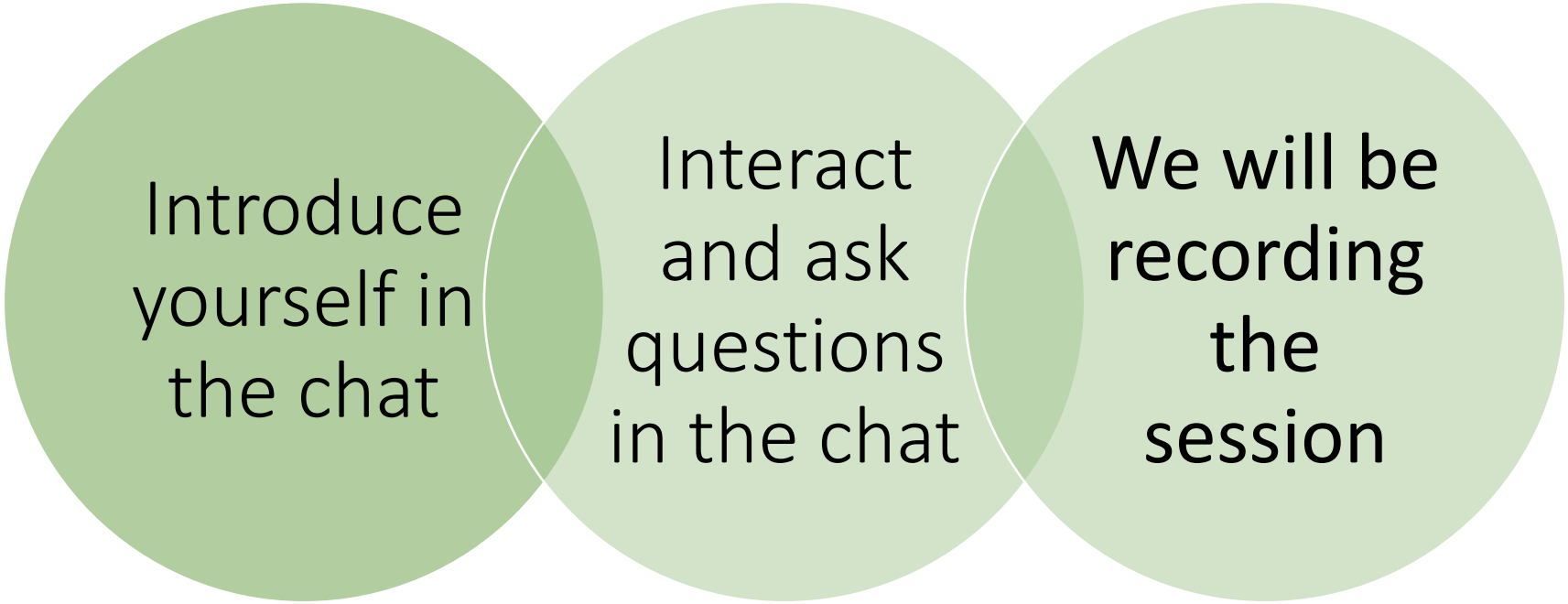
Safer use of time critical medicines webinar

Tuesday 1st July 2025

The first stop for professional medicines advice

Welcome & Introductions

Housekeeping



Learning outcomes

- Understand the challenges surrounding time critical medicines
- Update on the Safer Use of Time Critical Medicines Programme, including work done so far and next steps
- Increase awareness of potential improvement interventions for the safer use of time critical medicines

Time critical medicines

Tony Jamieson

Patient Safety Specialist & Clinical Improvement Lead

Medicines Safety Improvement Programme, NHS England

The medicines safety improvement programme aims to address the most important causes of severe harm associated with medicines, most of which have been known about for years but continue to challenge our health and care systems.

Background


NHS
National Patient Safety Agency

Rapid Response Report

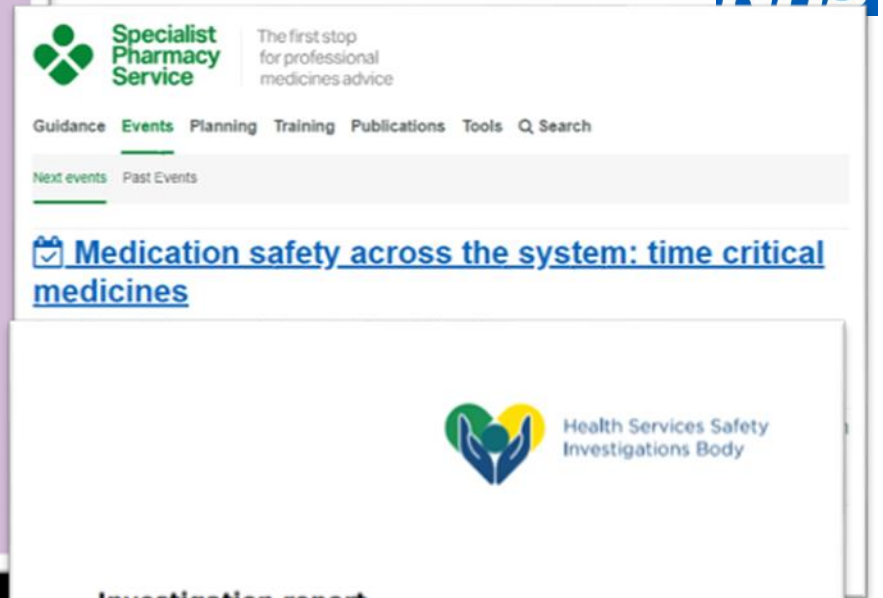
NPSA/2010/RRR009

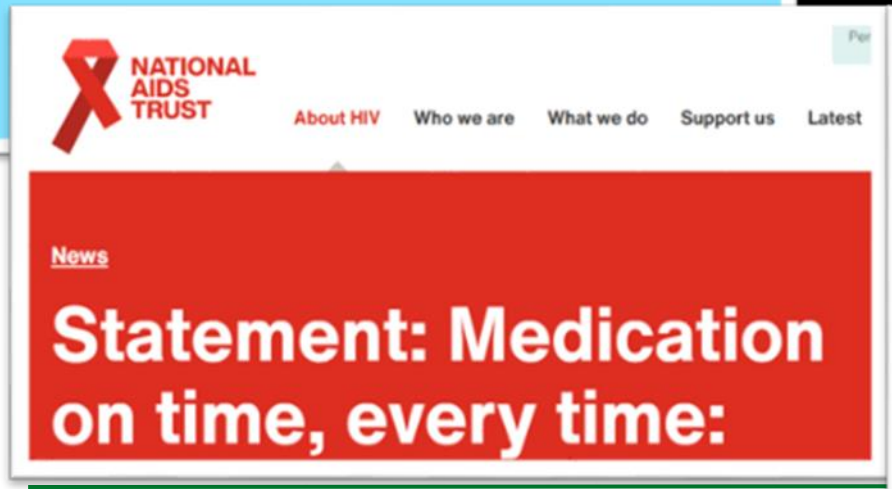
From reporting to learning 24 February 2010

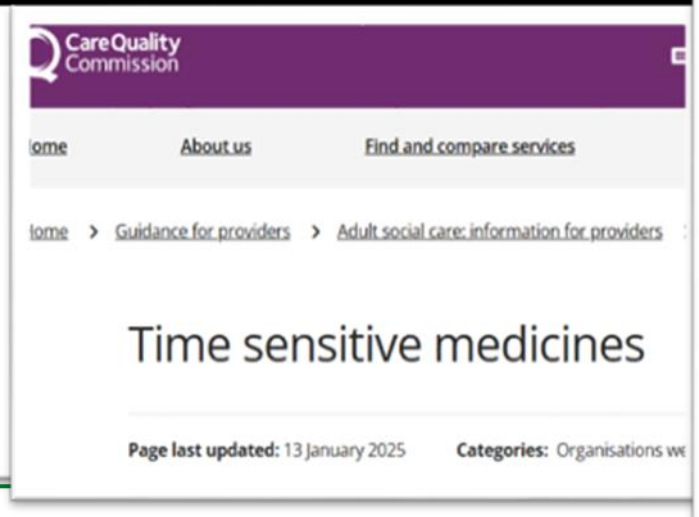
Reducing harm from omitted and delayed medicines in hospital

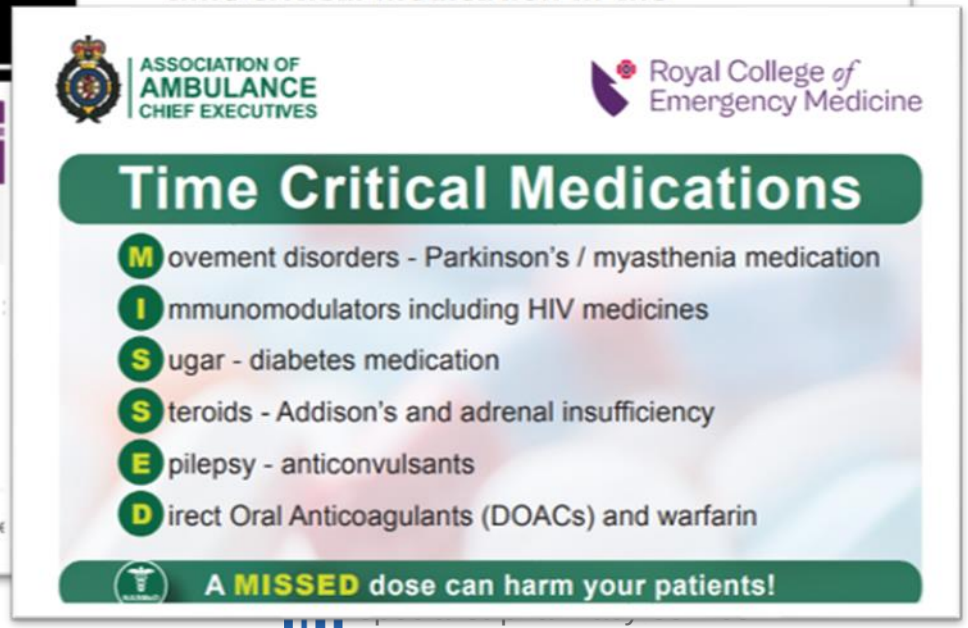
Specialist Pharmacy Service

Background









The problem

Patients suffer harm, distress and increased length of stay, and staff experience increased pressure, when patients don't get their time critical medication on time due to failure of medication processes

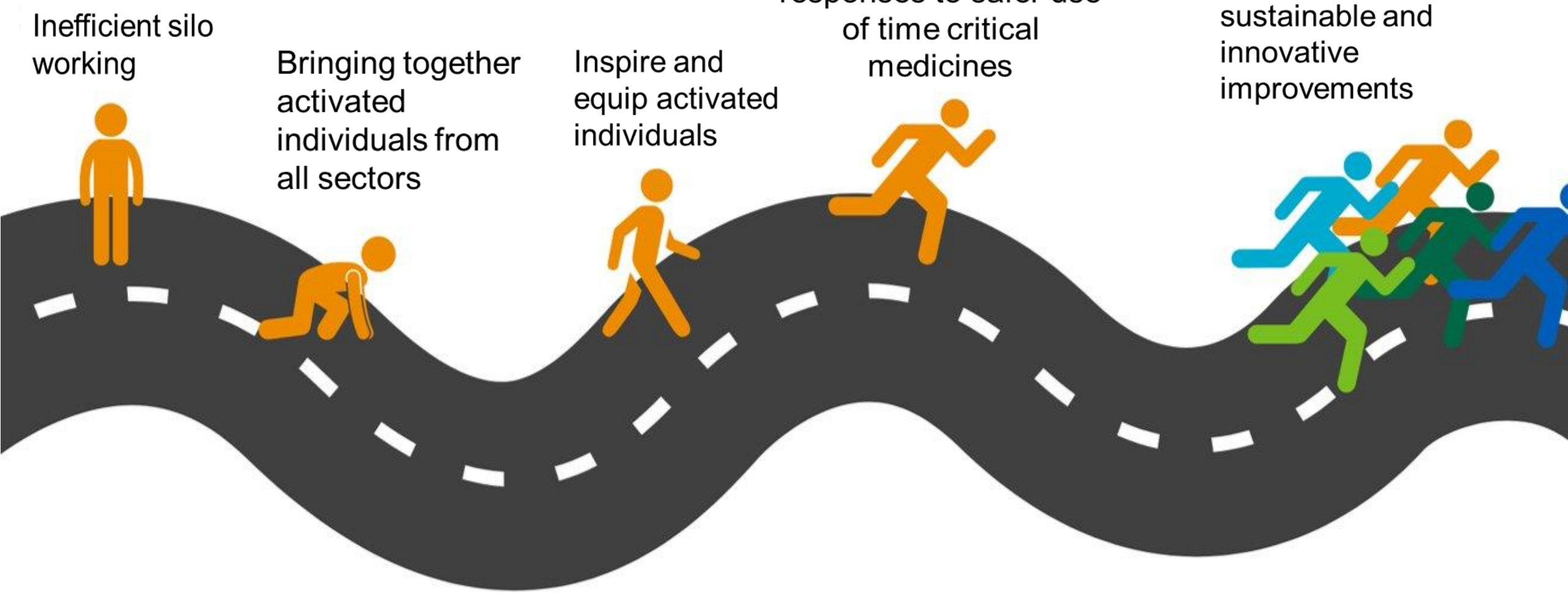
1 in 17 patients die
as a result of problems with time critical medicines during their inpatient stay

67% increase in length of stay

Safer Use of Time Critical Medicines Programme

- Part of NHS England's Medicines Safety Improvement Programme
- Led by SPS time critical medicines team
- Aims to improve the safer use of time critical medicines

The Journey


Inefficient silo working
Bringing together activated individuals from all sectors
Inspire and equip activated individuals
System-wide responses to safer use of time critical medicines
A community of activated individuals and teams, delivering sustainable and innovative improvements

Time Critical Medicines
A Carer's Perspective

Safer Use of Time Critical Medicines Programme

Safer Use of Time Critical Medicines Programme Team

Key principles of the programme

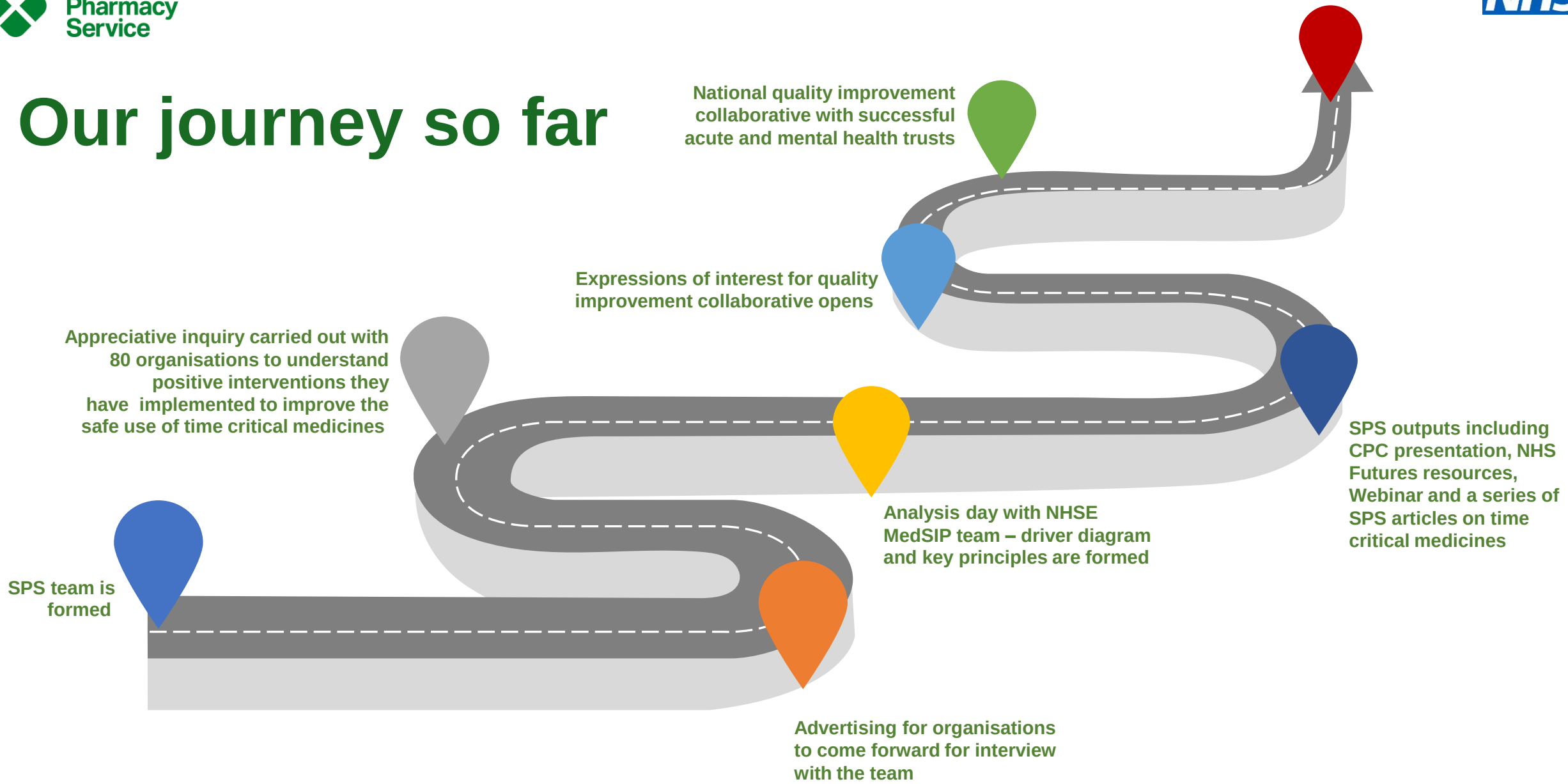
Proactive identification of patients at first contact with the service and identification of their needs throughout the entirety of their journey

Time critical medicines are prescribed, available, prepared and administered on time every time

Data, both real time and retrospective, must be available for staff to respond to their patient's needs

The patient, family and carers' voice is a powerful driver and people are enabled and empowered to take responsibility for their time critical medicines

Our journey so far



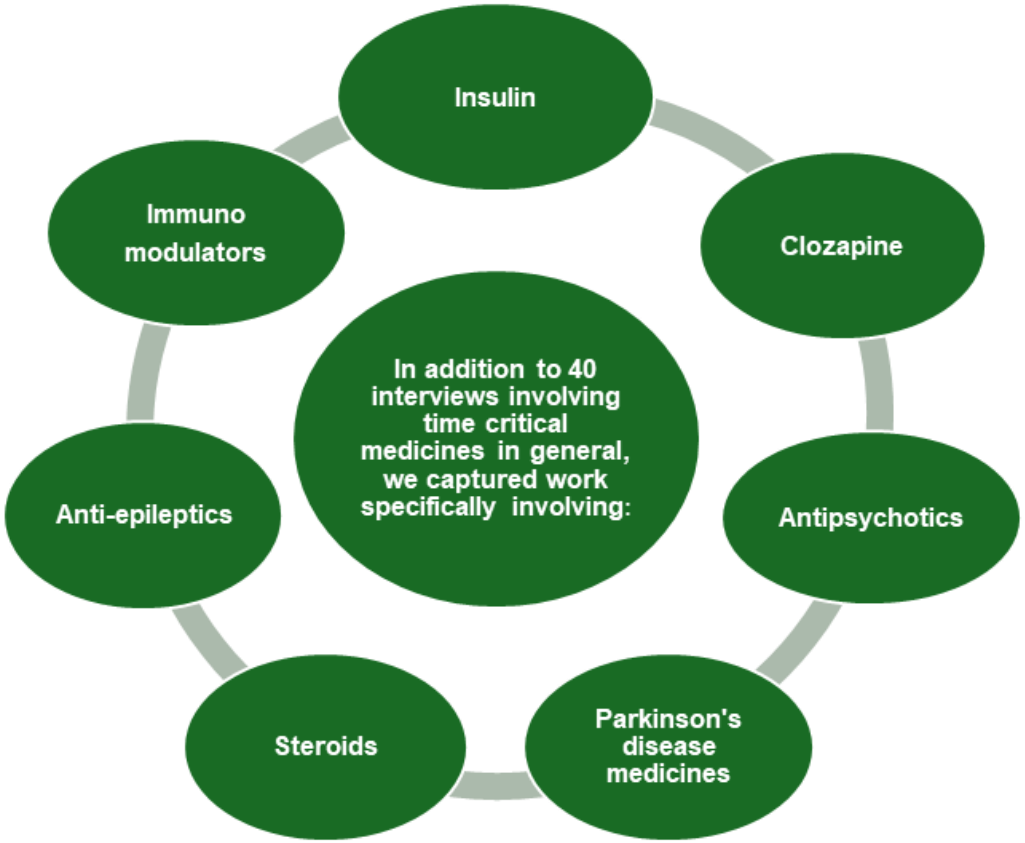
Appreciative inquiry

80 interviews

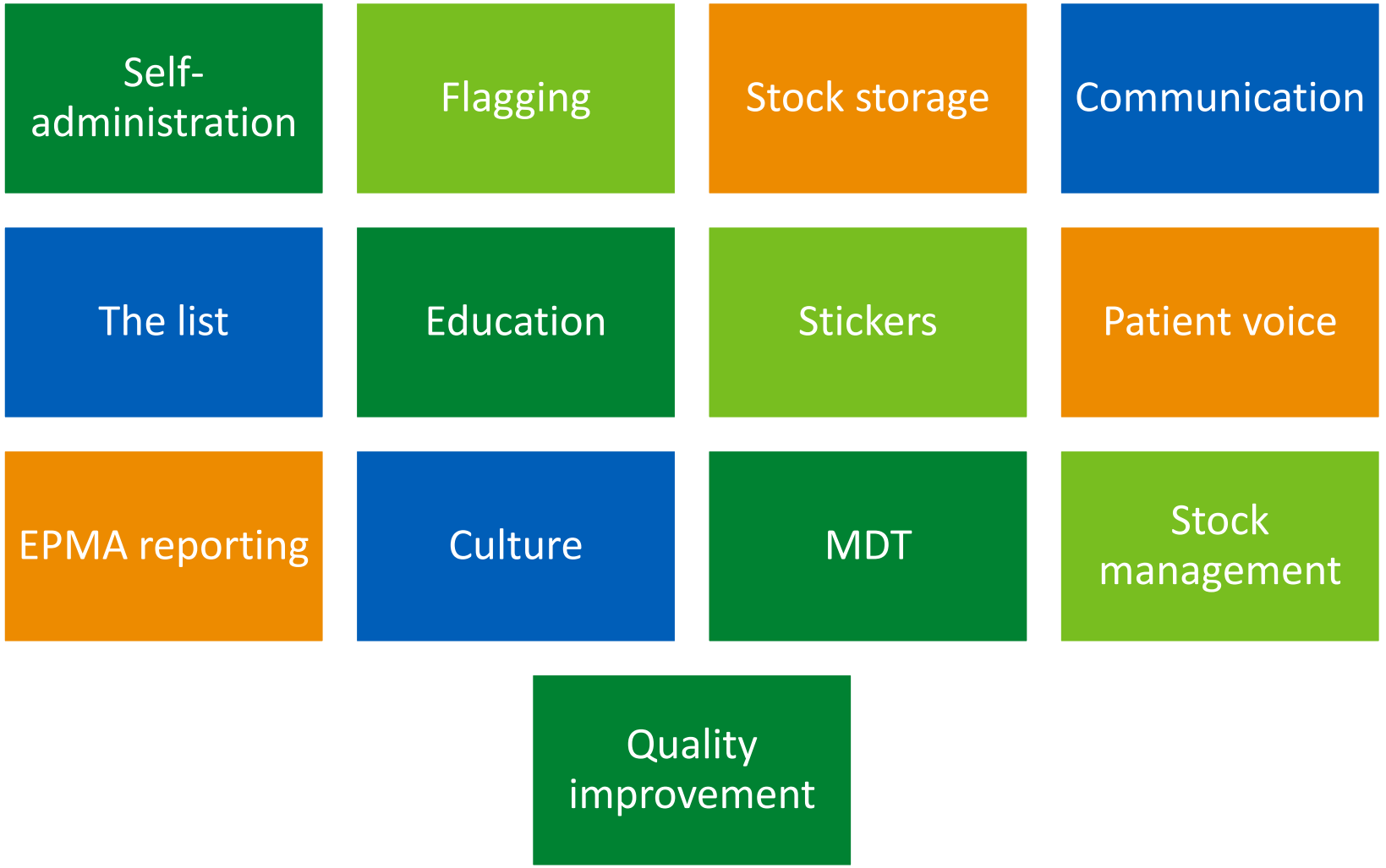
Interviews represent work being done across varied organisations with the highest representation from Acute trusts

Engagement from all geographical regions

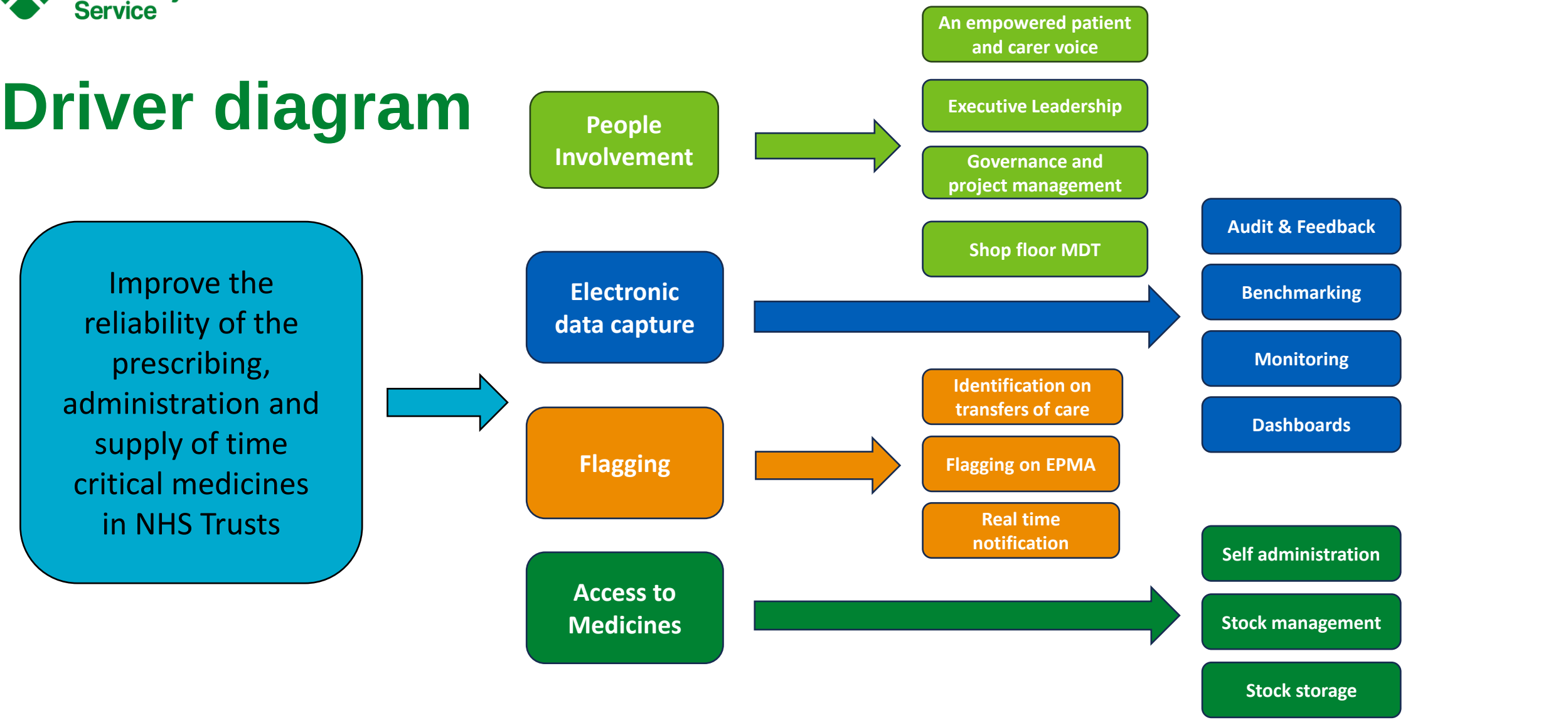
Stakeholders from a wide range of professional backgrounds



Appreciative inquiry analysis



Driver diagram



Measurements

- No universal time critical medicines (TCM) definition, adds to complexities to measure improvement
- Agree scope & aim of project at the start
- Baseline data collected before improvement journey
- Organisations have resources to support with measures for TCM

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Time Critical Medications at LTHTr

Judith Argall – Medicines Safety Officer
Sophie O'Dolan – Medicines Safety Pharmacist

Excellent care with compassion

Lancashire Teaching Hospitals
NHS Foundation Trust

The % target for missed doses to be set throughout the Trust for CRITICAL MEDICATIONS is below **1%**

Introduction

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Delayed and omitted doses of medicine pose a threat to patient well-being and can lead to patient harm, therefore should be avoided wherever possible.

The NPSA published an alert “Reducing Harm from delayed and omitted medicines in Hospital” in February 2010 and reducing missed doses therefore became a key Medicines Safety initiative at LTHTr.

Medication-related incidents remain one of the most frequently reported categories of patient safety incidents, accounting for around 8% locally within the trust.

Ensuring medicines aren’t omitted reduces the risk of harm from administration errors and also prescribing errors as this work also affects duplicate doses.

Key aims and objectives

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To reduce medication omissions across inpatient areas to less than 1% for critical medications.

To ensure that all staff know how to identify when a dose of medication is omitted, how to document the reason for an omission and the processes that they should follow to ensure medications are given to patients in a safe and timely manner.

To develop a sustainable system for data collection and monitoring

How did we set out to achieve

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- Used CI methodology to engage an initial set of wards to work within a traditional collaborative approach. We met regularly as a collaborative and supported ward staff to test PDSA cycles and share outcomes and learning, together building a change package that we could later scale up and spread to further areas across the trust.
- Worked with senior nursing colleagues to agree appropriate outcomes and the 1% target threshold.
- We developed a BI dashboard which showed live data of delayed doses from EPMA that updated every 15 minutes – which identified doses of critical medicines that had been omitted with and without a valid reason. Worked in conjunction with BI and IT teams to ensure the data included was accurate and easily interpreted.
- Created a Trust SOP for Medication Omissions to ensure all areas were clear on what actions to take regarding medication omissions, ensuring clear messaging and prioritising patient safety.
- The progress was tracked through the individual wards via the CI project and then later included within the Pharmacy Medication Safety audit conducted monthly on all ward areas and reported to Medicines Governance Committee and divisional Always Safety-First meetings.

Barriers

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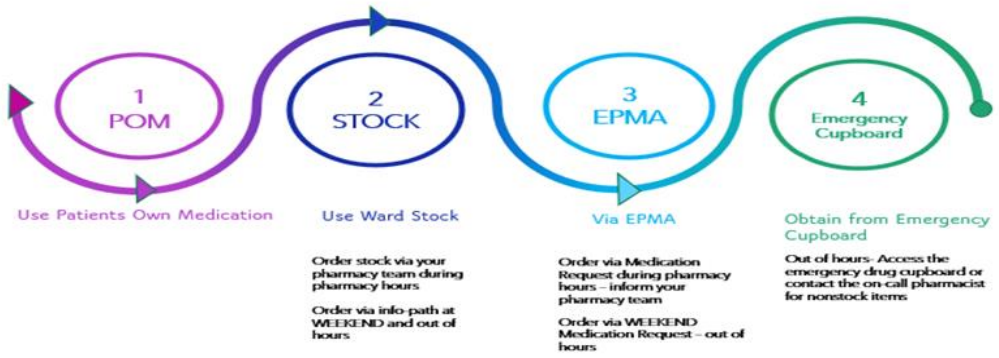
- Engagement with nursing team and blurring lines of responsibility for ensuring patients received doses on time.
- IT/BI app system restrictions and testing
- No national standard for definition of missed dose or what proportion of omitted doses is acceptable

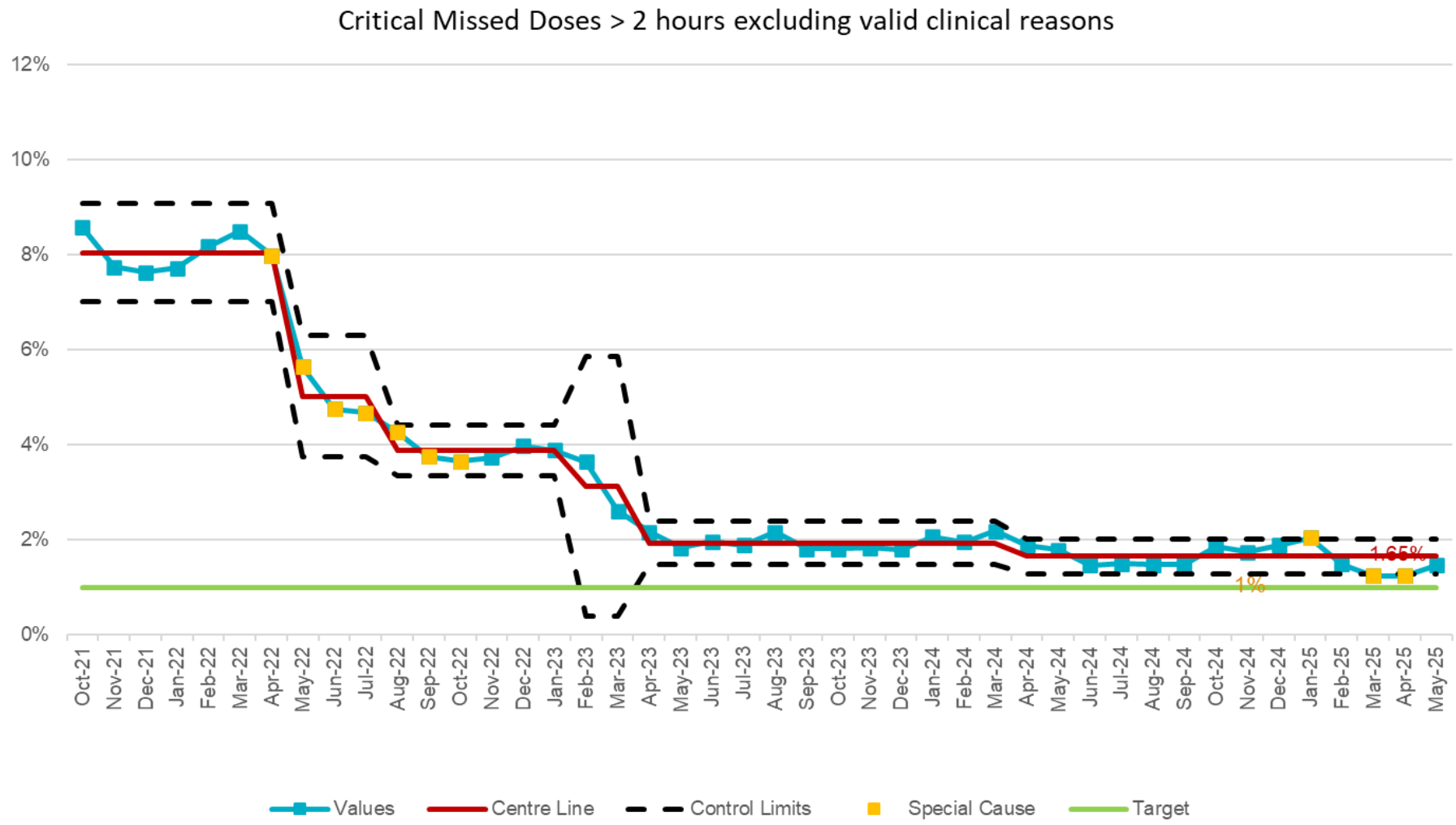
Successes

- Making the data public to all wards and then celebrating success when they achieved (e.g. by putting posters up on the ward), this encouraged nurses to want to continue to do the work and do well.

- Missed doses seen as high priority at the trust.

- Ordering system developed to promote safe supply of medications.




Critical Missed Doses > 2 hours excluding valid clinical reasons
12%
10%
8%
6%
4%
2%
0%
1.65%
1%
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
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May-25
Values
Centre Line
Control Limits
Special Cause
Target

Missed Doses BI app

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- Updated every 15 minutes
- Doses included are for a 24-hour period
- Can be filtered by ward and by medication type
- Gives real time missed dose information

Missed Doses

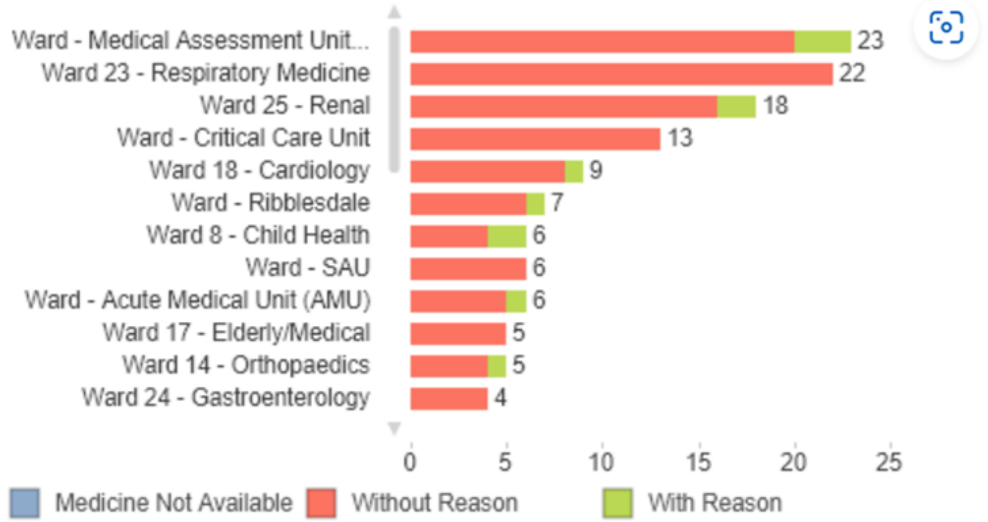
Last Reload - 12/06/2025 09:48

Selections...

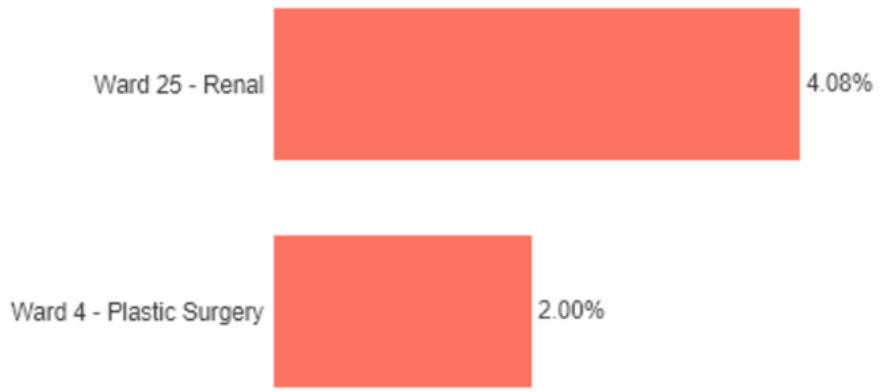
Site	
Ward	
Order Type	CRITICAL MED
Enteral Flag	NOT ENTERAL

Missed Dose - Medicine Not Available	Missed Dose - Without Reason	Missed Dose - With Valid Reason	Total Missed Doses	Total Doses	% Doses Missed Without Valid Reason >2hr
1	144	22	167	1469	0.20%

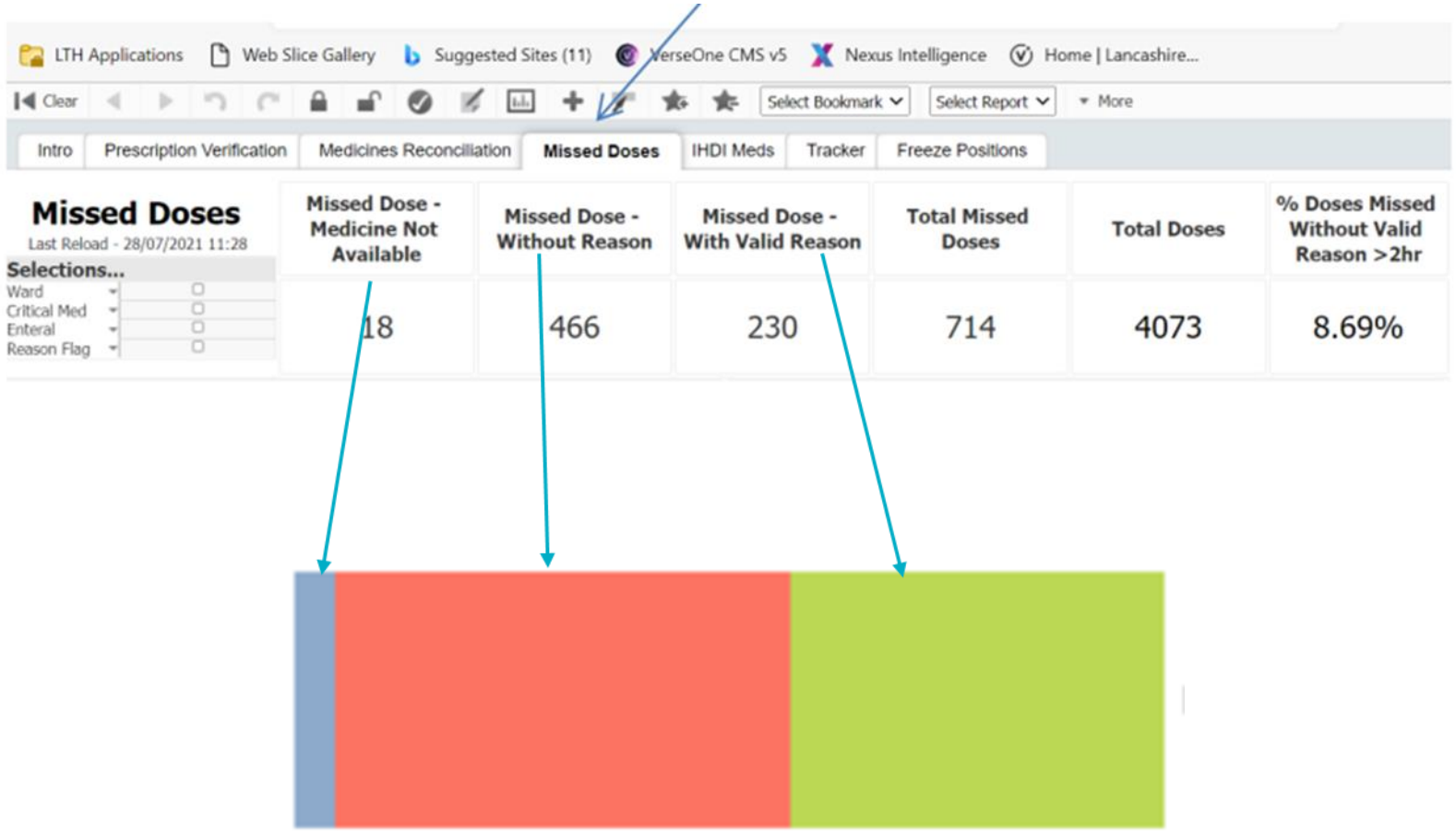
Missed Doses - 167

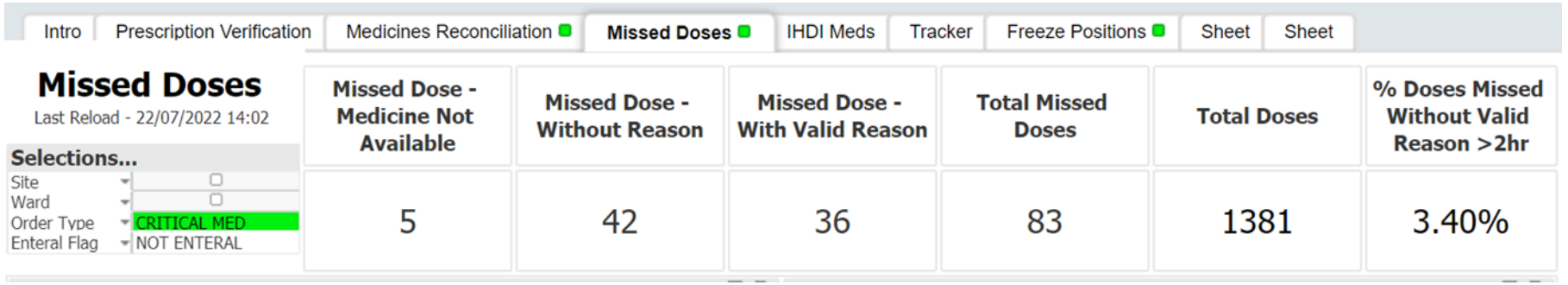


% Doses Missed Without Valid Reason - 0.20%



Using the Missed Doses app you are able to filter information by Site, Ward and Order Type





Intro | Prescription Verification | Medicines Reconciliation | **Missed Doses** | IHDI Meds | Tracker | Freeze Positions | Sheet | Sheet

Missed Doses

Last Reload - 22/07/2022 14:02

Selections...

Site	
Ward	
Order Type	CRITICAL MED
Enteral Flag	NOT ENTERAL

Missed Dose - Medicine Not Available	Missed Dose - Without Reason	Missed Dose - With Valid Reason	Total Missed Doses	Total Doses	% Doses Missed Without Valid Reason >2hr
5	42	36	83	1381	3.40%

$$\%= \frac{Medicines\ Not\ Available + Missed\ without\ reason > 2\ hours}{Total\ Doses}$$

When to check

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- After each Medication Round check the BI portal (or EPMA missed medication report)
- Any medications which have not been given should be highlighted to the RGN.
- The RGN should take the following actions

a) Give the medication as soon as reasonably possible
b) Reschedule the dose
c) Document a reason on EPMA to why the medication is missed

Tips for wards to achieve under 1%

- Always reschedule and enter the appropriate reason for any missed medications – these will not count towards your data
- Be aware of how to order inpatient medication
- Ensure all relevant staff have access to the BI Portal

Discussion

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- The project has dramatically decreased the number of medication omissions at LTHTr, ensuring that our patients receive the best care possible during admission and reducing avoidable harm.
- This has been achieved by collaborative working with nursing, pharmacy, IT and CI teams – to ensure accurate data was available to ward teams, appropriate documentation of missed doses when this was clinically appropriate and prioritising the supply of critical medications that were not available at ward level.
- Using the Medication Safety Audits to monitor progress has given the project visibility to the divisional teams and has worked as an additional method to motivate wards to use the tools available to ensure patients receive medication as it is prescribed. It has also allowed us to provide specific support to areas that are not achieving the target level and identify barriers to achieving the target.
- This project has been a success and has ensured that medication safety and safe medication administration is at the forefront of all our healthcare professionals minds.
- This project was also proudly a HSJ Patient Safety Awards Nominee

HSJ PATIENT SAFETY AWARDS 2023

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Time Critical Medications at LTHTr

Judith Argall – Medicines Safety Officer
Sophie O'Dolan – Medicines Safety Pharmacist

Excellent care with compassion

NHS
Cornwall Partnership
NHS Foundation Trust

Time Critical Meds
A QI Approach

Kylie Lock, Quality Lead

Outstanding care for all

GREAT

Objective and Background

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Luke Huntley, Pharmacist, at Newquay hospital noticed the considerable difference in one of his patients with Parkinson's disease, when he wasn't receiving his medication on time. Incorrect or missing drug doses can cause a decline in mobility and swallowing leading to an increase in the length of stay and increased level of dependence whilst in hospital.

In March 2021, we set out to ensure people with Parkinson's received their medication within 30 minutes of the prescribed time within our inpatient community hospitals.

Our approach

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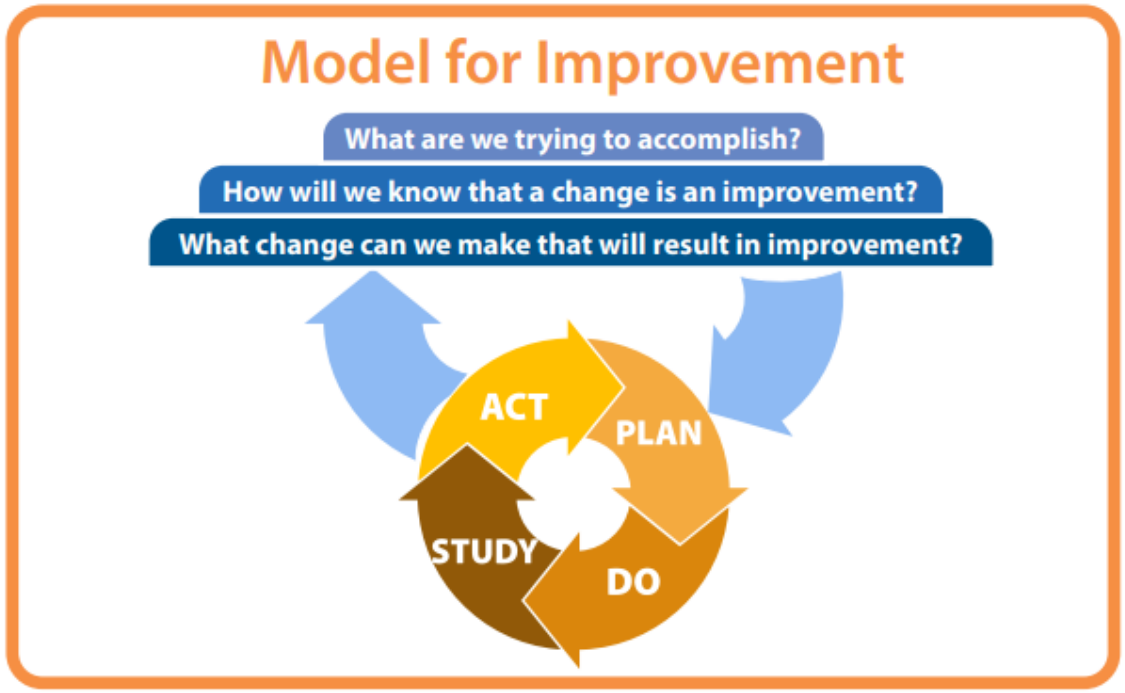

Measures

- Improved staff knowledge
- Awareness of time critical meds
- Data and reporting
- Patient survey and experience
- Engagement with Inpatient wards

Change Ideas

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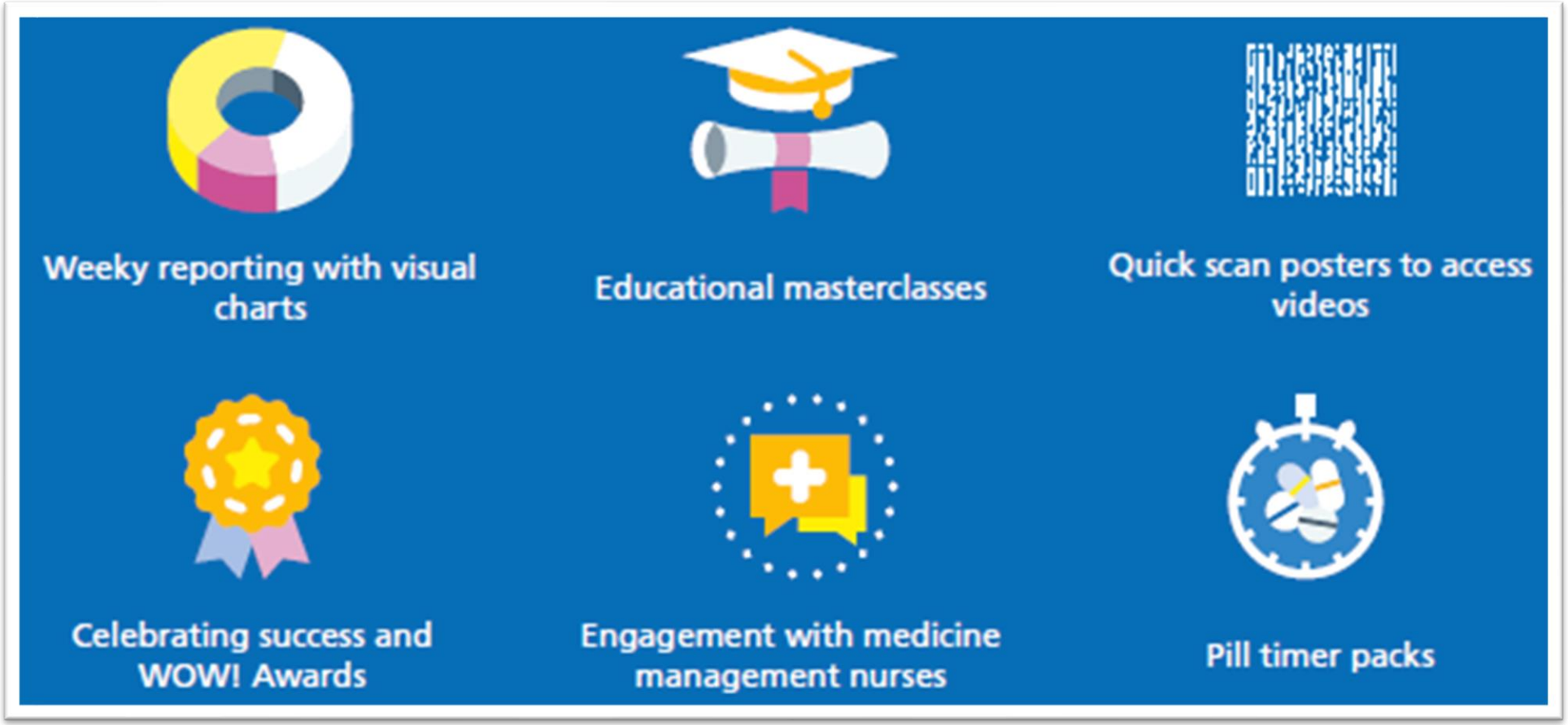

Patient Feedback

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NHS Foundation Trust

I do not need to keep repeating everything when the ward staff have more knowledge about Parkinson's. This gives me reassurance that my medication will be given on time.

Inpatient quote

Results

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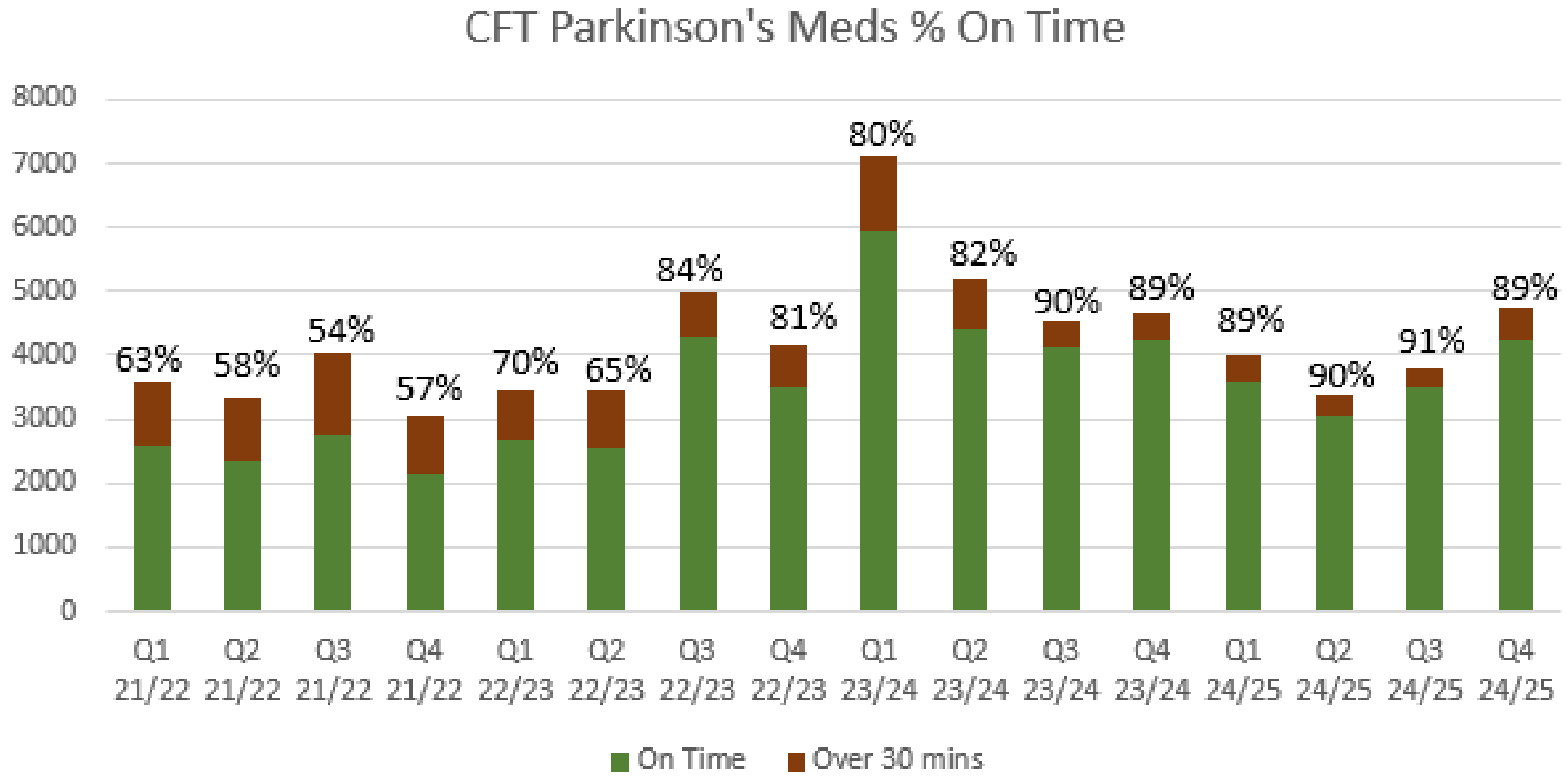


Celebrating and Sharing Success

NHS
Cornwall Partnership
NHS Foundation Trust

Parkinson's Service: Time Critical Medication QI Project

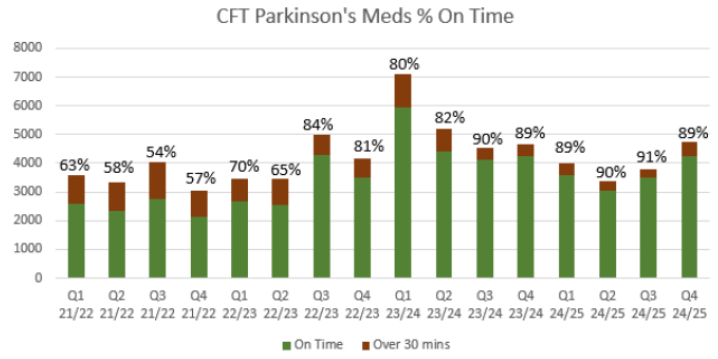
NHS Cornwall Partnership NHS Foundation Trust

Project leads: Lynne Osborne - Consultant Nurse Parkinson's, Luke Huntley - Pharmacist, Jacqui Chamberlain - Parkinson's Nurse Specialist, Kylie Lock - Quality Lead,

Aim and Timeline for Delivery	Why is this important?	Measures and controls
To ensure Parkinson's patients within our inpatient settings receive their medication within 30 minutes of the planned time. The project commenced in March 2021 and has continued since. The aspiration is that we ensure the project work is embedded into the operational delivery on ACS Wards.	A delay in medication can lead to serious health implications for someone living with Parkinson's. Parkinson's UK data from shows there were 1075 admissions in Cornwall in 2021/22 compared to a national average of 910 admissions. The average length of stay for Parkinson's patients in Cornwall had risen by 21.4% compared to the previous year.	• Improved staff knowledge • Awareness of time critical medication • Reporting across all wards on weekly basis • Patient Survey • Staff Survey • Engagement with inpatient wards

Results

The chart below shows the percentage of doses administered on time within the 30-minute window. There has been a **26% improvement** since the start of the project, and we have seen this sustained over the last 18 months.



What we implemented

- Weekly reporting sent to ward managers in data tables & visual charts – easy to read
- Parkinson's educational masterclasses
- Posters & videos shared to raise awareness about impact of delayed meds
- Celebrating success / WOW Awards
- Engagement with meds management nurses
- Pill timers on inpatient wards
- Roll out to MH wards and RCHT

Recommendations

- Patient involvement in the project
- Lunch & learn events
- RiO to flag Parkinson's patients at admission
- Guidance for management of Parkinson's patients in an inpatient ward
- To implement medication self-administration
- RCHT ED QIP – Time critical meds project.

Top Tips

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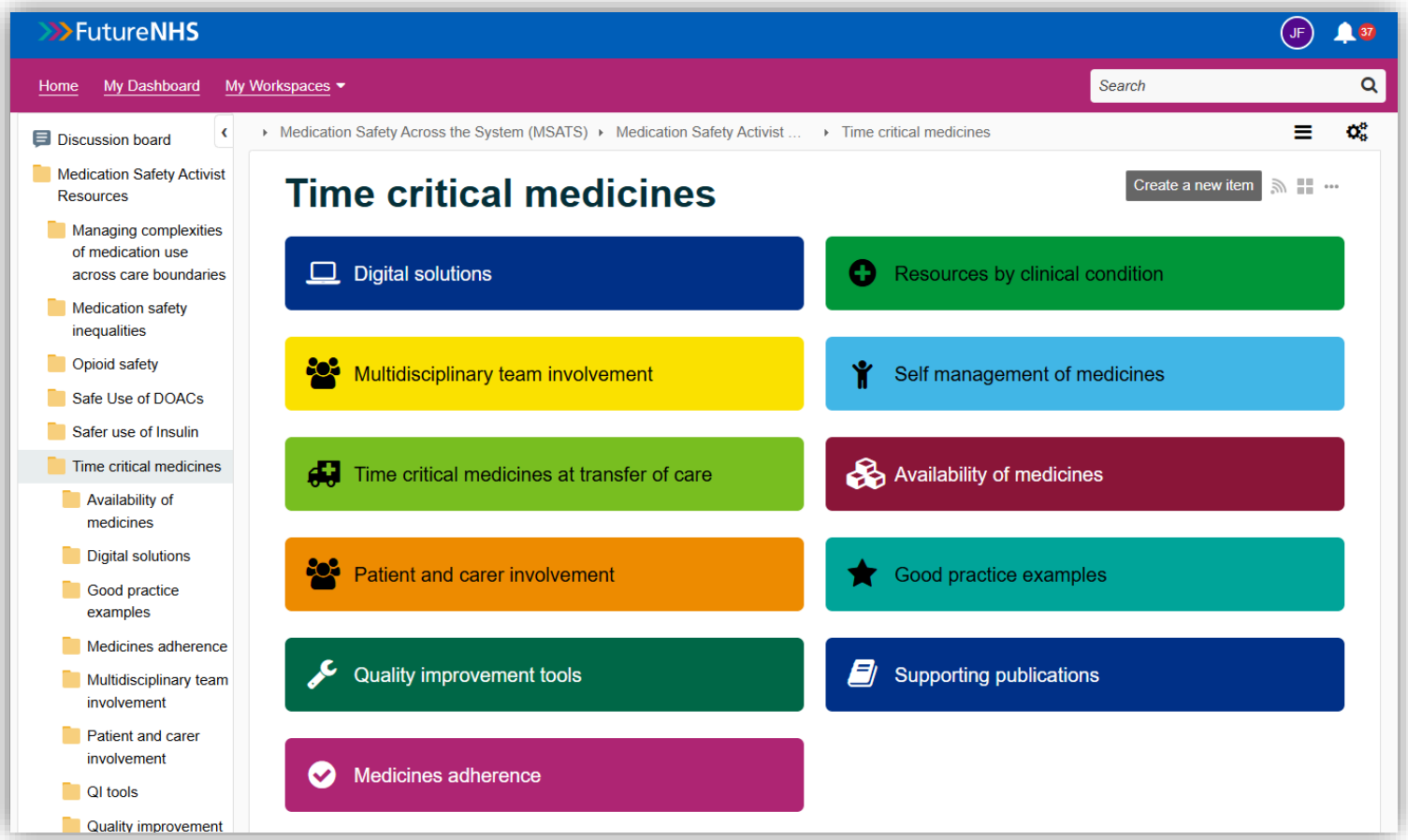
- Engagement with Stakeholders is key
- Think about your circle of control and influence
- Consider sustainability: What infrastructure do you have to monitor and support the project long term?
- Visual data and reporting has been our biggest win!

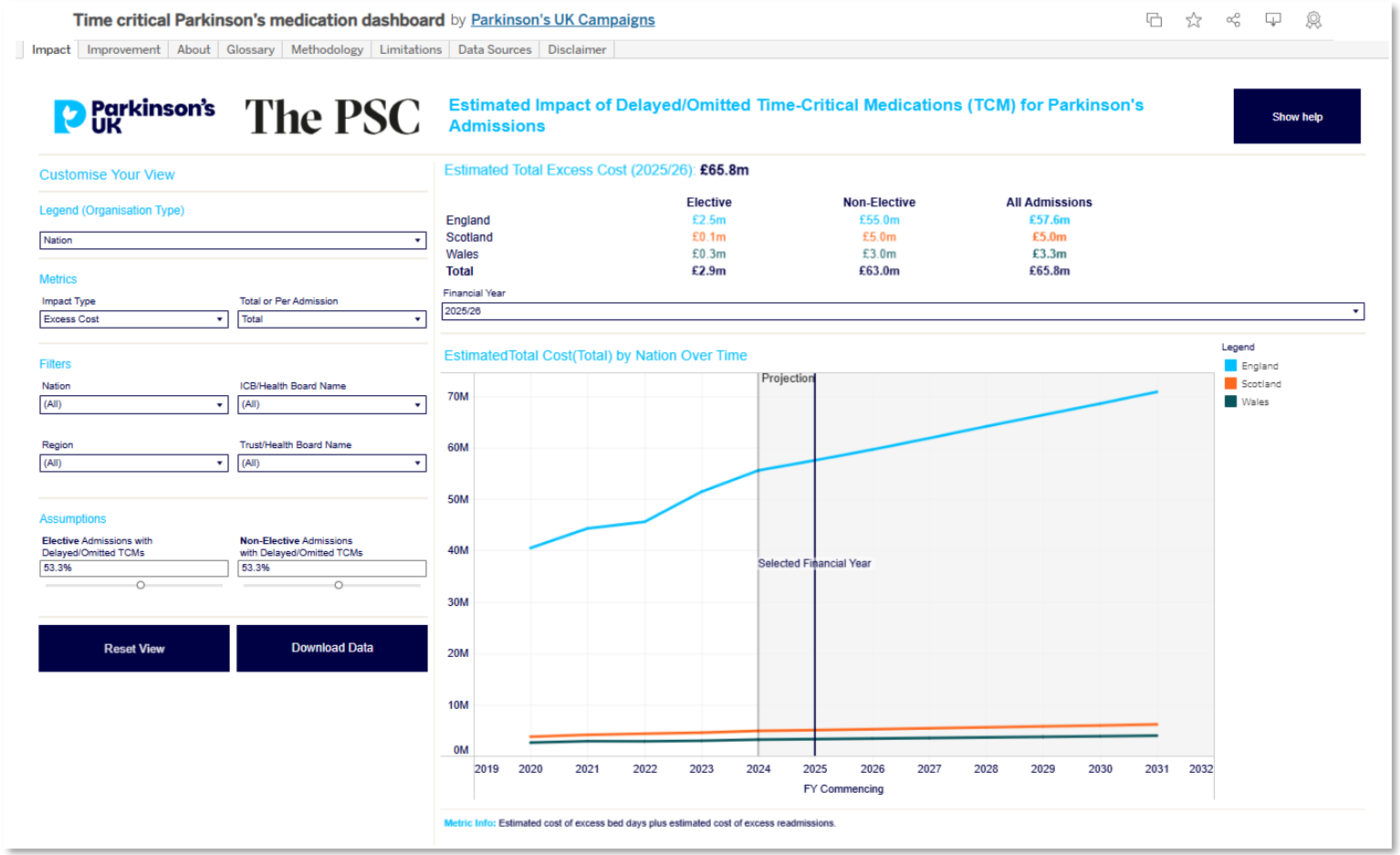
Time Critical Medicines Resources

Repository of shared resources



Parkinson's UK Dashboard

Estimates the direct cost for hospitals and the impact on patient outcomes of delays and omissions with Parkinson's medicines.



https://www.parkinsons.org.uk/professionals/resources/unlock-value-timely-medication-parkinsons-uk-time-critical-medication

SPS resources

Self-administration of medicines

Supporting safe use of adrenal crisis emergency management kits

Ensuring time critical use of rasburicase

Clinical considerations for patients prescribed clozapine

Parkinson's disease medicines in swallowing difficulties

Articles on TCMs in development

Medicines supply tool (website registration required)
Latest information on supply issues, actions to take, alternatives to use, & expected resolution dates. Content provided by DHSC and MVA team, NHS England

Take away messages

- There is no one size fits all solution to improving the safe use of time critical medicines
- Improvement will involve multiple change ideas
- Involving the multi-disciplinary team, including patients, carers and families is crucial

Thank you to all our speakers and attendees

Please complete the evaluation form in the chat