of required items and quantities • create a plan for restocking the equipment
How should we prepare the ward?	• talk to all shifts and determine which activities can be done prior to the start of each medicine round
How do we ensure that all patients receive the right medication at the right time?	• look at other ward activities happening at the same time and decide the best place to start • determine the best layout of clinic room to minimise walking • ensure there is a system of knowing who was unavailable to receive their medicines for follow-up • determine how to best prioritise patients

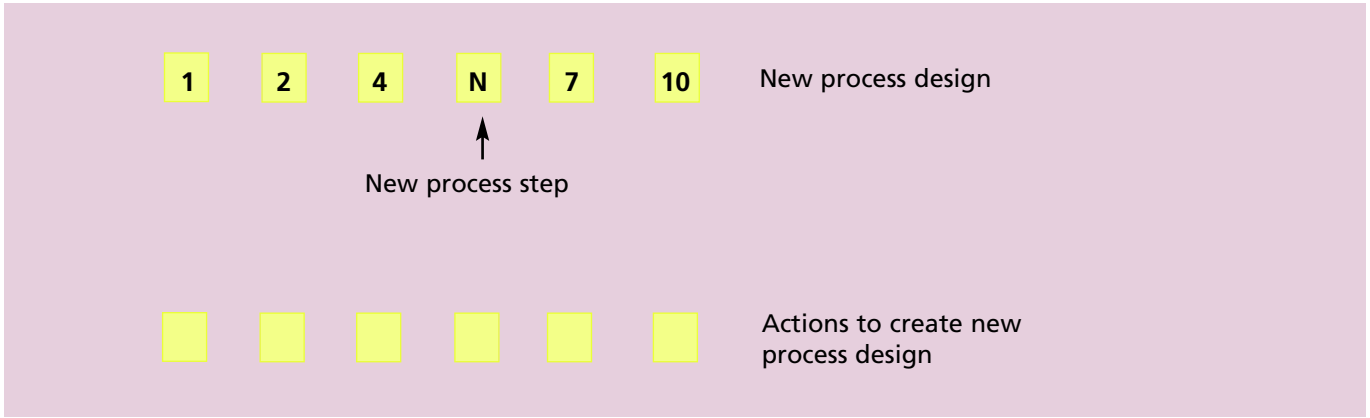
Create your new design

Complete your new design process map by continuing to use Toolkit tool no. 10. Using your team's expertise and the discussion around the examples, you will generate a number of things that will need to be done to implement your new design of medicine round.

Current state:



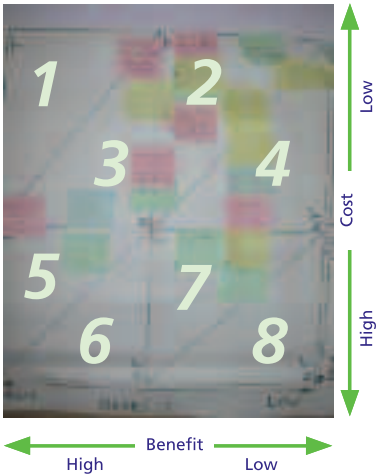
Future state:



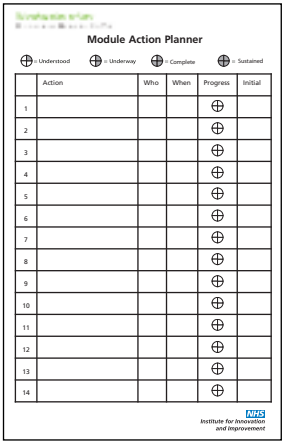
Create your plan for the implementation of your newly designed observation process

Use Toolkit tools 11 & 12 (Cost/Benefit Analysis, Module Action Planner sheets) to create your implementation plan. Display the plan by putting your completed Module Action Planner sheets in a prominent position on the ward.

Use visual management to explain the new standard operating procedure (SOP). A good place is on the medicine trolley



Use your judgement to prioritise within each triangle and then list the problems.



Module Action Planner

	Action	Who	When	Progress	Initial
1				⊕	
2				⊕	
3				⊕	
4				⊕	
5				⊕	
6				⊕	
7				⊕	
8				⊕	
9				⊕	
10				⊕	
11				⊕	
12				⊕	
13				⊕	
14				⊕	

Create a standard operating procedure

The Module Action Planner sheet you have created now contains a prioritised list of all of the things that need to be done to create your newly designed medicine round.

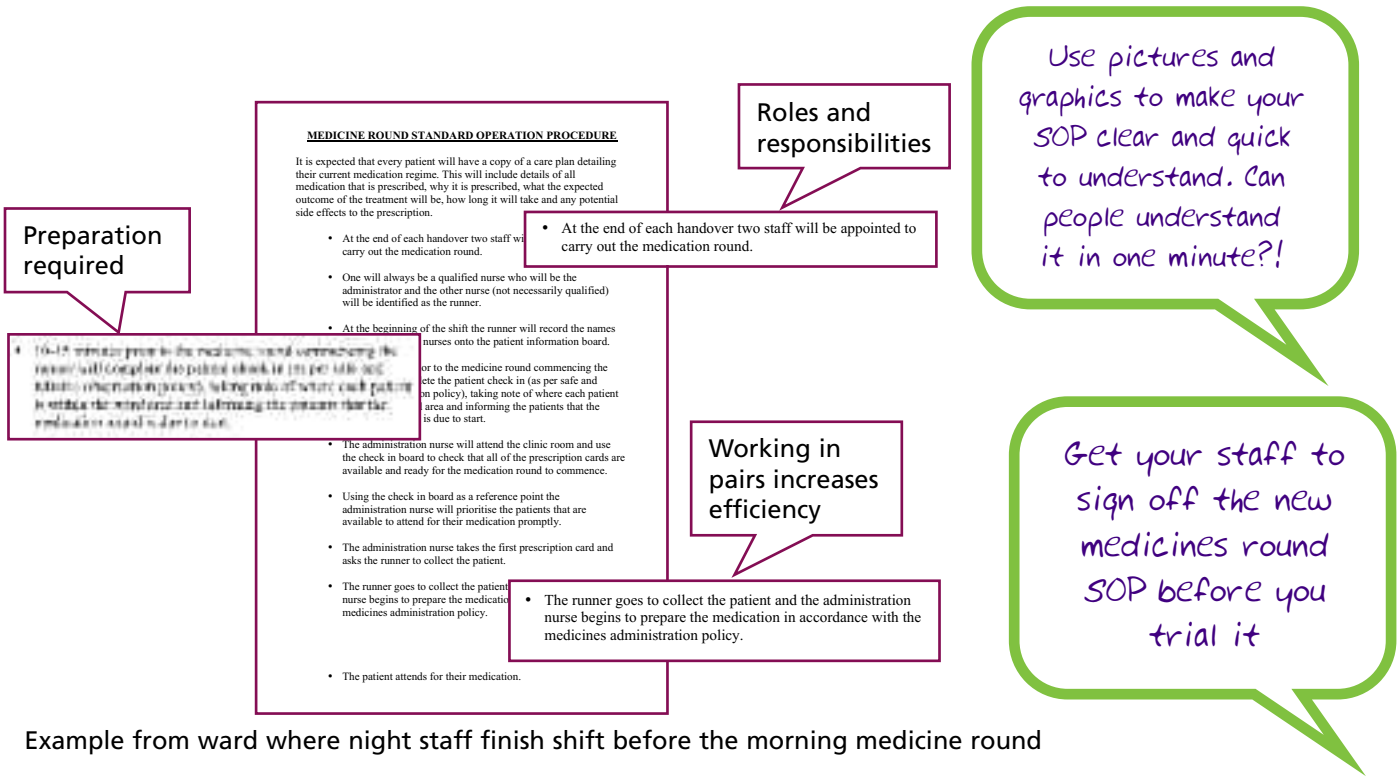
A number of these things may involve a change in working practice from your staff. For example, ensuring patients are prepared beforehand, or the use of a certain prioritisation method.

It is important to summarise the new medicine round working practices in a standard operating procedure. This can be on a flipchart or an A4 document.

This is a simple exercise that clearly communicates the new way of working. It has the added benefit of helping to set the standard for staff new to your ward - either new starters or bank and agency staff.

When making changes, clear communication is vital for patient safety

Standard operating procedure on display



Example from ward where night staff finish shift before the morning medicine round

Plan - milestone checklist

Move on to 'Treat' only if you have completed ALL of the items on these checklists

Checklist	Completed ✓
1. Consider examples of ideas that have worked.	☐
2. Consider results of 'Assess' section.	☐
3. Create new design map.	☐
4. Create prioritised schedule on Module Action Planner sheet.	☐
5. Create process standard operating procedure.	☐

Make sure all shifts are aware of progress - discuss as a part of the shift handover

Effective teamwork checklist	Tick if YES
1. Did all of the team participate?	☐
2. Was the discussion open?	☐
3. Were the hard questions discussed?	☐
4. Did the team remain focused on the task?	☐
5. Did the team focus on the area/process, not individuals?	☐

Treat - go do it!

Treat

What are we testing?

- have we reduced errors?
- have we improved the timeliness of the medicine round?
- have we reduced wasted time during the round?
- have we improved the patient's experience?
- have we improved the staff experience?

Test what the team has agreed. Get a nurse from another ward to read the new SOP and carry it out while observed, on one patient. If they can do the new process, then the SOP has worked!

Before the test starts

- decide how long to run the test for, and when it will start
  - a week should be long enough to measure whether there has been an improvement in timeliness or in less time wasted
  - number of errors are best measured over a longer time frame
- inform all staff personally at handover meetings across all shifts, especially if the storage location of medicine has been changed
- be ready to modify your new medicine round during the test if new issues arise

During the test

- film the new medicine round
- use a stopwatch to time the new medicine round as before:
  - use the same starting and finishing points
  - take at least five timed measurements for each scheduled medicine round
- provide an anonymous suggestion box for staff, read the responses daily and implement any quick solutions before the next round (avoids frustration building up)
- communicate successes to the entire ward team as they are implemented

Treat - milestone checklist

Move on to 'Evaluate' only if you have completed ALL of the items on these checklists

Checklist	Completed ✓
1. Test period decided.	☐
2. All staff informed, document in notebook.	☐
3. Medicine round timed every day, three times, for five days.	☐
4. 'New round' photos and video shot.	☐

Make sure all shifts are aware of progress - discuss as a part of shift handover

Effective teamwork checklist	Tick if YES
1. Did all of the team participate?	☐
2. Was the discussion open?	☐
3. Were the hard questions discussed?	☐
4. Did the team remain focused on the task?	☐
5. Did the team focus on the area/process, not individuals?	☐


Quiet Room
FUTURE STATE
DEPAKOTE
Fabrinex
ZYPREXA
EFFEXOR XL
I.V.
& BLOO
Equipme
YOUR 1-1 NURSE
MEDICATION
PLEASE DO NOT

Evaluate

Step 1 - collect information

A) Gather the data:
- how long did it take?
- were there any incidents or near misses?
- film 'after' video

B) Talk to staff:
- was the team chosen appropriate?
- was the medicine trolley/patient cabinet ready to go?
- were patients prepared?
- what interruptions to staff were there?
- was the ward well prepared?
- were the items, quantities and levels of equipment appropriate?
- was the qualified nurse chosen to do the round appropriate?
- was there an overall perception that risks to patient safety had been reduced?

Step 2 - analyse information - 1

Did the changes make an improvement?

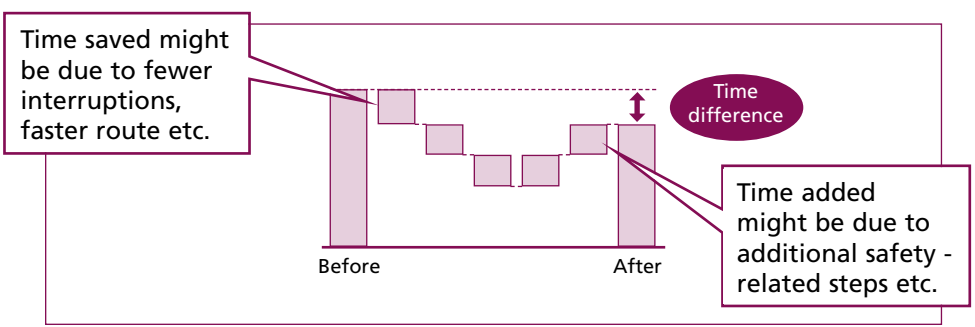
- was the medicine round safer?
- was the medicine round shorter?
- was there more time to spend with patients?
- did the patient experience improve?

Step 2 - analyse information - 2

Did the changes make the medicines round quicker?

- how much time was saved?
- how much time was added back to achieve the objectives of improved patient safety and improved patient experience?

A chart like the one below can assist in understanding where time was spent or saved on different activities - post the chart up in the ward to show staff and patients what has changed since you started



Step 3

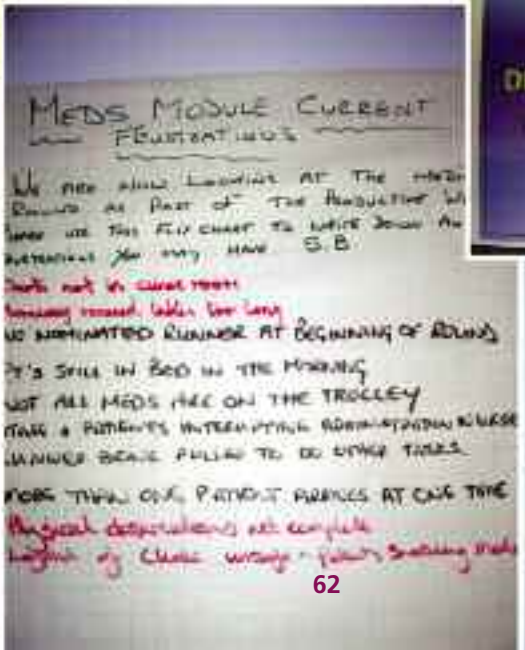
- decide where there are still opportunities for improvement and if there are additional changes that can be made to the area, eg, a piece of equipment kept in the area wasn't used after all


FUTURE STATE


ZYPREXA
olanzapine
EFEXOR XL


YOUR
MEDIC
8 AM
1 PM


PLEASE DO NOT
DISTURB
DRUG ROUND IN PROGRESS
YOU WILL BE CALLED FOR YOUR
MEDICATION
THANK YOU


MEDS MODULE CURRENT

Evaluate - milestone checklist

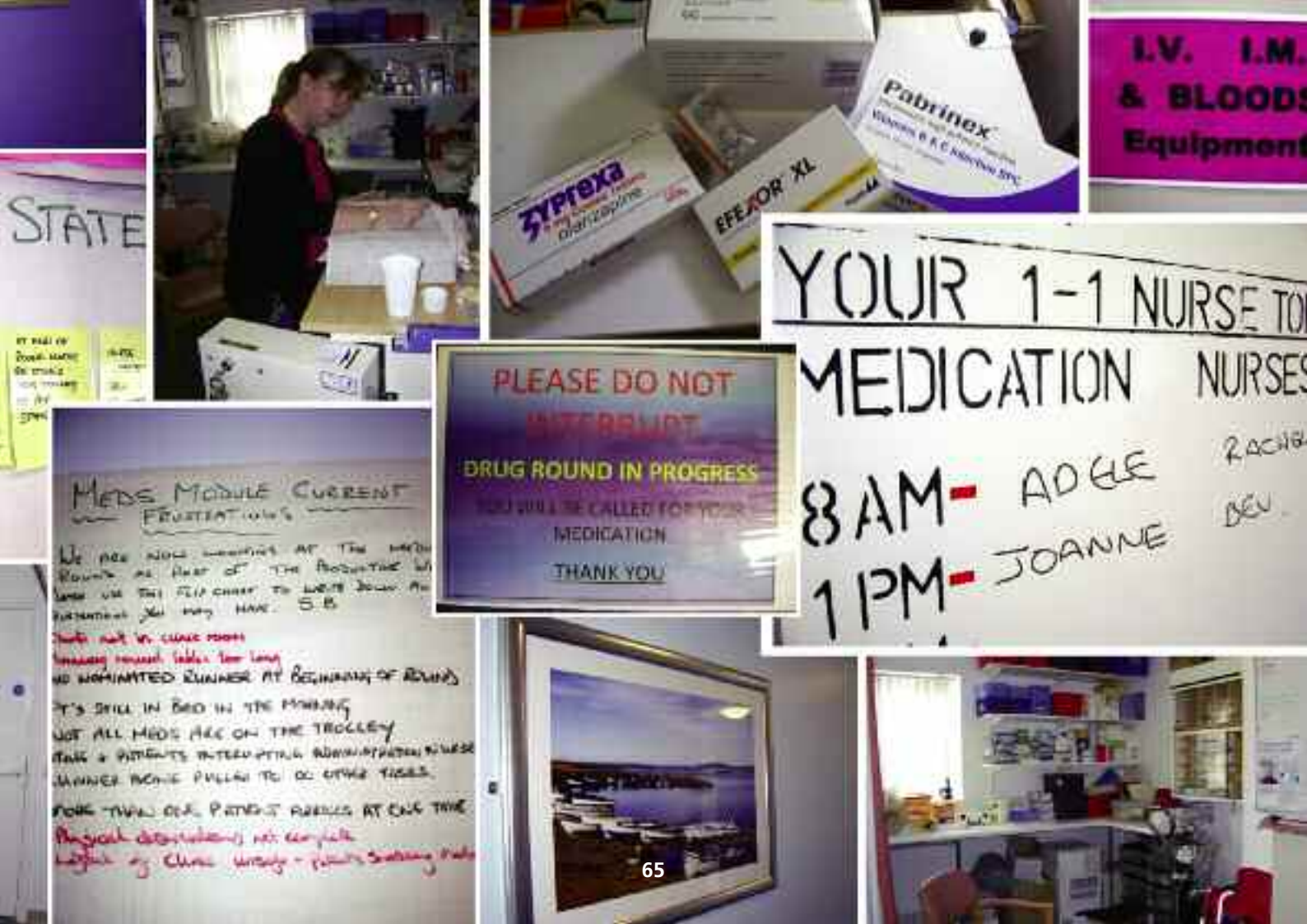
Checklist	Completed ✓
1. Talk to staff about the new medicine round.	☐
2. Look at before and after timings - log changes.	☐
3. Look at before and after medicine-related incidents per month - log changes.	☐

Make sure all shifts are aware of progress - discuss as a part of shift handover

Effective teamwork checklist	Tick if YES
1. Did all of the team participate?	☐
2. Was the discussion open?	☐
3. Were the hard questions discussed?	☐
4. Did the team remain focused on the task?	☐
5. Did the team focus on the area/process, not individuals?	☐

How can I make it stick?

Monitor and audit continually	• continue to monitor time taken, at least once a day - discuss this if required, but assess it monthly • compare the actual process with the standard operating procedure once a month (at least) - to ensure basic changes made are being followed and link to the ward performance board
Ensure leadership attention	• get the monthly process check done by head of nursing or equivalent • ensure you (ward leader) discuss audit results with ward staff at least once a month (even if for five minutes in a 20 minute catch-up meeting) • ensure changes made and timings/reduced errors achieved are brought to the attention of senior leadership and appropriate risk manager
Do not stop improving	• encourage ward staff to continue to find new and better ways of doing things - it is not about doing this once and then applying standard operating procedures, but about improving them continually • consider compiling your standard operating procedures into a ward operating manual


STATE
Pabrinex
Zyprexa
olanzapine
EFEXOR XL
I.V. I.M.
& BLOODS
Equipment
YOUR 1-1 NURSE TO
MEDICATION NURSES
8AM- ADELE
1PM- JOANNE
PLEASE DO NOT
DISTURB
DRUG ROUND IN PROGRESS
MEDICATION
THANK YOU
MEDS MODULE CURRENT
FRUSTRATIONS
65

Learning objectives complete?

Seven objectives were set at the beginning of this module.

Test how successfully these objectives have been met by asking three team members (of differing grades) the questions in the following grid. Ask the questions in the first column and make an assessment against the answer guidelines in the second column.

The results of this assessment are for use in improving the facilitation of this module and are not a reflection on staff aptitude or performance.

If all three team members' responses broadly fit with the answer guidelines then the learning objectives of the module have been met.

Note the objectives where the learning has only been partly met and think about how you can change the way you approach the module next time so that the responses are fully met.

It sometimes helps to re-read the module and reflect on the experiences of implementing the module first time round.

Question (ask the team member)	Answers for outcome achieved
Describe the things you need to do in the prepare stage of the module?	• find out hospital policy • find out patient satisfaction results • talk to staff • find out incident information • video the process • time the process
What does '*The Productive Mental Health Ward concentrates on process, not individuals*' mean?	• not about blaming • we have to move from blame so that we can talk openly about safety • by talking about the process, not individuals, we are able to improve
Why is organisational policy important, and why should we keep up to date with it?	• organisational policy on medicines administration reflects national best practice • organisational policy is updated as new best practice is determined, must also keep up-to-date
What is a Cost/Benefit Analysis and when should we use it?	• helps the team prioritise improvements • grid, where you put ideas in boxes relating to cost and benefit • complete the low cost, high benefit ideas first • should use when we have lots of ideas and need to know where to start

Question (ask the team member)	Answers for outcome achieved
Describe the basic stages of process mapping and why it is important?	• team creates a picture of what the process looks like now (current state) • team all agrees on current state • team creates a picture of their vision of what the process should look like (future state) • it is important because it moves from opinions to fact that everyone agrees
What has the most impact on the medicine round?	• preparation and planning • ensuring ward tasks do not clash • ensuring responsibilities are clear
How do standards support the new medicine round process?	• important tool for communicating • key to sustaining new medicine round process • agreed by the team, not by an individual • record the best known (highest quality) way the team knows for medicine round process
Where do audits fit into the Medicines module and how are they used?	• ensures people are carrying out the new medicine round process • should be quick • based on the standard created by the team • never stop using audits

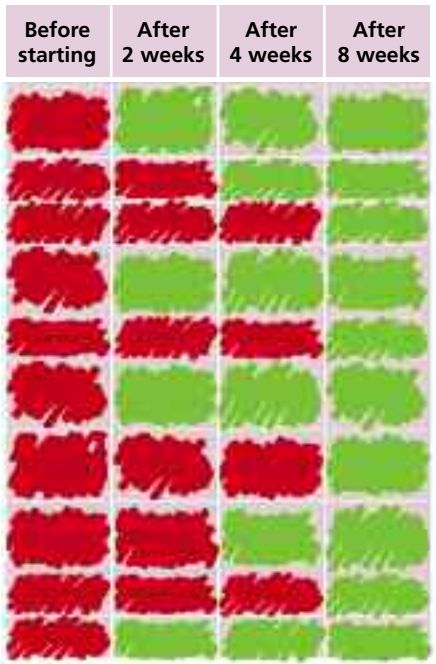

Quiet Room
DEPAKOTE

10 point checklist

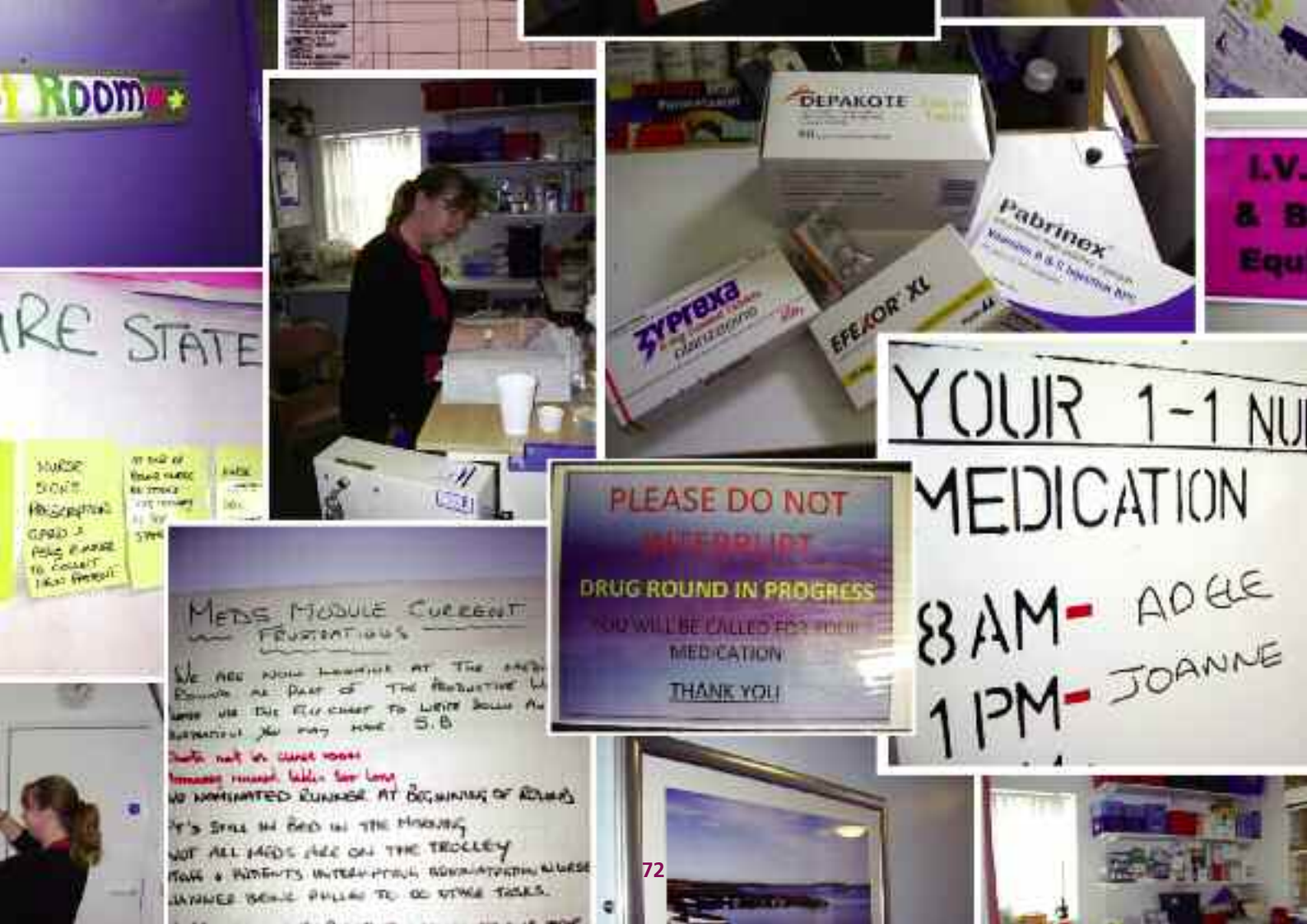
Example

The grid to follow allows you to measure your performance against the 10 point checklist for this module. You should shade in the boxes according to your achievement of the measure. Your progress is clearly visible.

You should continue to monitor monthly.



10 point checklist Medicines	Before Starting	After 2 Weeks	After 4 Weeks	After 8 Weeks
The person responsible is decided in advance				
There is a clear and understood method for prioritising patients				
Equipment is always in the same location, ready-to-go				
Patients who require observations are known before starting the round				
There is a procedure for following up patients who have missed medication due to being away from their bed				
Steps specified to reduce the risk of errors occurring, thereby increasing patient safety				
Steps have been taken to reduce wasted time to improve the timeliness of administration, thereby increasing patient safety				
The new process has been documented in a standard operating procedure and displayed prominently in a staff area				
Random process audits are conducted every month against the standard operating procedure to ensure the process is followed correctly				
The adverse incidents measure is showing improvement over a period of six months				


DEPAKOTE
Pabrinex
Zyprexa
EFEXOR XL
PLEASE DO NOT
DRUG ROUND IN PROGRESS
MEDICATION
THANK YOU
YOUR 1-1 NU
MEDICATION
8AM- ADELE
1PM- JOANNE
MEDS MODULE CURRENT
72

Acknowledgements

Thank you to all staff at:
The Oakwell Centre, Kendray Hospital, Barnsley PCT
North Staffordshire Combined Mental Health Trust
Oxleas NHS Foundation Trust
Birmingham and Solihull Mental Health NHS Foundation Trust
Basingstoke and North Hampshire NHS Foundation Trust
Barnsley Hospital NHS Foundation Trust
Royal Liverpool and Broadgreen University NHS Trust
Luton and Dunstable Hospital NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Central Manchester and Manchester Children's University Hospitals NHS Trust
NHS Institute for Innovation and Improvement, and staff from our improvement partners,
who have had an input into this document

This module has been developed by:
Liz Ward, Clinical Facilitator, NHS Institute for Innovation and Improvement
Nick Downham, Associate, NHS Institute for Innovation and Improvement
Helen Bevan, Director of Service Transformation, NHS Institute for Innovation and Improvement
Maggie Morgan-Cooke, Interim Head of Productive Ward, NHS Institute for Innovation and Improvement
Kate Jones, Head of Safer Care programme, NHS Institute for Innovation and Improvement
Sean Manning, Senior Associate, NHS Institute for Innovation and Improvement
Neil Westwood, Associate, NHS Institute for Innovation and Improvement
Cathy Adcock, Improvement Manager, Luton and Dunstable Hospital NHS Foundation Trust
Bruce Gray, Improvement Manager, Luton and Dunstable Hospital NHS Foundation Trust
Lizzie Cunningham, Clinical Facilitator, NHS Institute for Innovation and Improvement
Cathie Blackwell, Clinical Facilitator, NHS Institute for Innovation and Improvement
Christine Wike, Clinical Facilitator, NHS Institute for Innovation and Improvement
Debbie Llewellyn-Sims, Clinical Facilitator, NHS Institute for Innovation and Improvement
Heather Palin, Clinical Facilitator, NHS Institute for Innovation and Improvement
Eileen Stonock, Clinical Facilitator, NHS Institute for Innovation and Improvement
Val Newton, Clinical Facilitator, NHS Institute for Innovation and Improvement

NHS
Institute for Innovation
and Improvement

Website: For more information please visit www.institute.nhs.uk/productivementalhealthward

Contact the Productive Mental Health Ward team:
productivementalhealthward@institute.nhs.uk

ISBN: 978-1-906535-56-8