Implementing the Paediatric NIMC

Sharing the lessons

The Royal Children's Hospital Melbourne

Overview

- Reasons for Change
- Implementation Strategy
- Post Implementation Audit Results
- Improvements
- Feedback from Staff
- Lessons learnt

Reasons for Change

- Required by minister to adopt changes
- Part of a national strategy
- Audit of current medication chart - 150 prescriptions
  - 73% drugs not administered at correct frequency
  - 70% ADR’ s documented on our charts

Implementation Strategy

- Monitored through Medication Safety Committee
- Developed implementation timeline
- Information sessions by Quality Unit
  - DHS assistance
  - Organisational
  - Departmental/ Craft groups
- Intranet/ Staff Bulletins
- Mock Charts

Key Audit Results

Criteria	2007 (n=30)	2008 (n=27)	2009 (n= 34)	Change from 2008
Pt name printed	N/A	30%	20%	⇓ 10%
ADR s documented	70%	81%	80%	=
Numbering of page numbers	93%	56%	60%	⇑ 4%
Error prone abbreviations used	N/A	N/A	4%	
Dose calculation by prescriber	N/A	N/A	21%	
Administered at prescribed frequency	73%	93%	95%	⇑ 2%

The Royal Children's Hospital Melbourne

Audit Results

- Action plan to be developed at Medication Safety Meeting (tomorrow)
- Quality Registrar communicated key findings to colleagues

Changes to the chart

- Redesigned to open the chart the other way
- Numbering of pages moved to the front
- Increased the space to print patient name
- Increased the readability

Feedback on the Chart

- “But we are different”
- Give us the old one back
- Doctors do not fill in the times
- Nurses don’t want us to fill in the time
- Difficult when the drug is 18hourly
- Chart opens the wrong way – drugs missed
- Being able to distinguish border between one drug and the next
- How do the attachments work?

Lessons Learnt

- People will always complain
- Never an ideal time to initiate such a change
- Printing and design takes longer than expected
- Hard to get people to education sessions
- Paediatrics is always different
- Children in other states are different