Nursing Medication Safety Review 2025

St Raphael's Hospice - Inpatient Unit

Reporting Period: 01 January 2025 - 24 December 2025

IPU Summary

This report focuses specifically on nursing-related medication safety interventions identified in our 10-bed Inpatient Unit during 2025. The analysis examines areas for development in medication administration and documentation practices, excluding prescribing-related issues which are addressed separately with medical staff.

All interventions were identified and resolved before patient harm occurred, demonstrating the effectiveness of our pharmacy team's monitoring and the robustness of our safety systems. This report provides an opportunity for shared learning and continuous improvement in our nursing medication practices.

Key Statistics

- **39 nursing-related medication safety interventions in 2025**
- Two primary categories account for 90% of nursing interventions
- Recording omissions identified in 14 instances (36%)
- Medicine not administered accounts for 64% of nursing interventions (25 instances)

2025 Nursing Interventions Overview

Intervention Type	Count	% of Total
Medicine not administered as out of stock	25	64%
Recording omissions	14	36%
TOTAL NURSING INTERVENTIONS	**39**	**100%**

Monthly Breakdown 2025

Month	Med Not Admin	Recording Omissions	Admin Times Differ	Other	Total
Jan	0	7	0	0	**7**
Feb	0	0	0	0	**0**
Mar	13	0	0	0	**13**
Apr	0	1	0	0	**1**
May	11	2	1	0	**14**

Month	Med Not Admin	Recording Omissions	Admin Times Differ	Other	Total
Jun	1	0	0	0	**1**
Jul	0	0	0	0	**0**
Aug	0	0	0	0	**0**
Sep	0	1	0	0	**1**
Oct	0	0	0	0	**0**
Nov	0	3	0	0	**3**
Dec	0	0	1	0	**1**
TOTAL	**25**	**14**	**2**	**0**	**41**

Monthly Trend Analysis

The monthly breakdown reveals significant clustering of medication administration challenges in March (13 instances) and May (14 instances), together accounting for 69% of all medicine not administered incidents for the year. Notably, July and August showed zero nursing interventions, while October also recorded no nursing interventions. Recording omissions were concentrated in January (7 instances) with sporadic occurrence throughout the rest of the year.

Understanding the Nursing Interventions

1. Medicine Not Administered (25 instances, 64%)

What This Means:

These are instances where prescribed medications were not given to patients. While the intervention description states 'out of stock', this highlights an important opportunity for nursing teams to strengthen escalation processes. When a medication is unavailable, prompt communication with pharmacy ensures continuity of patient care.

NMC Standards Relevance:

This connects with:

- NMC Code (2018) - Standard 10: Keep clear and accurate records relevant to your practice
- NMC Code (2018) - Standard 19: Be aware of, and reduce as far as possible, any potential for harm associated with your practice
- Standards for Medicines Management (2018) - Standard 8: Ensure safe and effective administration of medicines

2. Recording Omissions (14 instances, 36%)

What This Means:

Recording omissions occur when documentation of medication administration is not completed on the drug chart. This creates uncertainty about whether a medication was

given, which in a 10-bed unit with multiple staff members caring for patients across shifts, makes accurate recording essential for continuity of care and patient safety.

NMC Standards Relevance:

This relates to:

NMC Code (2018) - Standard 10: Keep clear and accurate records relevant to your practice

Standards for Medicines Management (2018) - Standard 8.5: Make a clear, accurate and immediate record of all medicine administered

Standards for Medicines Management (2018) - Standard 8.6: Where medication is not given, the reason for not doing so must be recorded

Current Best Practice in Medication Administration

The Six Rights of Medication Administration

Best practice encourages nurses to verify six critical elements before administering any medication:

1. **Right Patient** - Verify patient identity using two identifiers
2. **Right Drug** - Confirm the medication name matches the prescription
3. **Right Dose** - Verify the correct amount is being administered
4. **Right Route** - Ensure correct method of administration (oral, SC, IV, etc.)
5. **Right Time** - Administer at the prescribed time
6. **Right Documentation** - Record immediately after administration

Immediate Documentation Protocol

Research consistently demonstrates that delayed documentation significantly increases error rates. Best practice supports medication administration being recorded immediately at the bedside. In our 10-bed IPU setting, with limited staff and high patient acuity, this principle becomes particularly important for maintaining continuity.

Escalation Procedures for Missing Medications

When a prescribed medication is unavailable, current best practice encourages nurses to promptly contact pharmacy, document the unavailability on the drug chart, inform the prescriber, and document the action taken. This ensures patient care continues without unnecessary delays.

Supportive Guidance for the IPU Team

The following suggestions are offered as supportive guidance specifically tailored for our 10-bed inpatient hospice unit. These are opportunities for us to work together on strengthening our medication safety practices:

1. Consider trialling a bedside documentation approach where medication charts are signed at the point of administration. Some units have found success with 'protected time' medication rounds where interruptions are minimised, allowing nurses to focus fully on the Six Rights and immediate documentation.
2. We could explore establishing a brief daily medication stock check as part of morning handover, perhaps with one designated nurse verifying availability of commonly prescribed medications and communicating any gaps to pharmacy early in the day to allow time for resolution.

3. It may be helpful to develop a simple escalation reference card that nurses can keep with their drug keys, providing clear steps for when medications are unavailable - a quick reminder of who to contact and how to document the situation.
4. Consider introducing brief monthly medication safety conversations during team meetings, using anonymised examples from our own data to discuss what happened and how we might handle similar situations differently. This creates opportunities for shared learning in a supportive environment.
5. We could develop a competency refresher on drug chart completion and NMC medication standards, with annual updates. This would be particularly valuable for agency staff and newly qualified nurses joining our team.
6. Consider introducing supportive peer observation of medication rounds where two nurses work together periodically, providing constructive feedback to each other in a spirit of mutual professional development rather than assessment.

Conclusion

The 39 nursing-related interventions in 2025 represent important learning opportunities for our IPU team. The concentration of medication administration challenges in March and May suggests there may have been specific pressures during these periods that we could explore together to better understand and prevent in future.

It's encouraging that all interventions were identified and resolved before patient harm occurred, demonstrating the effectiveness of our pharmacy team's vigilant monitoring and the strength of our safety checks. Our nursing team's commitment to excellence is evident in the overall quality of care we provide.

As professionals, we understand that the NMC Code reminds us we are each personally accountable for our practice. By reflecting together on how these interventions connect to our professional standards and exploring the supportive guidance outlined in this report, we can continue building on our strengths and providing the compassionate, safe palliative care that our patients and families deserve.

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For discussion at IPU Team Meeting