



## *An evaluation of a quality improvement activity to improve the documentation of medication patches as part of skin integrity checks*

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### Background:

Medication patches, primarily those which contain opioid medications, have the potential to cause harm. In a Swedish study of opioid medication patch incidents, 151 errors were reported over seven years. Harm was reported in 17% of cases, including manifestations of both overdose (sedation) and withdrawal (nausea and vomiting) (1). Local incidents highlighted a need to improve practices in communicating the presence of patches.

### Aim:

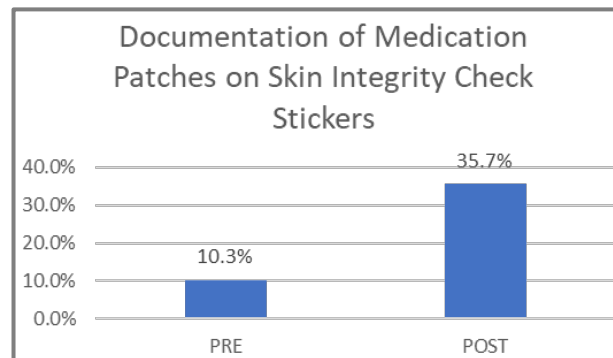
Unnoticed medication patches have the potential to impact a patient's clinical care, and it was identified that the skin integrity check undertaken by nurses provides an opportunity to identify patches and ensure appropriate management.

The aim of this Quality Assurance and Improvement activity was to determine the effect of adding the item 'Medication Patch' to the 'Skin Integrity Check' sticker at Caboolture and Kilcoy Hospitals.

### Method:

In a collaborative exercise between Nursing, Pharmacy and the Service Improvement Unit, the 'Skin Integrity Check' stickers which included 'Medication Patch' were introduced in May of 2020.

The method for this study was a retrospective chart audit of inpatient clinical records of patients discharged on an opioid patch in October/November 2019 (pre-change) and October/November 2020 (post-change) to assess rates at which the presence of patches was documented in the 'Skin Integrity Check' sticker.



Example of 'Post' intervention Skin Integrity Check sticker from audit

### Results:

The charts of 43 patients on opioid patches were reviewed prior to the change, and 28 charts were reviewed post-change. Prior to the change, 91% (39/43) of patients on an opioid patch had a the 'Skin Integrity Check' sticker in their chart during their inpatient stay. Post change 100% of patients (28/28) on an opioid patch had a 'Skin Integrity Check' sticker completed. In the pre period only 10.3% (4/39) of charts reviewed had a patch documented as part of this check. In the post period this increased to 35.7% (10/28, Yates correction,  $p=0.03$ ).

### Conclusion:

Even in the absence of education to increase awareness and documentation of medication patches among nursing staff due to COVID-19, a change to the skin integrity check sticker available on wards significantly increased documentation of medication patches on skin integrity assessments.

### References

1) Lövborg H, Holmlund M, Hägg S. Medication errors related to transdermal opioid patches: lessons from a regional incident reporting system. BMC Pharmacology and Toxicology. 2014;15(1).

### Acknowledgements

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