The AHSN Network

NHS Improvement


# Reach for the Charts

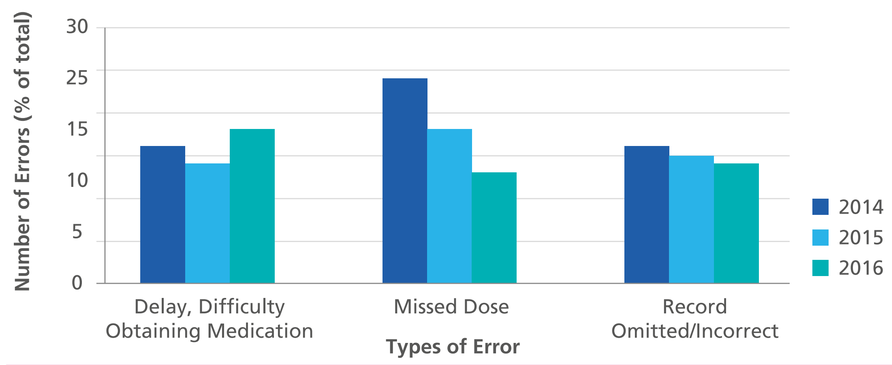
The idea for the project came following attendance at the South of England Mental Health Collaborative event in December 2015, during which we were challenged to look at using media as an educational tool. Wessex PSC supported this project by funding the production of the video created by Dorset Healthcare University NHS Foundation Trust.

1. **Aim:** To raise awareness of medication safety issues in a fun and novel way.

2. **Problem and scope:** the top three medication errors occurring across the Trust were:

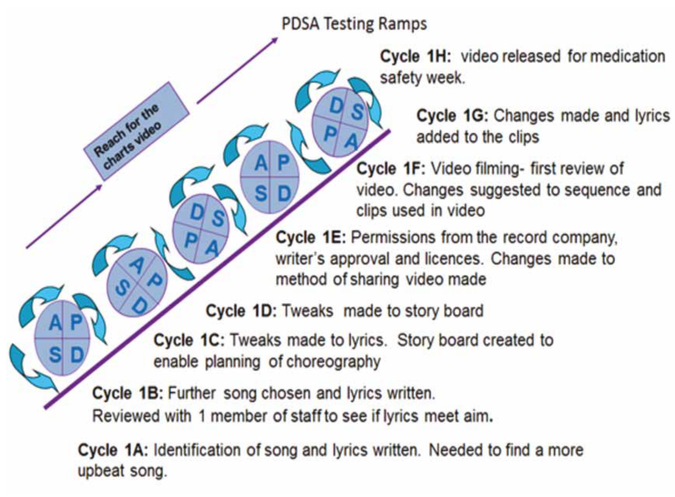
   - delay or difficulty in obtaining medication
   - missed doses
   - records being omitted or incorrect
   - Trust data reflects national data themes regarding medication errors (National Patient Safety Agency 2010; Morely et al 2016)

**A Graph to show the top 3 reported errors, shown as a percentage of the total reported errors for 2014, 2015 and 2016**




3. **Measures:** Baseline data from the Ulysses incident reporting system showed the numbers of medication safety incidents Involving difficulty or delay in obtaining medication, missed doses and record omitted / incorrect.

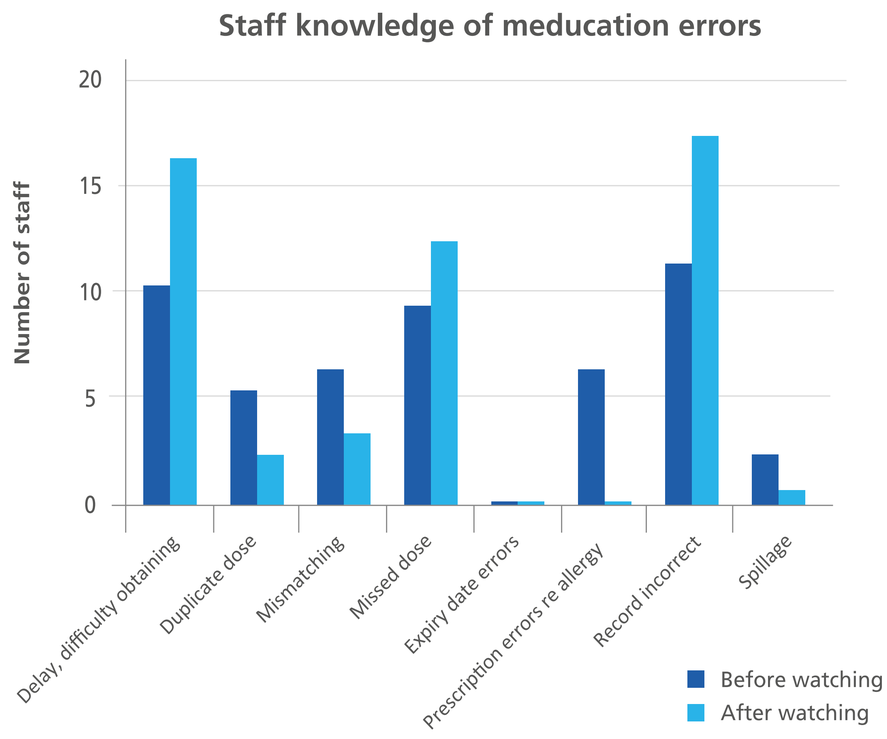
   A survey collected baseline data of staff awareness of medication errors before and after viewing the video.




4. **Results:** Staff were asked to rank what they believed were the top three reported medication errors before and after watching the video.

   Results show an increased awareness in medication errors has been achieved.

**Staff knowledge of meducation errors**




5. **Lessons Learnt:**

   - The importance of a clear aim to ensure the video had a clear message
   - The process of gaining permissions from the record company, writer's approval and licences was timely and complex.

6. **Outcome:** Awareness of medication errors across the Trust has increased.

   The video has been viewed over 2300 times to date.

   Video shared with the wider community via BBC radio Solent, Wessex FM and Dorset Echo.

**For more information** please contact Katie Griffiths, Medication Safety Officer at katie.griffiths3@nhs.net or Laura Smith, Patient Safety Advisor at laura.smith106@nhs.net

## References:

National Patient Safety Agency., 2010. *Rapid Response Report NPSA/2010/RRR009: Reducing harm from omitted and delayed medicines in hospital,* London: NPSA

Morely, C., McLeod, E., McKenzie, D., Ford, K., Walsh, K., Chalmers, L., Gordon-Croal, S., Baver, G., Peterson, G., 2016. Reducing dose omission of prescribed medications in the hospital setting: a narrative review *Drugs and Therapy Perspectives* 32 (5) 203250314 -208