



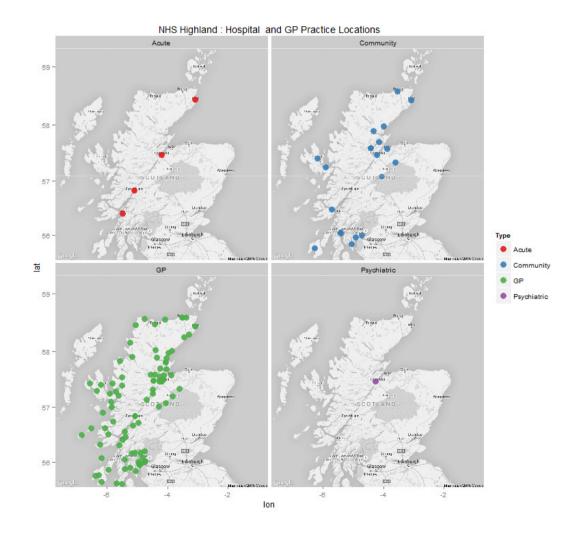






Medication Reconciliation: Story so far

4 Acute Hospitals since 2008 100 GP practices 2 Acute Mental Health units 1 Paediatric unit 7 Community Pharmacy sites (5 pharmacies, 2 dispensing practices)





Local NHS Highland Infrastructure





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Clinical Governance Committees



SPSP Senior Leadership Team

Medicine's safety sub-group

Community Pharmacy











2008-2012

2012-2016

2012-2016

2013-2016

2012 -2015

Local Delivery Groups Meeting's for Each of the Individual programmes

Measurement System for Process and Outcome Measure Reporting

Methodology: Model for Improvement and Measurement for Improvement







Primary care





SPSP – Primary Care

- Provide Safe and Effective Medicines Management in Primary Care.
- One piece of the 'safer medicines' workstream.
- Enhanced Service introduced May 2014, now year 2
- GP and Manager Attended Learning event
- Practices complete Medicines Reconciliation bundle.
- Provide evidence of process mapping and develop Protocol and Reflection sheet.











 Aim: 95% or > of GP Practices have Safe and Reliable systems for Medicines Reconciliation following Discharge by 2016:

Medicines Reconciliation Bundle:

Measure 1: Has the Immediate Discharge Document (IDL) been workflowed on the day of receipt?

Measure 2: Has medicines reconciliation occurred within 2 <u>working days</u> of the IDL being workflowed to the GP/Pharmacist?

Measure 3: Is it documented that any changes to the medications have been acted upon?

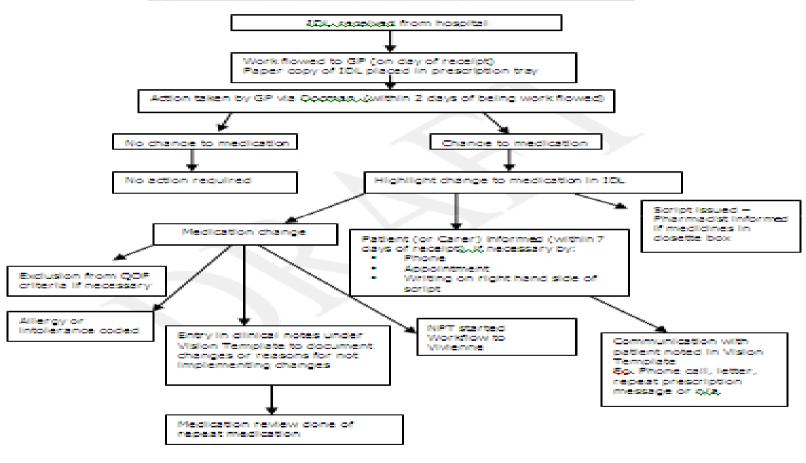
Measure 4: Is it documented that any changes to the medications have been discussed with the patient or their representative?

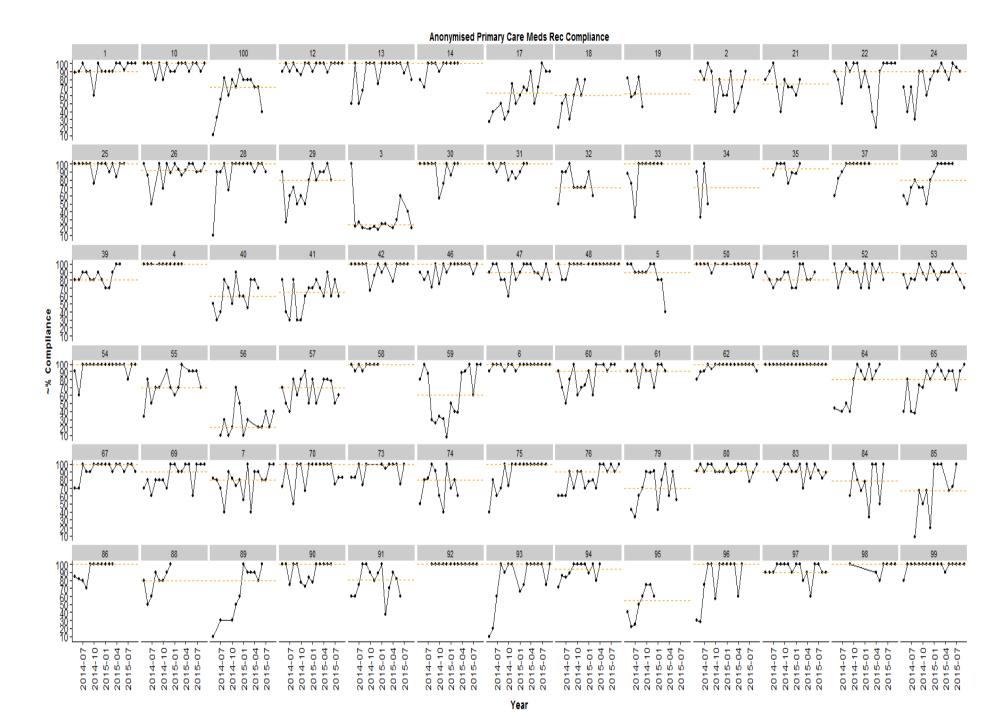
Measure 5 Have all measures been met (compliance with full bundle)?

• The CEL 03 (2013) Patient Safety in Primary Care establishes the requirement for NHS Boards to support the SPSP-PC work stream. Boards are required to report progress against these aims nationally.



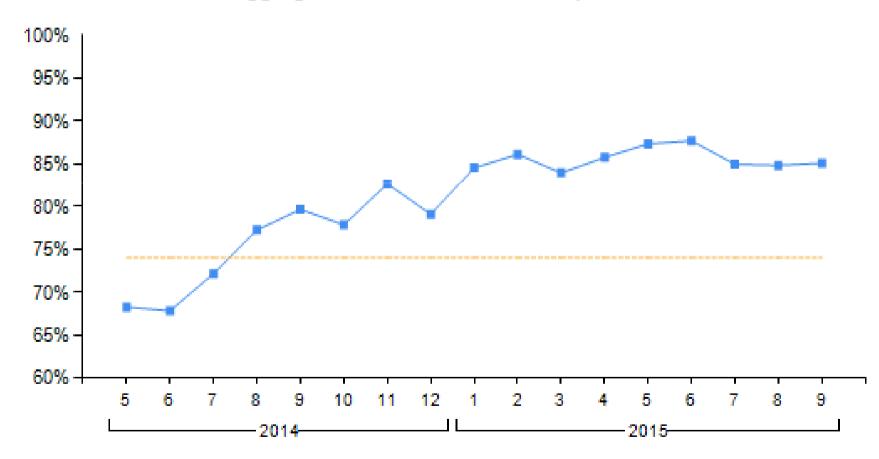
MEDICINES RECONCILIATION FLOWCHART







Aggregated Overall Bundle Compliance







What are we trying to accomplish? How will we know that a change is an improvement? What change can we make that will result in improvement? Act Plan Study Do

Successes and Challenges

Great to see data being reported, although some submissions dropping off

Champion practices identified

Local PC learning events

Need to develop a mechanism for shared learning - local and National

Lack of QI facilitator support and GP clinical lead



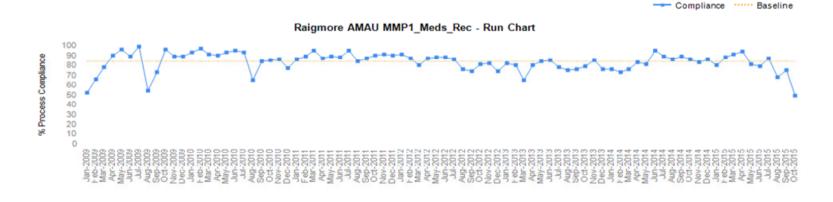


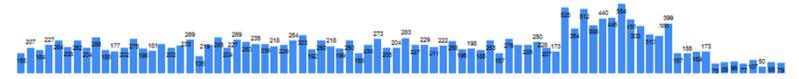


Acute Care



May contain CONFIDENTIAL and/or PATIENT IDENTIFIABLE data SPSP Run Chart Viewer





Monthly Denominators

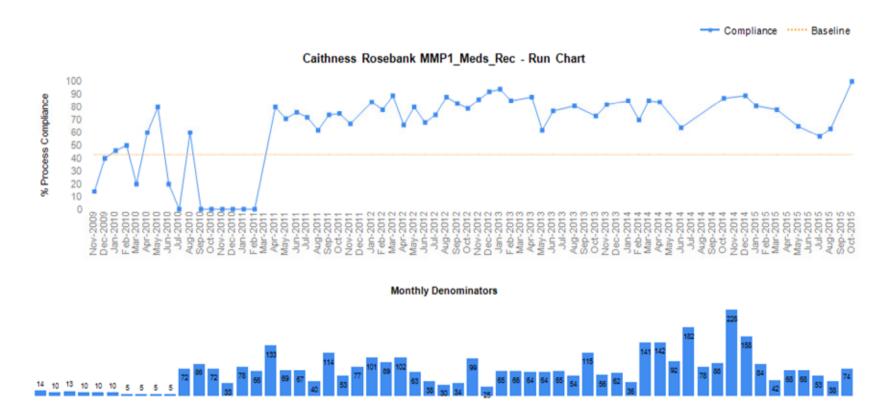
Positive Runs above Median

Start Date	End Date	Run Length
Jul 2009	Jul 2009	1
Oct 2009	Jul 2010	10
Oct 2010	Nov 2010	2
Jan 2011	Jul 2011	7
Sep 2011	Feb 2012	6
Apr 2012	Jul 2012	4
Jun 2013	Jun 2013	1
Nov 2013	Nov 2013	1
Jun 2014	Oct 2014	5
Dec 2014	Dec 2014	1
Feb 2015	Apr 2015	3
Jul 2015	Jul 2015	1





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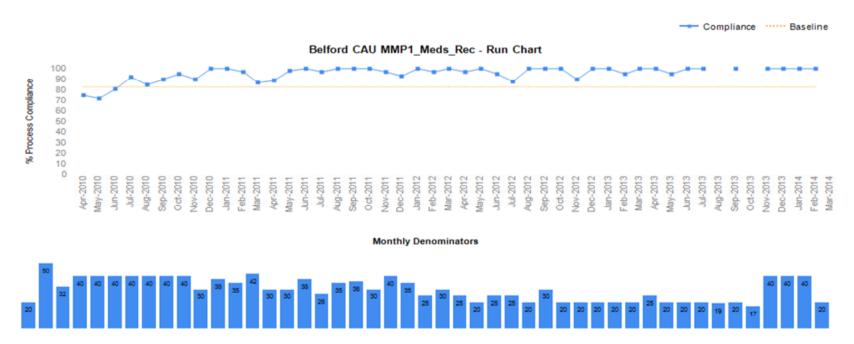
Positive Runs above Median

Start Date	End Date	Run Length
May 2010	May 2010	1
Aug 2010	Aug 2010	1
Apr 2011	Oct 2015	41





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Positive Runs above Median

Start Date		
		Length
Oct 2010	Feb 2014	41





	ATTACH PATIENT LABEL				NHS Highland
		Date docume	nt started:		
	GENERAL SU ENT & M		FACIAL		
	PRE-ASS ADMISSI	SESSME	NT AND		
	plete this section in clinic or office on pre-assessed patients (e.g. adm				
	patient is participating in the ANCED RECOVERY PROGRAI	MME (ERAS)?	YES	NO _	
This	patient has been pre-assessed	d?	YES	NO 🗌	
Lead R	leviewer – Mr K Waller, Consultant Surgeon				V280711



c Inpatient Emergency CAD.pdf - Adobe Reader Tools Window Help Find Drug History (Medicines Reconciliation) Remember: The commonest error leading to patie Venous Thromboembolism Prophylaxis Assessment Protocol use for patients aged 16 and above Details: Day case local anaesthetic procedure without sedation, children under Mandatory Three Source(s) of History: Plus one below if ECS unavailable or the age of 16 & pregnant women admitted directly to the obstetric unit. Unobtainable Checked inappropriate for use: 1. Assess Risk Patient ● □ Emergency Care Summary* Age > 60 ☐ ☐ GP Referral Letter Label Obesity (BMI > 30kg/m²) Patient or Relative ☐ GP Surgery Active cancer or cancer treatment Anticipated significantly reduced mobility for 3 days or more ☐ ☐ Patient's Own Drugs ☐ Other Hospital/Nursing Home Drug Chart Known significant medical co - morbidity e.g. symptomatic heart failure, chronic respiratory disease, chronic inflammatory condition Other: Thrombogenic medication i.e. hormone replacement therapy, oestrogen DO NOT containing oral contraceptives, tamoxifer, raloxifene, cyproterone 3 ADMISSION MEDICATION: NONE □ Or: Note: Unless indicated to stop/hold, medication should be administer anti-coagulant if a continued on daug chart/discharge. Personal history of, or first-degree relative with a history of VTE (NB Check for specialist prescribed medicines e.g. chemotherapy lumbar puncture, epidural, Confirmed or suspected sepsis Name, Form/Route Comments (if medication held, stopped or Acute surgical/gynaecological admission with inflammatory or :hanged) & Start Date if short course (if known) intra-abdominal condition Continuing pregnancy or < 6 weeks post parturn Extensive varicose veins Femoral vein catheter Lower limb plaster cast Orthopaedic trauma including pelvic, multiple long bone, hip fractures, lower limb fractures and dislocations Any higher risk surgical procedure (any surgical procedure not defined

Previous Adverse Effects During Anaesthesia? Previous Adverse Effects of Analgesia?	NONE	Or:	
Steroid Use in the Past Six Months?	NONE	Or:	
S Info. unavailable Adverse reaction	ns / Allergi	es (This section is alway	s mandatory)
No Known OR Drug/Substance:	ns / Allergi Reaction:	es (This section is alway Drug/Substance:	Reaction:
No Known Drug/Substance:			

Sign:

Sign:

4 NON-PRESCRIPTION MEDICATIONS, HERBAL MEDICATION AND ILLICIT DRUGS: NONE

bax belaw	Severe pe
Lower risk surgical procedures e.g. Excision of skin lesion isoft tissue (incl. head neck and face) larymposcopy, vasectomy, release of campa manipulation of fracture, injection/leapination of joint, hysteroscopyligas colonoscopy and biopsy, endometrial abletions, vulvet procedures and	tronel, Cellultis / Dermetitis / Dermetitis / Major leg i
Guide: intranet policies library	No ticks Anticoagulant NOT required So to step 3 Acute stro No Prescri
2. Assess Contraindications (tick all that apply)	
Active bleeding	
Acute head injury	4. Indica
Acquired bleeding disorders (e.g. acute I'ver failure)	
Full anticoagulant therapy at time of admission (excluding anti- platelet agents)	Platelet c
Acute stroke within 14 days	eGFR res
BP above 230/120 mmHg (systolic or disstolic)	1
Thrombocytopenia (<75 x 10 ⁹ /L) result date	5. Sign a
Untreated inherited bleeding disorders i.e. haemophilia or yon Willebrand disease	Name
Head & neck/ENT surgery: thyroid, parethyroid, parotid, tonsil, middle ear or nasal surgery	Signature
Ophthalmic surgery - all procedures	Date
Dental Extractions	
Uralogy - TURBT, TURP	Commen
Neuro-surgery : all procedures	
Spinal surgery : all procedures	
Non operative high bleeding risk procedure e.g. liver, renal & lung biopsies & all radiological guided biopsies	
Prescribe ENOXAPARIN 40mg daily No ticks 1 or n ticks	noire
If eGFR is <30 or body weight <50kg DO N	OT Name :
Reduced dose of ENOXAPARIN 20mg daily presc (see desage instructions below)	ribe Signature :
	Date:

spinal or regional anaesthetic block is expected within 12 hours or has been performed in the previous 4 hours	
TED Stockings Assess exclusion criteria	
Orthopaedic or medical patient	
Pulmonary cedema (e.g. heart failure)	Г
Severe peripheral neuropathy	1
Severe peripheral arterial disease	1
Massive leg oedema	1
Cellulitis / ulcers	1
Major leg deformity	
Acute stroke within past 14 days	Ł
No ticks Prescribe TEDS 1 or more ticks TEDS not required Do not prescribe	
Indicate below which results were available (SCI store must be checked)	
Platelet count Available Not available Date GFR results Available Not available Date Date	
5. Sign and date	
Name	
Signature	
Date Time	
Comments / Variance to protocol	
Name :	

1800 administration ose straight away, then 1800 thereafter 11

Yest SPSP VTE Group Draft 9 Medical and Emergency

Medical illustration July 2015

Time:

COMPLETED Name:

Owner: Mr Ian Rudd, Pharmacist

Lead Reviewer - Mr B Wolf, Consultant Surgeon 10

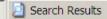




Date:

Date:

Grade



BY -

Reviewed by

pharmacist -



- A consistent team achieves improved reliability
 - Active Pharmacy input
 - Pre-assessment nursing team
- Medicines reconciliation form being placed within CAD

- Lack of medical leadership support
- pressing junior doctors to do it better whilst at the same time expecting them to discharge patients sooner

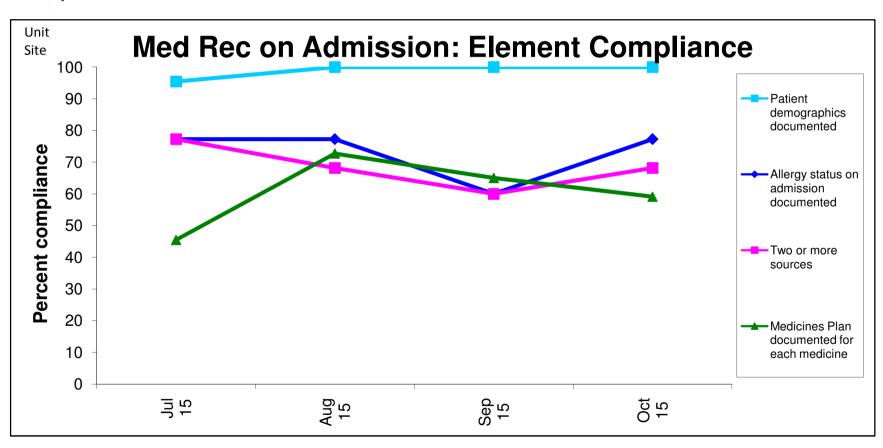


Mental Health





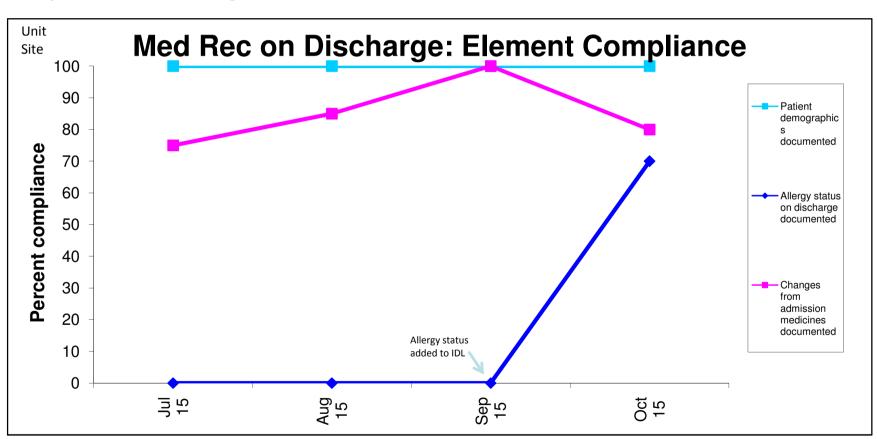
Mental Health, New Craigs Hospital Compliance with Admissions Criteria:







Mental Health, New Craigs Hospital Compliance with Discharge Criteria:







Successes and Challenges

- New Craigs Hospital was the first mental health hospital to achieve full roll out of admissions and discharge medicines reconciliation.
- New Craigs is now testing the use of CMO letter criteria in a mental health setting.





Community Pharmacy





Community Pharmacy

No data yet

Due to start collecting data after learning event in November 2015





Community pharmacy innovation

Community pharmacists given access to SCI store so they can view IDLs after hospital discharge (via Caldicott Authorisation)





Next steps.....



- National picture
- Further collaboration between programmes whole system approach
- Other activity we are still to work on in is the quality of meds rec at discharge
- Person-centred is there more we can do?









"Coming together is a beginning. Keeping together is progress. Working together is success."
~ Henry Ford



