Reducing Medicines Harm Across Transitions

Medication Reconciliation WebEx Series 2016

Thursday 21 July 2016
3pm–4pm

Presented by:
NHS Forth Valley

#SPSPMeds2016 @SPSPMedicines

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SCOTTISH PATIENT SAFETY PROGRAMME

MEDICINES

SPSP Medicines

July 2016 WebEx

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Welcome

Support the learning and sharing between boards regarding medication reconciliation as a whole system

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A few WebEx etiquette points for our meeting today:

- If you are not presenting your phone is automatically on mute
- Be open to learning and sharing
- Please use the chat box to participate in the discussion during the presentation, and type in any questions you might have
- There will be time at the end of the WebEx for Q and A with the presenting board, and we will be monitoring the chat box

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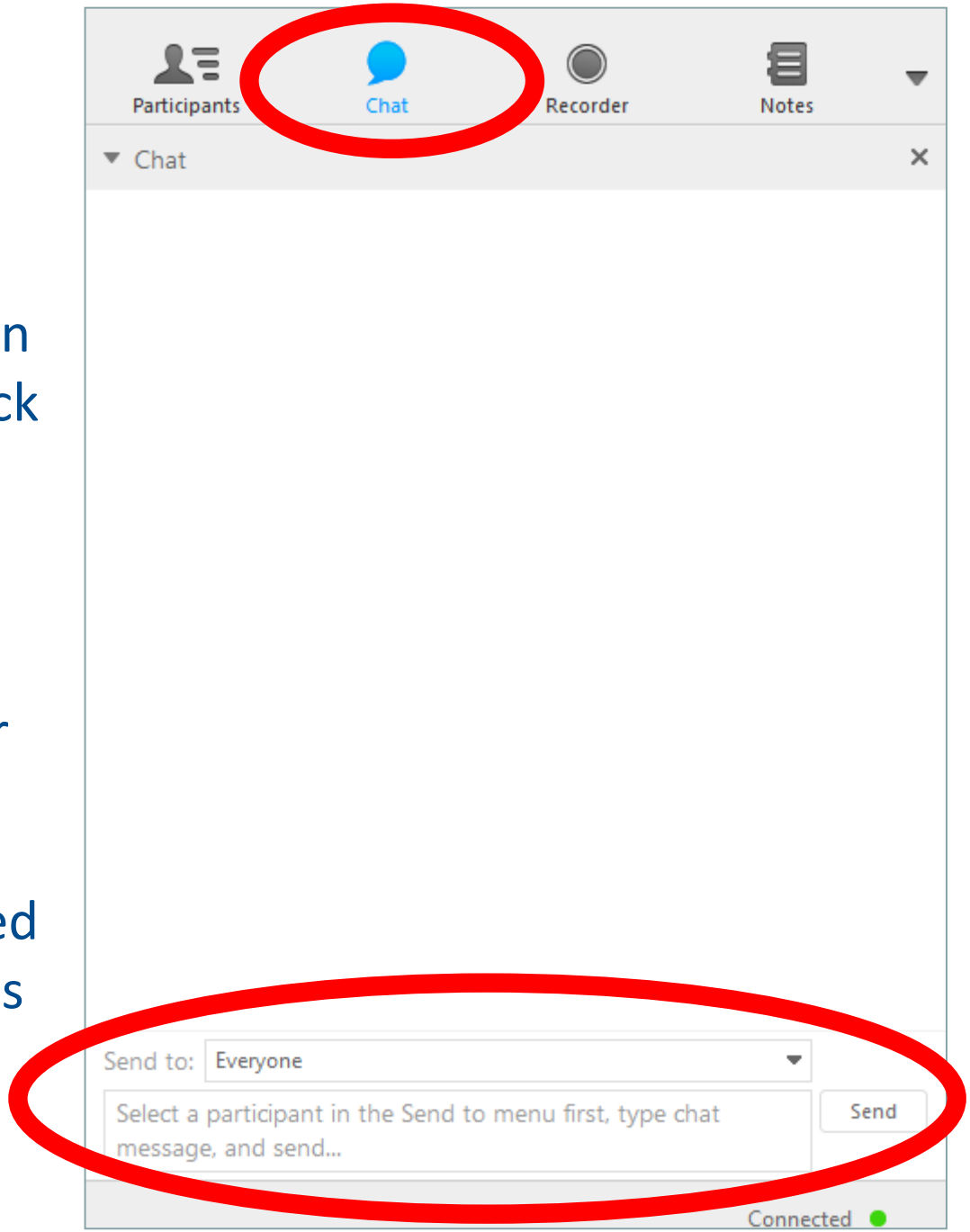
If you want to get involved in the conversation, please click on the Chat icon circled in red.

Select **Everyone** from the drop down menu, type your message then click send!

This WebEx is being recorded as a resource for SPSP teams

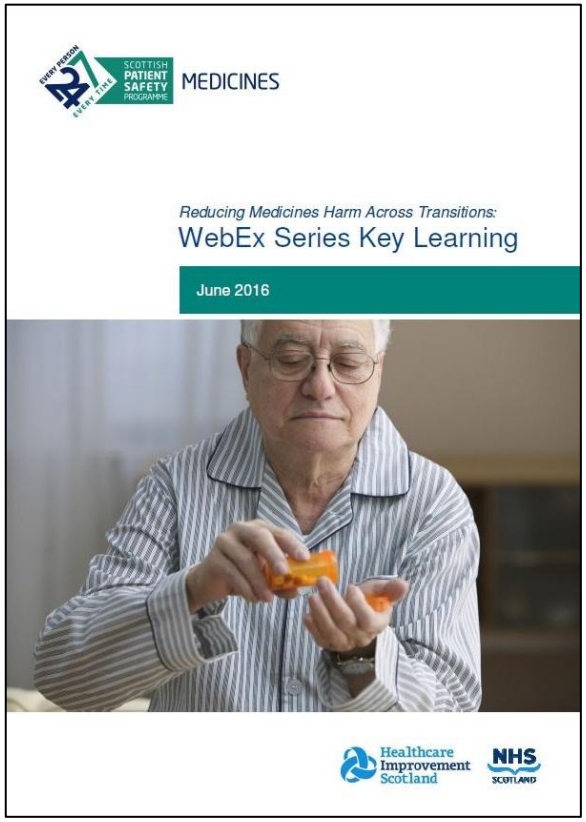


SCOTTISH PATIENT SAFETY PROGRAMME MEDICINES

From previous 3 WebExes:

- April 19th (NHS Ayrshire and Arran)
- May 19th (NHS Fife)
- June 16th (NHS Grampian)

National Level
Medication reconciliation is a complex clinical process
Senior medical engagement is key to success in the acute care setting
Boards are looking at ways to capture feedback across points of transition regarding the quality of information being communicated



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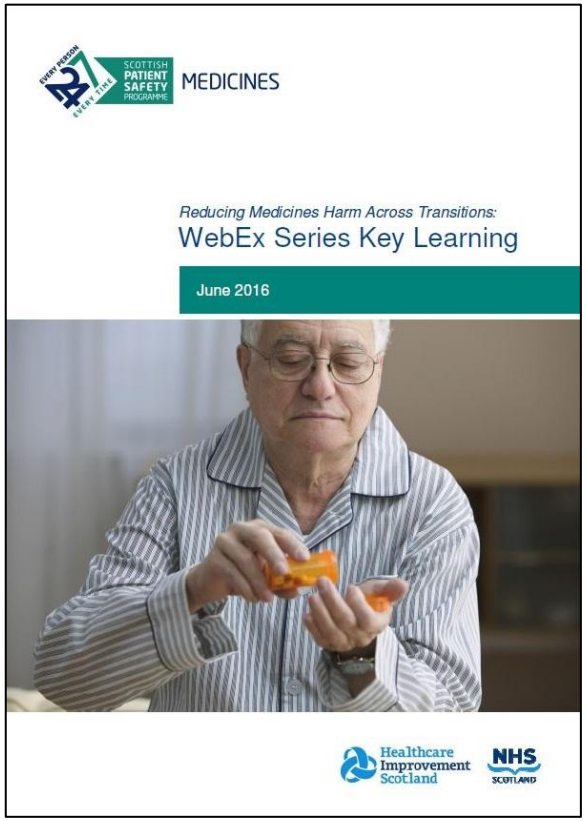
NHS Grampian (June 2016)
Development of structured ward rounds and admission booklets are increasing compliance
NHS Grampian is at various stages of medication reconciliation improvement across the whole system
Would be keen to hear about Boards who are using electronic records



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NHS Grampian

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MEDICINE RECONCILIATION IN FORTH VALLEY ROYAL HOSPITAL

Scott Hill

Acute Lead Pharmacist

NHS Forth Valley

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Medicines Reconciliation - process

- At admission
  - Accurate drug history from 2 sources
  - Document allergies
  - Document a plan for each medicine
  - Transcribe drugs on to kardex

- At Discharge
  - Medicines reconciled for discharge
  - Changes to medication clearly documented
  - Allergies documented
  - Clinically appropriate IDL generated

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Medicines reconciliation – Measuring the performance

- For admissions into our admissions wards
  - As per the CEL
  - 20 sets of random notes audited each month
  - Check for demographics, allergies, 2 or more sources, plan for each medicine, accurate list of medicines, accurate transcription of clinically appropriate medicines
- For admission for orthopaedic/ED admissions
  - Notes are selected in the ward over the month
- For discharge measurement
  - Same set of randomly selected notes use for admission wards
  - Check for demographics, allergies, documented changes to medicines, accurate prescribing of clinically appropriate medicines

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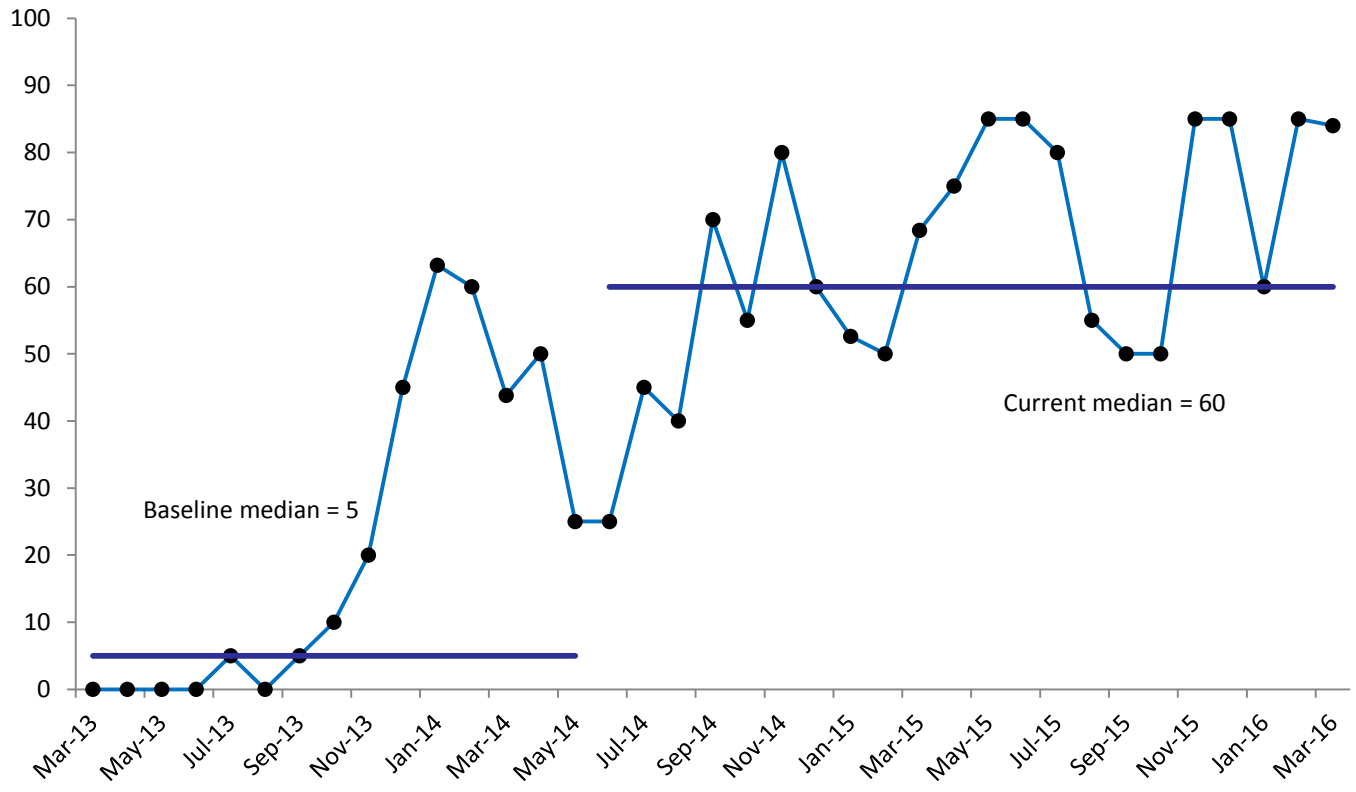
Our performance – Admission wards
% of patients with meds rec within 24 hours



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Performance – Admissions wards

Percent of patients with an accurate in-patient prescription chart within 24 hours of admission

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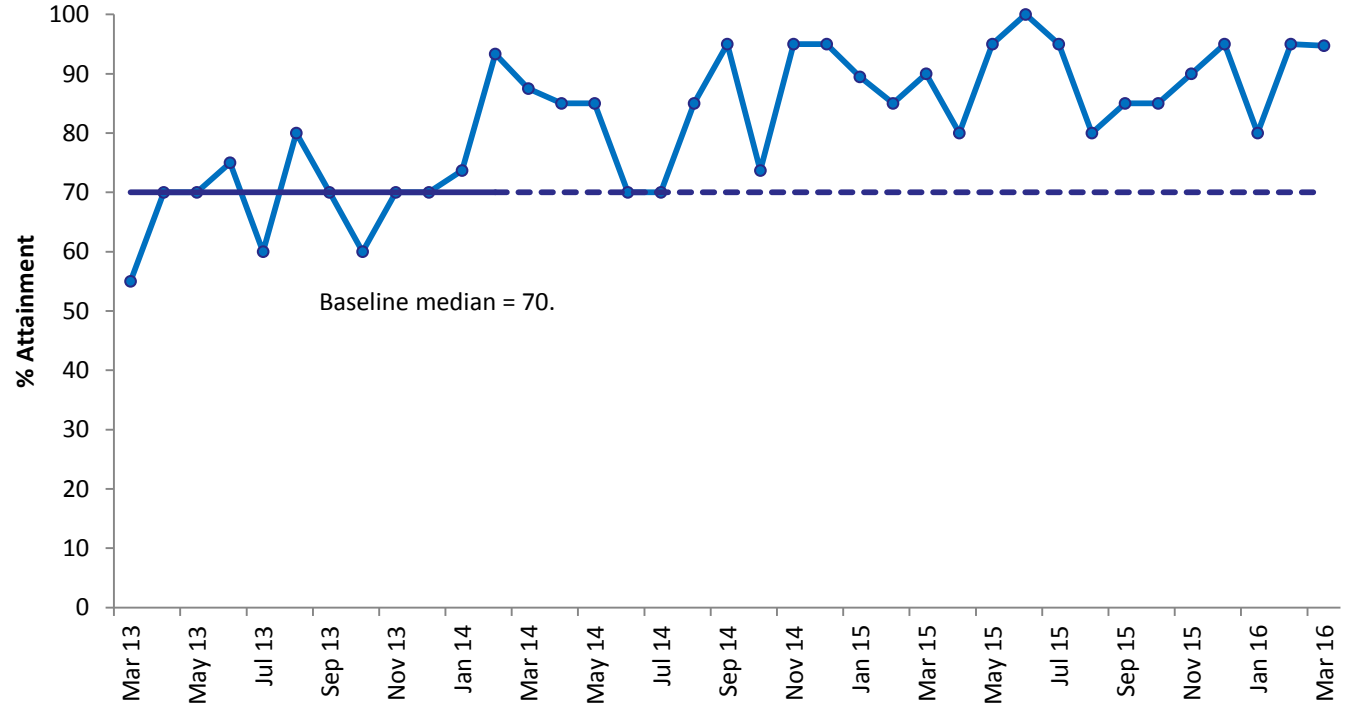

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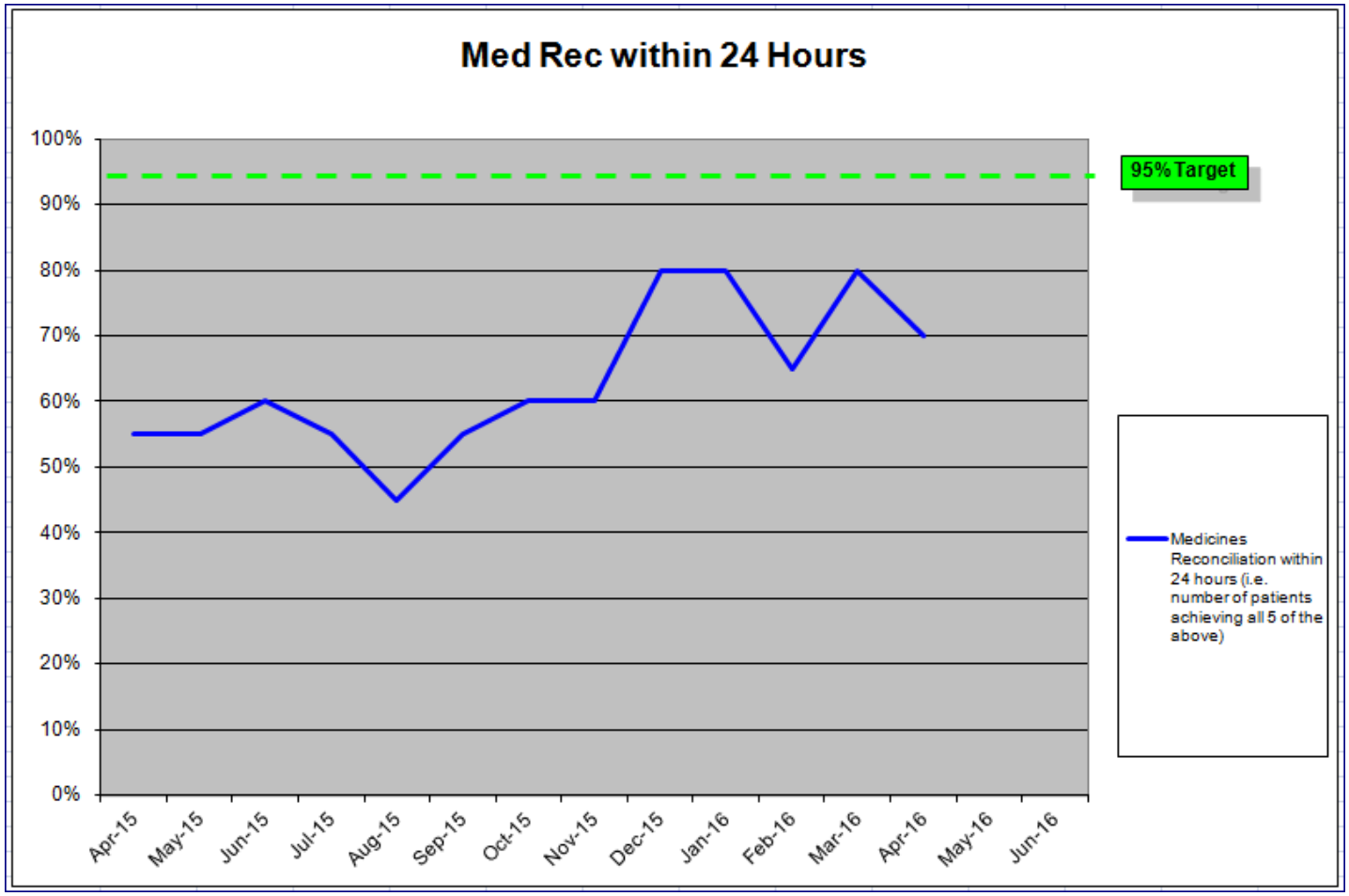
Performance – Orthopaedic ward



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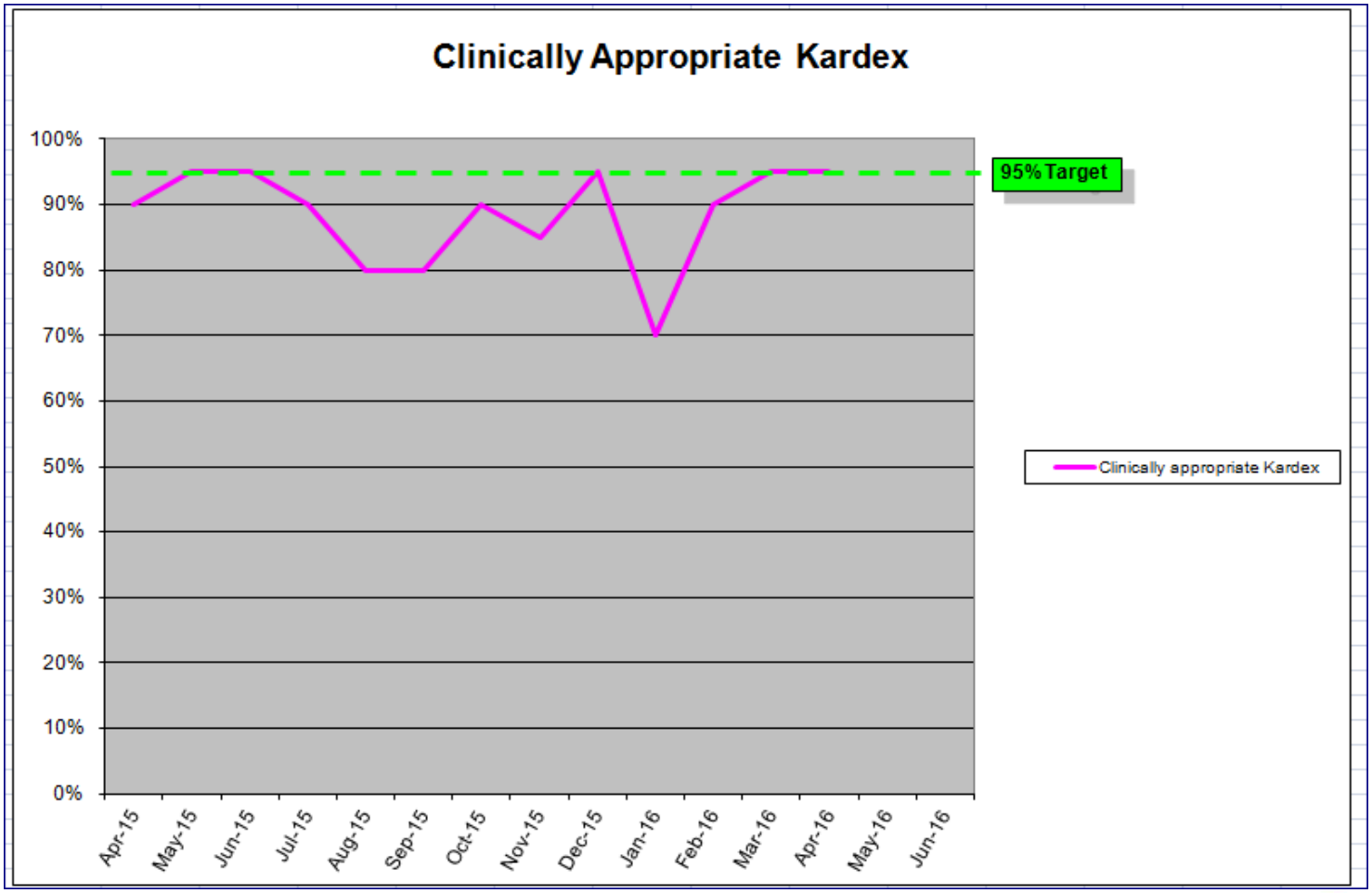
Performance – Orthopaedic ward



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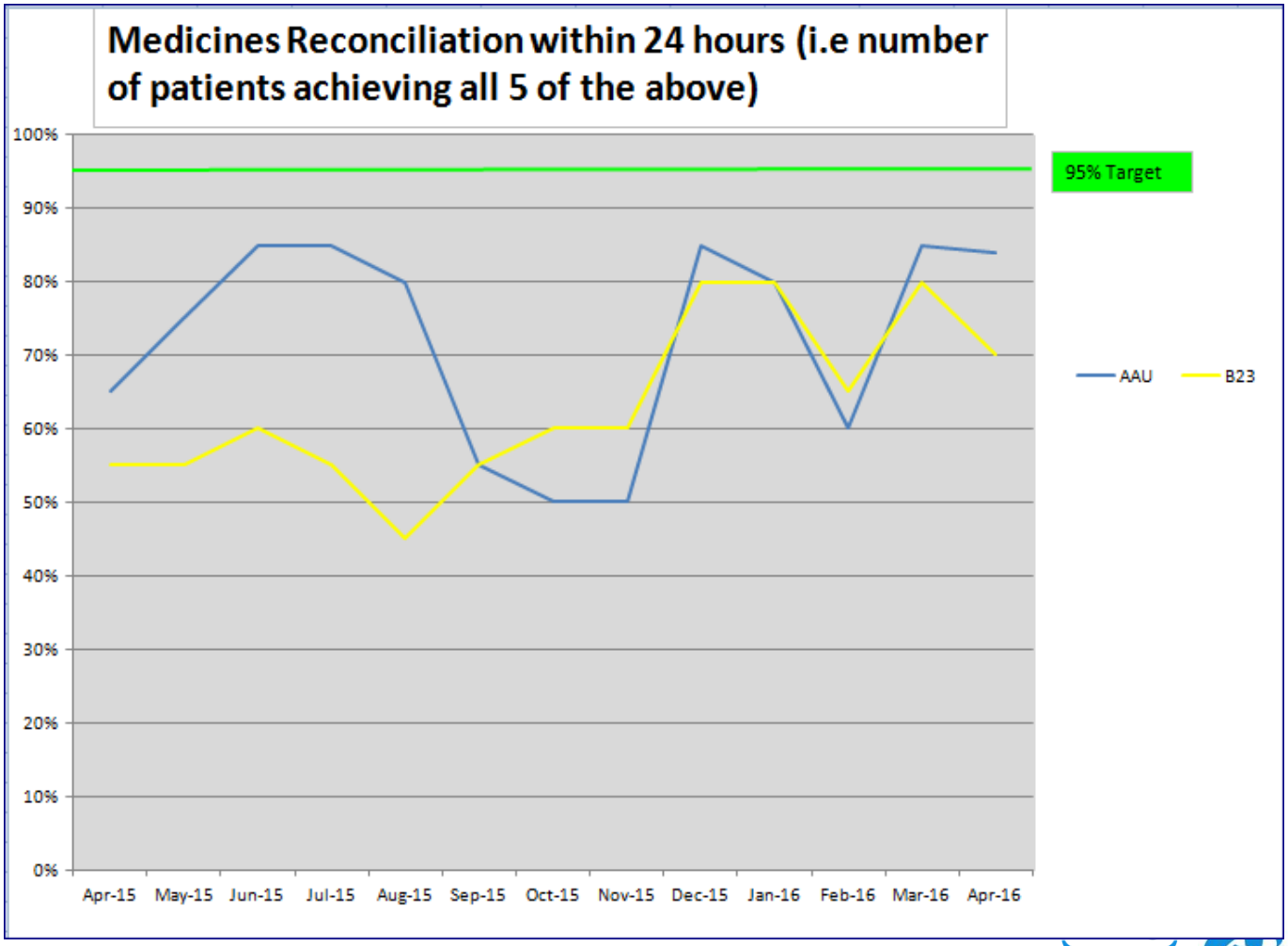
Comparison of admission ward and orthopaedic ward



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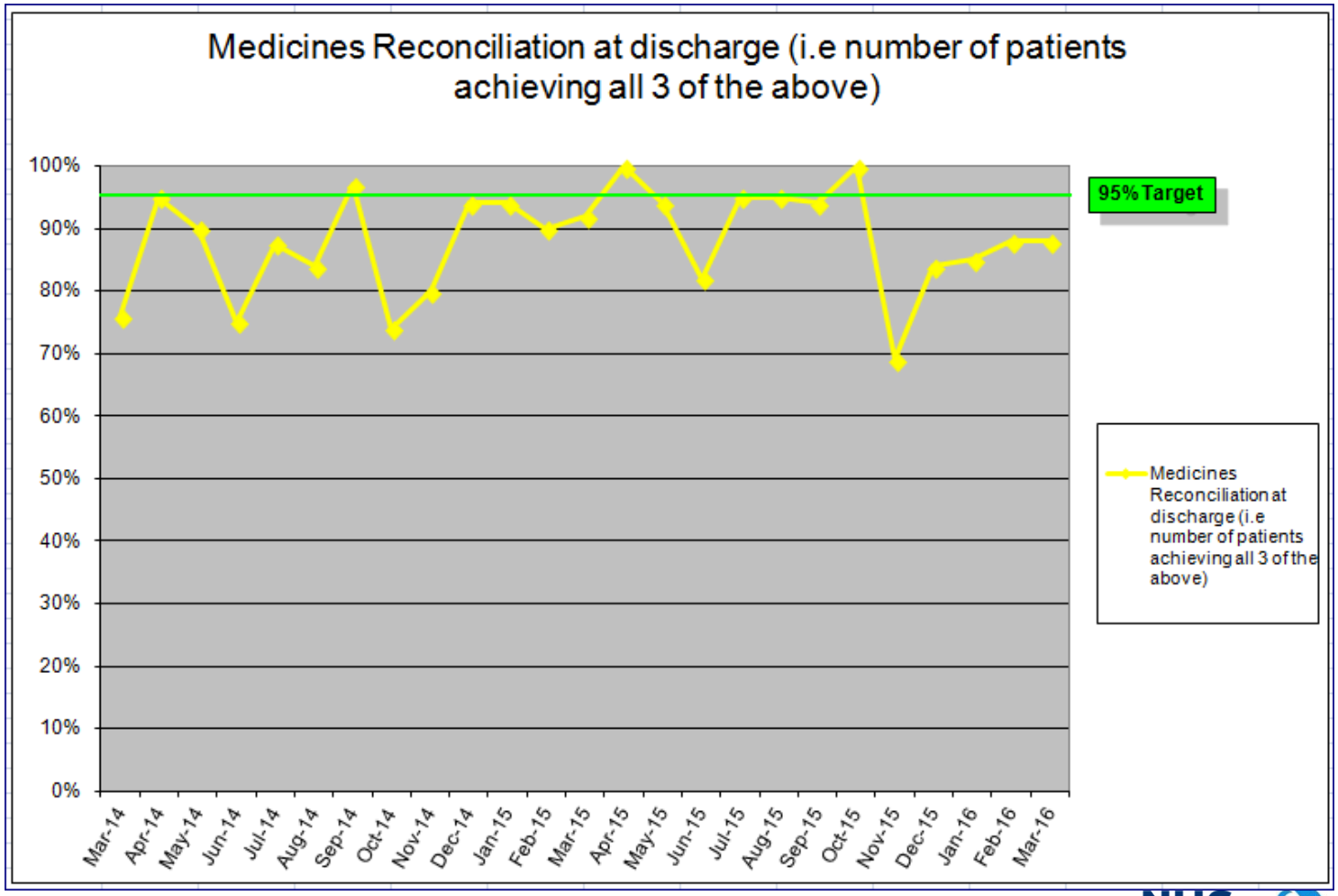
Performance - discharge



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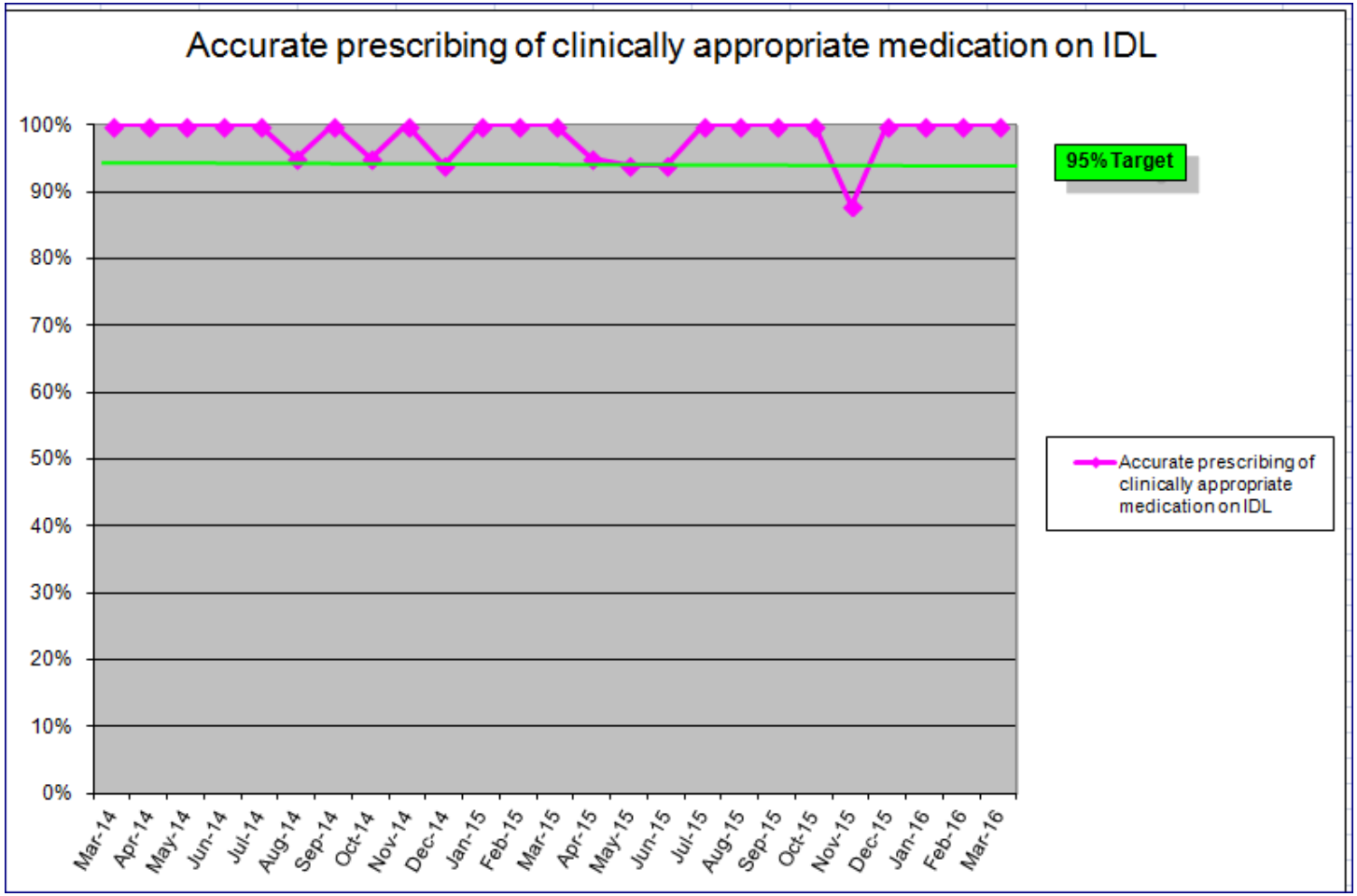
Performance - discharge



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Successes and learning

- Appropriate kardex on admission
- Engagement of acute care consultants
- Monthly review at Acute Care Quality and Risk meeting
- Consultant champion
- Weekly discussion at Admission unit handover
- Standing item on Acute DTC
- Feedback by Consultant Champion to individuals
- Discharge performance – 100% for 3 months of accurate IDL
- Orthopaedic wards – performance of appropriate kardex on admission
- Engagement with orthopaedic medical staff (AMD and surgeons and Consultant champion

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Challenges

- Maintaining momentum with competing priorities
- Maintaining results with changes in medical staff

Future challenges

- HePMA – now live in our admissions wards – expected impact on performance
- But benefits in numerous ways as we establish our processes and roll out of the rest of the hospital

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MENTAL HEALTH

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Medicines Reconciliation in Mental Health

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We started in 2012 looking at...

- Presence of Med Rec form in patient notes.
- Inclusion of medicines, name/form/dose/frequency
- Future plan for medicine documented (Continue/stop/amend)
- More than one source of information used
- Completion of form within 72 hours of patient admission
- Signature of person who completed form
- Designation of staff member completing form
- Review of form by pharmacist/medic
- If the Kardex correspond to the medicines reconciliation sheet?
- If there were any episodes of incomplete or incorrect prescribing during the first 72hours of admission

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It's everyone's job

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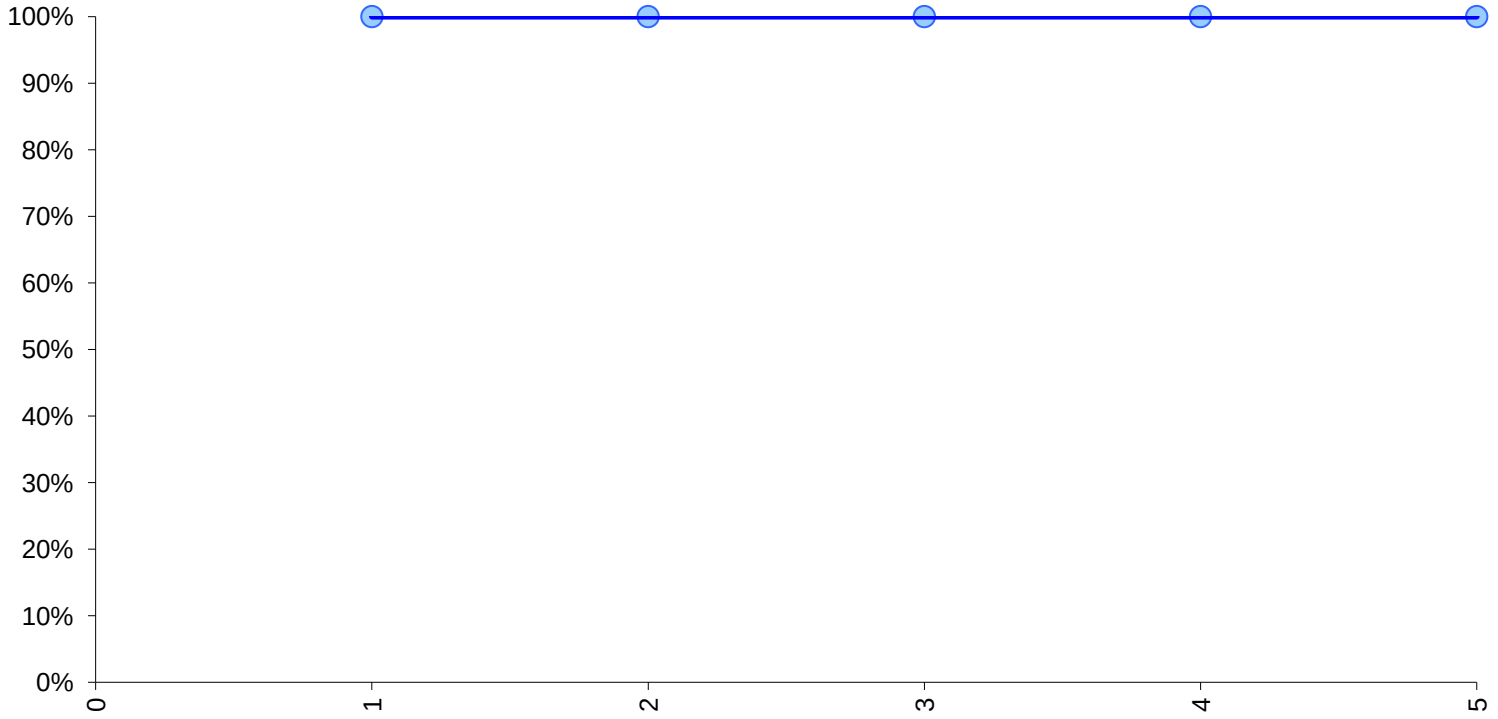
Medicines Reconciliation Results

Medicines Reconciliation Form in Patients' Notes



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Bundle 1

- Education
- Engaging staff
- Engaging managers

Bundle 2

- Review of paperwork
- Prompts – big ones
- Discipline-specific direction

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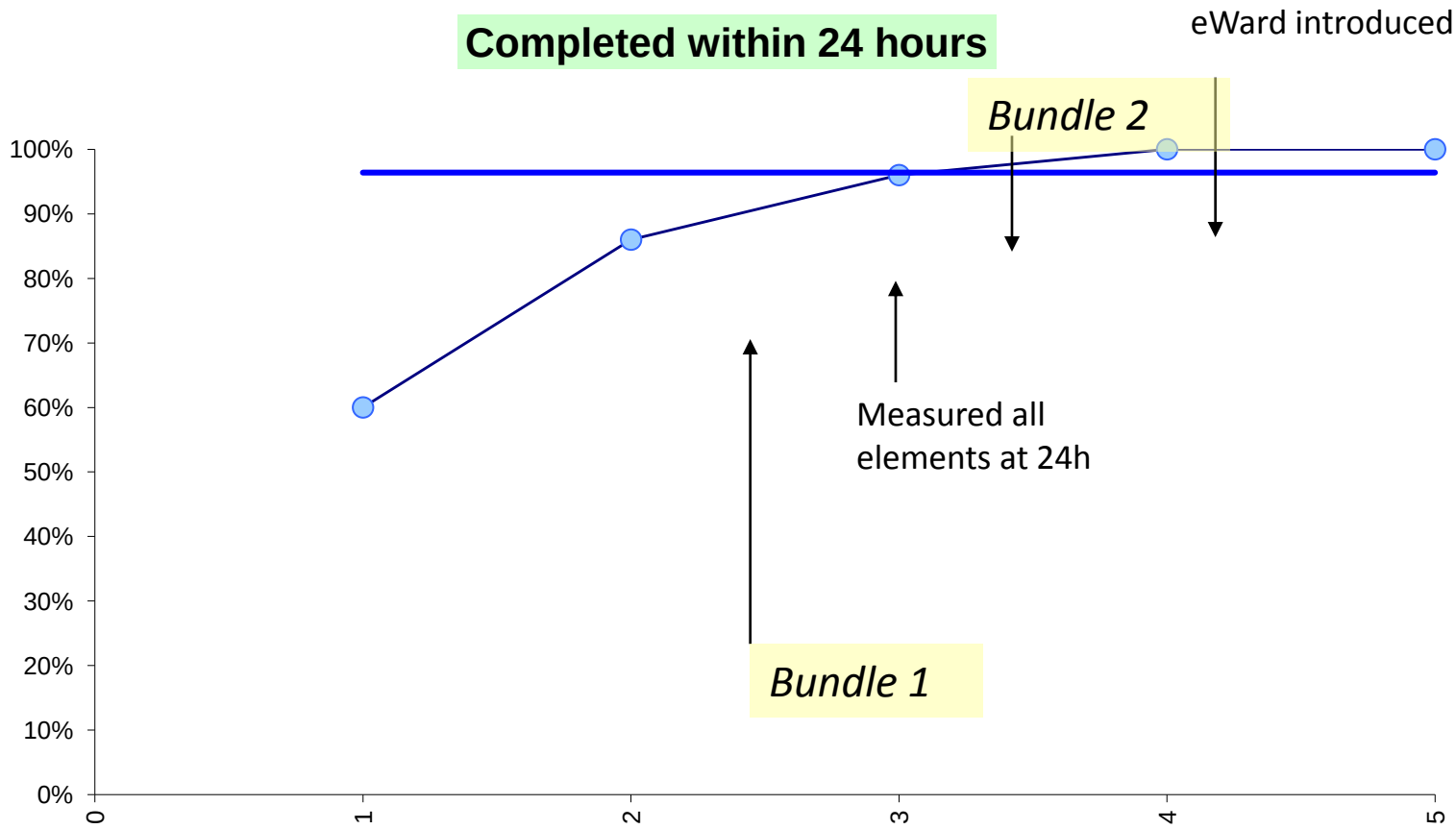

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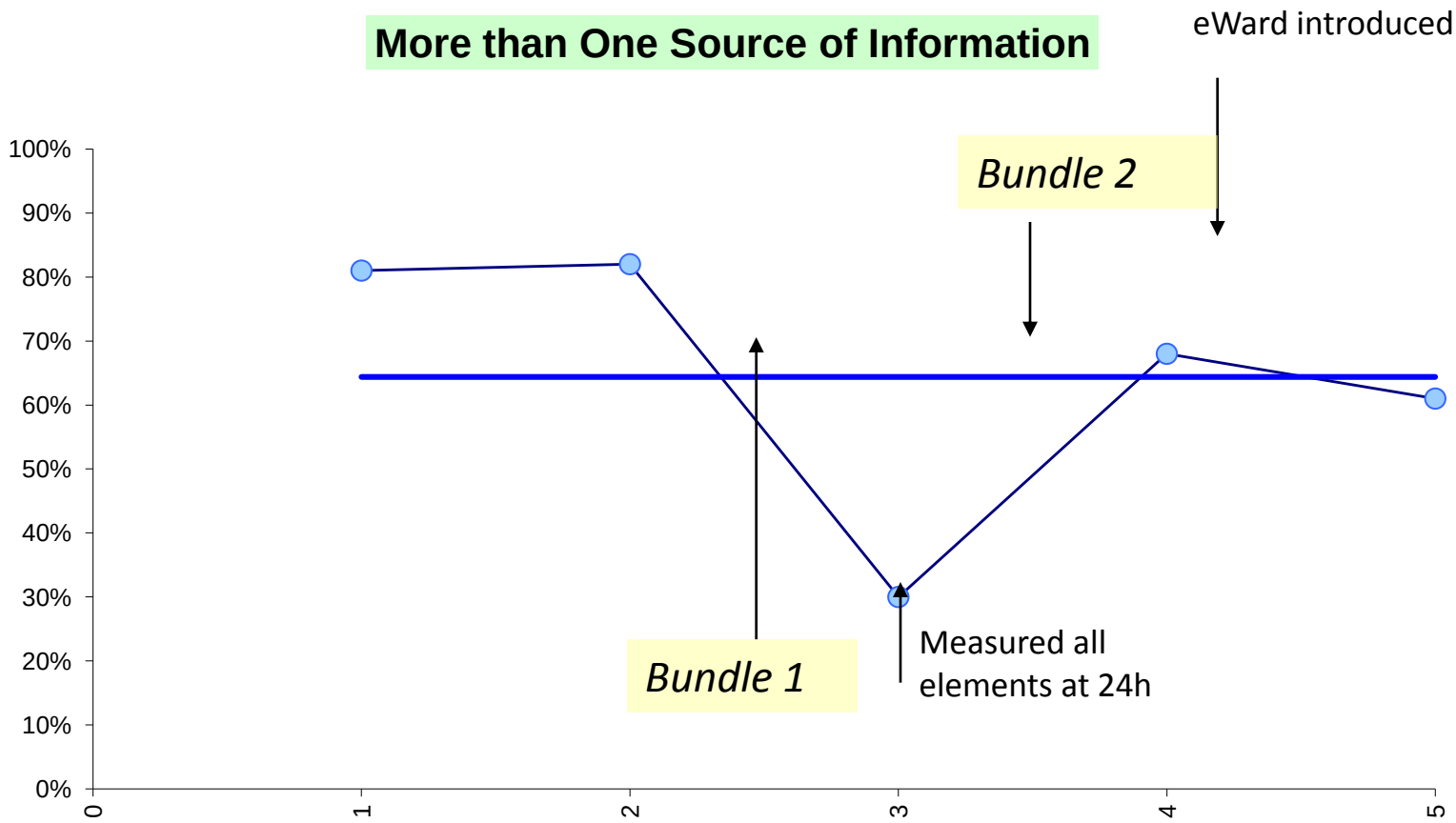
More than One Source of Information



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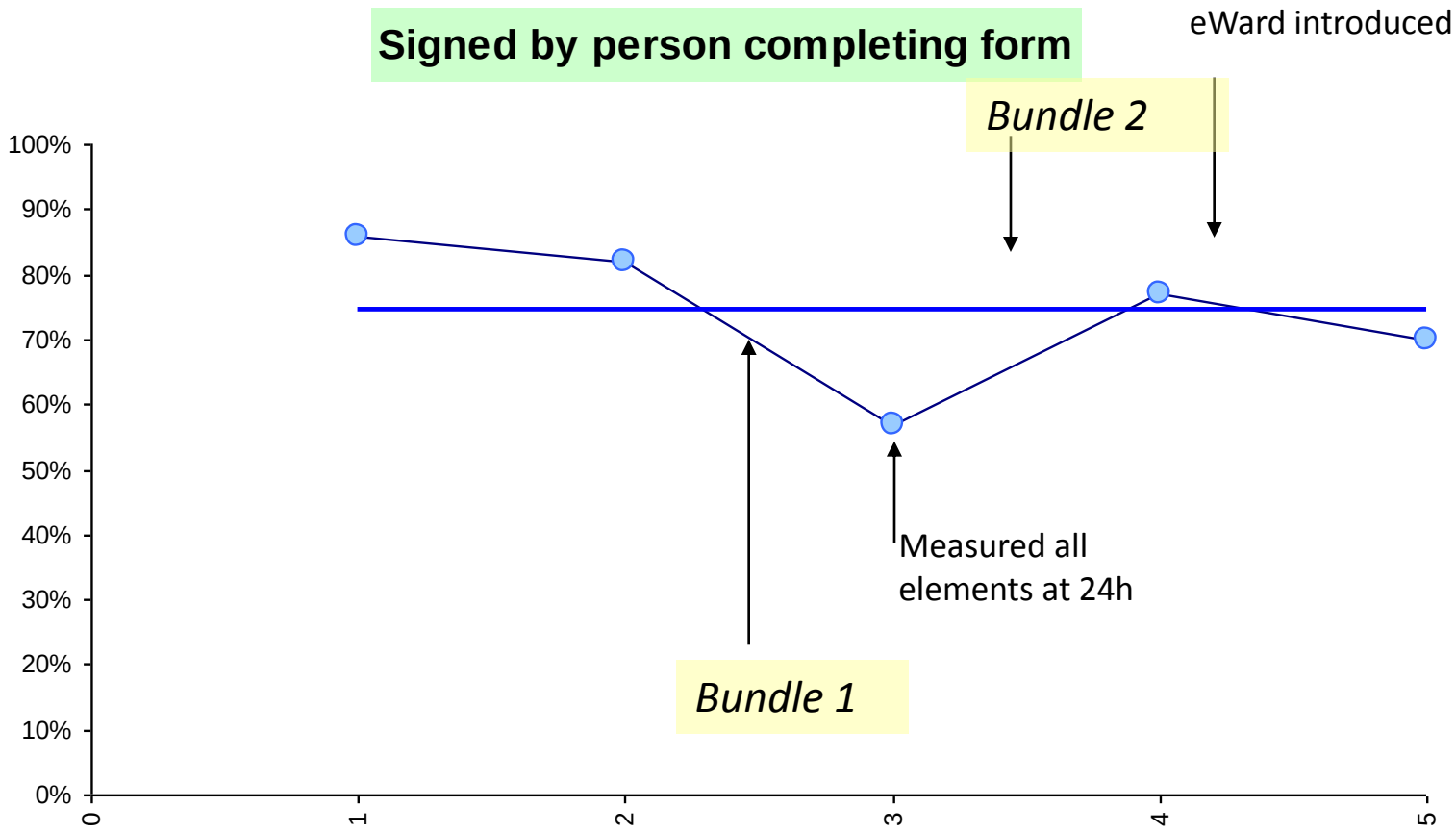
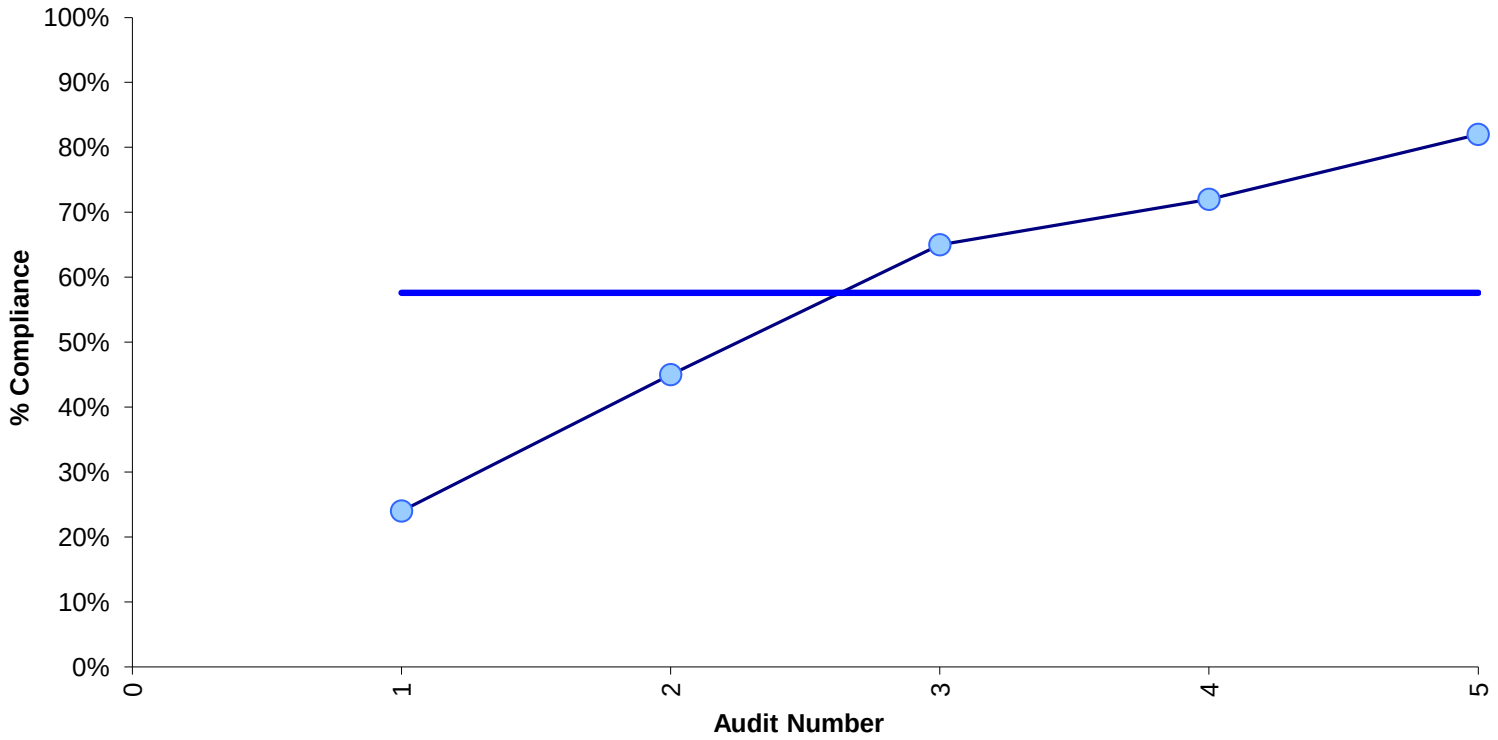

Signed by person completing form
eWard introduced
Bundle 2
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0
1
2
3
4
5
Measured all elements at 24h
Bundle 1

Medicines Reconciliation Results

Plan for Medicines Documented



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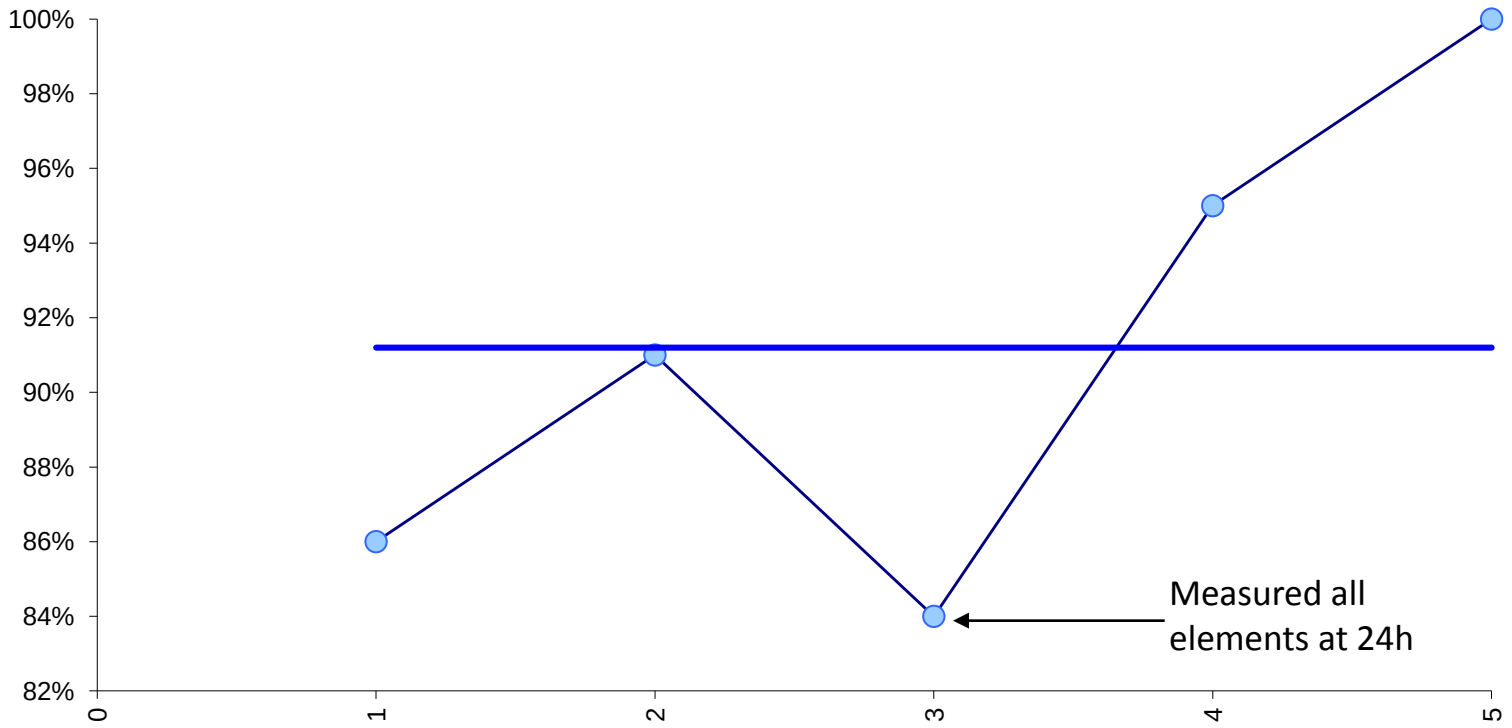
Medicine Name, Dose and Frequency Identified



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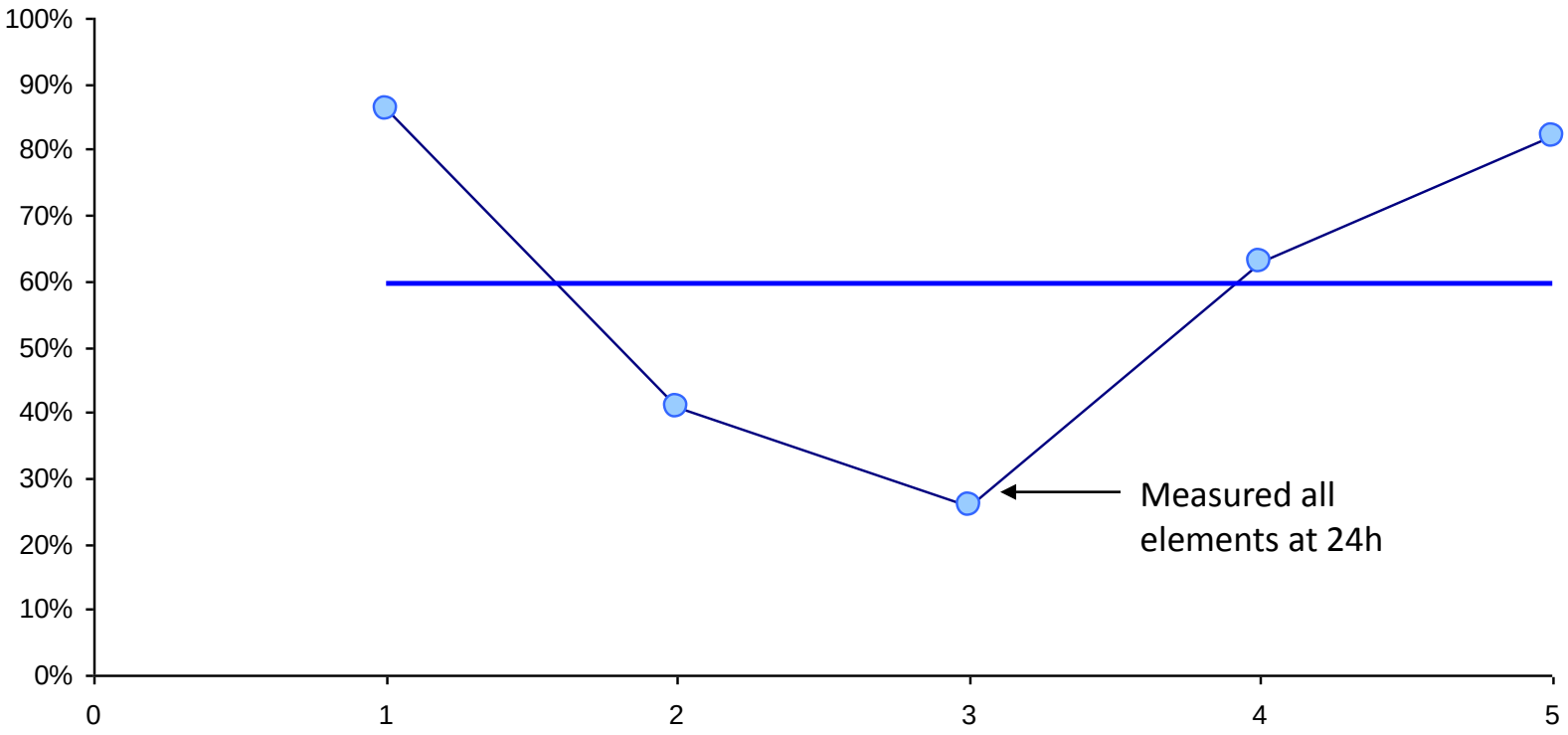
Checked By a Pharmacist or Medic



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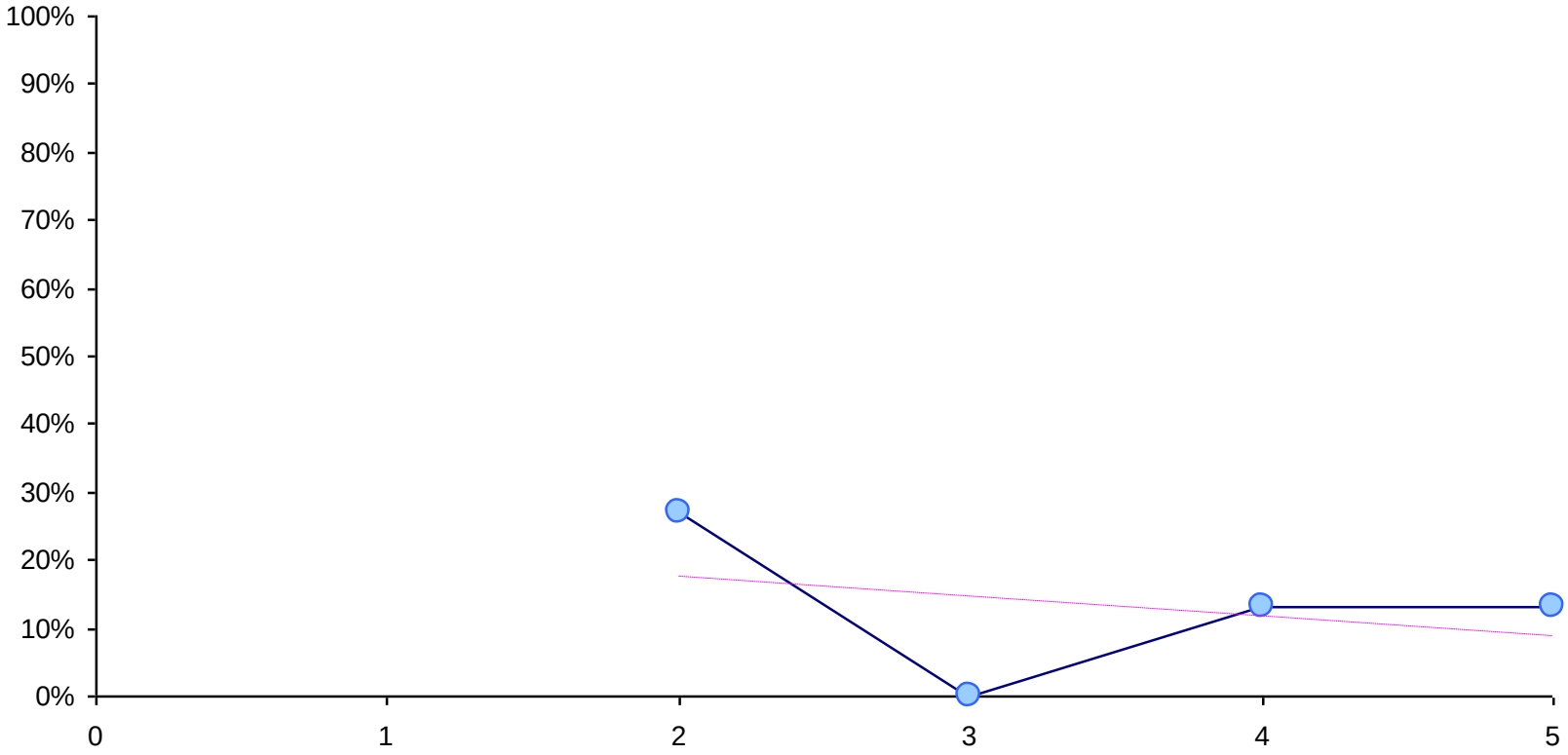
Incorrect or Incomplete Prescribing



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Lessons Learned

- We learned more about the importance of multidisciplinary teamworking in management of medications.
- We also learned about potential barriers to 100% medicines reconciliation, as we were able to identify specific areas that did not meet 100% compliance. This allowed us to tailor local interventions.
- **It is practicable and feasible to bring about change using low-cost, efficient methods including training and visual prompts.**

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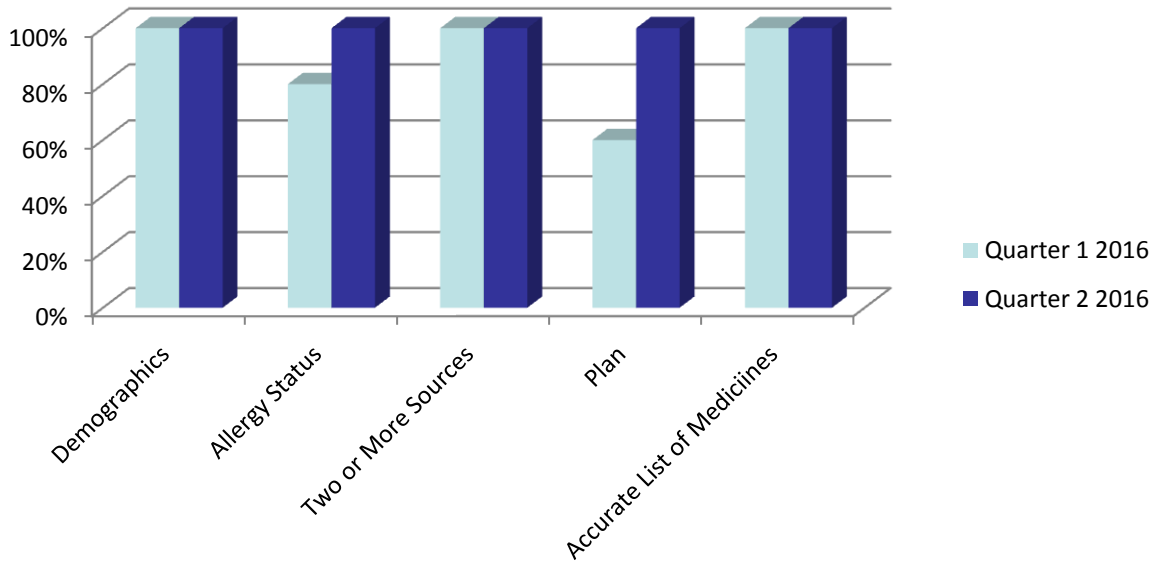
Where we are in 2016

- We now audit quarterly as medicines reconciliation is imbedded



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Medicine Reconciliation Scheme for Community Pharmacy in Forth Valley

Carole Smith
Community Pharmacy Champion
NHS Forth Valley

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Medicines Reconciliation in Community Pharmacy - process

- Following discharge a report is sent electronically to the nominated community pharmacy.
- The report is reviewed and compared to the list of medication previously dispensed for that patient.
- Discontinued medication awaiting collection is not issued.
- The first prescription received is checked against the report and any discrepancies are investigated.
- Any changes to medication are discussed with the patient or carer to check understanding and answer queries.

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Medicines reconciliation – care bundle

1. Was the PCPR reviewed and any changes documented within 2 working days of receipt?
2. Were the dispensed items checked and any discontinued/amended items removed?
3. Where the first prescription was received within 4 weeks, was it checked against the PCPR?
4. If discrepancies were noted, were these investigated and a current list of medications agreed?
5. Was the current list of medications shared and discussed with the patient/carer?
6. Were all of the above measures met?

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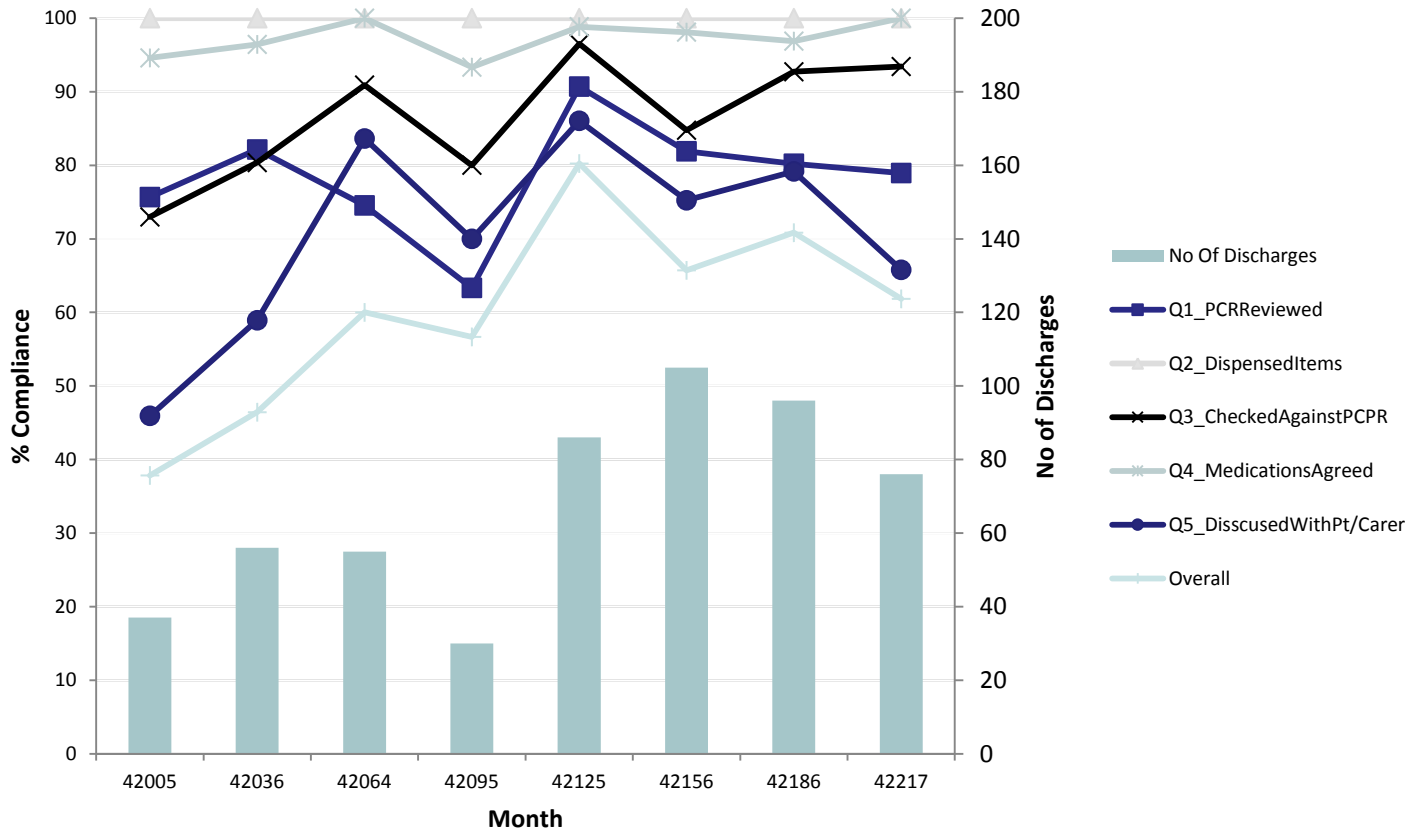

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Successes

- 60% aggregate median overall bundle data compliance.
- Dispensed items were always checked and discontinued items always removed.
- Community pharmacies have involved pharmacy team members and GP surgeries to establish communication pathways to undertake medicine reconciliation.
- Overall communication has increased and improved across the primary and secondary interface.

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Challenges

- Locum pharmacist awareness/engagement.
- Pharmacy Care Plan Report (PCPR) reviewed and change documented in 2 working days.
- Opportunities to discuss medication changes with all patients or carers.

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Next steps.....

- Electronic messages/PCPR being sent to all Forth Valley community pharmacies.
- Share the learning from this project and roll out medicines reconciliation to all 76 community pharmacies.
- Ensure information still flows to community pharmacies following the introduction of HEPMA at FVRH.

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Improving Medicines Reconciliation in Primary Care

Leslie Simpson
NHS Forth Valley

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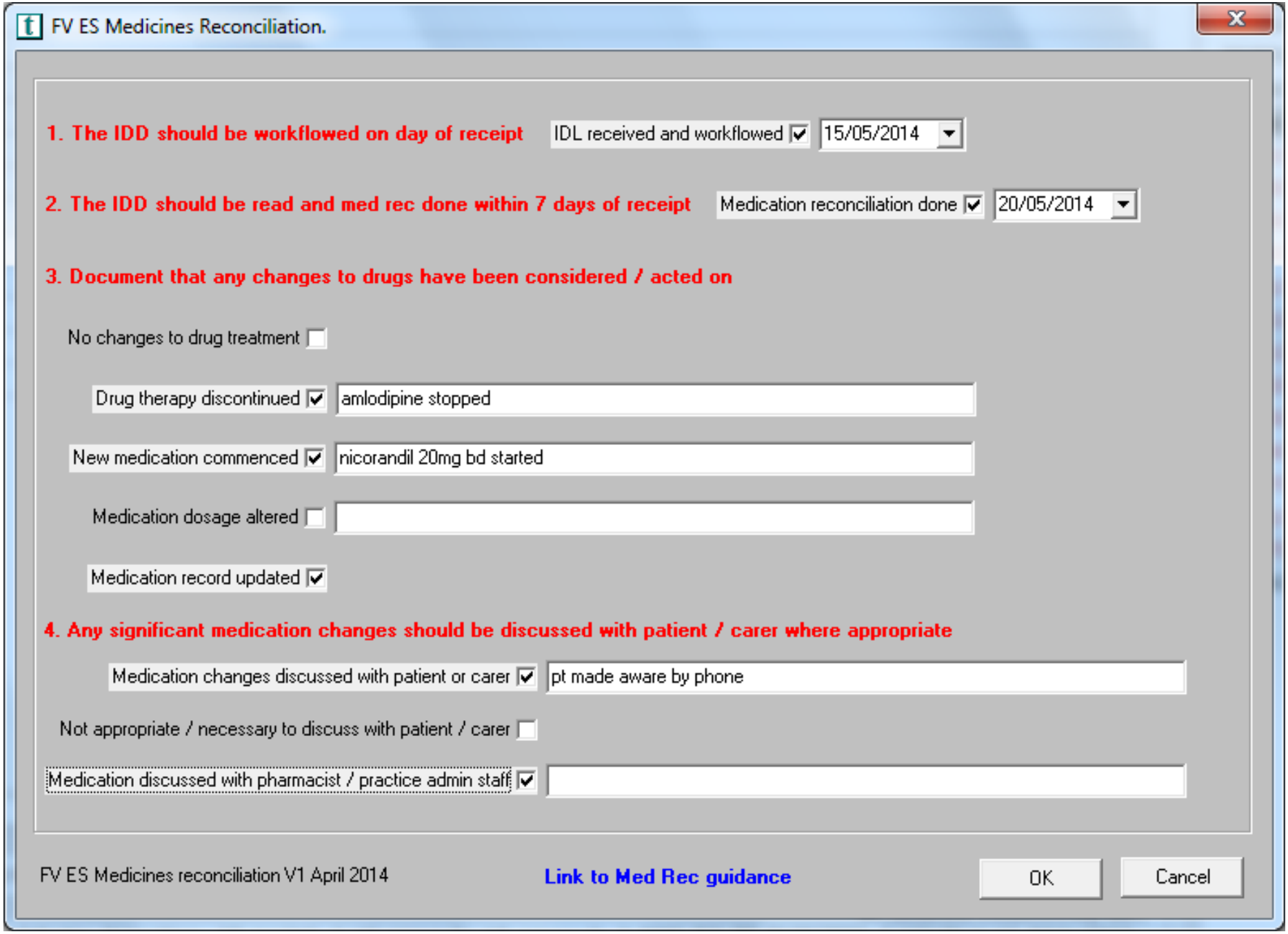
FV General Practice - Medicines Reconciliation Bundle Measures

1. Has the immediate discharge document (IDL) been forwarded to a clinician on the day of receipt?
2. Has medicine reconciliation occurred within 7 days of the IDD being received by the practice?
3. Is it documented that any changes to the medication following reconciliation have been updated in EMIS within 7 days of the IDL being received by the practice?
4. Is it documented that any *significant changes to medications have been discussed with the patient or their representative if appropriate within 7 days of the IDD being received by the practice?

   *significant changes include a repeat medication being started or stopped or alteration in dose

5. All measures have been met


FV ES Medicines Reconciliation.
1. The IDD should be workflowed on day of receipt
IDL received and workflowed
15/05/2014
2. The IDD should be read and med rec done within 7 days of receipt
Medication reconciliation done
20/05/2014
3. Document that any changes to drugs have been considered / acted on
No changes to drug treatment
Drug therapy discontinued
amlodipine stopped
New medication commenced
nicorandil 20mg bd started
Medication dosage altered
Medication record updated
4. Any significant medication changes should be discussed with patient / carer where appropriate
Medication changes discussed with patient or carer
pt made aware by phone
Not appropriate / necessary to discuss with patient / carer
Medication discussed with pharmacist / practice admin staff
FV ES Medicines reconciliation V1 April 2014
Link to Med Rec guidance
OK
Cancel

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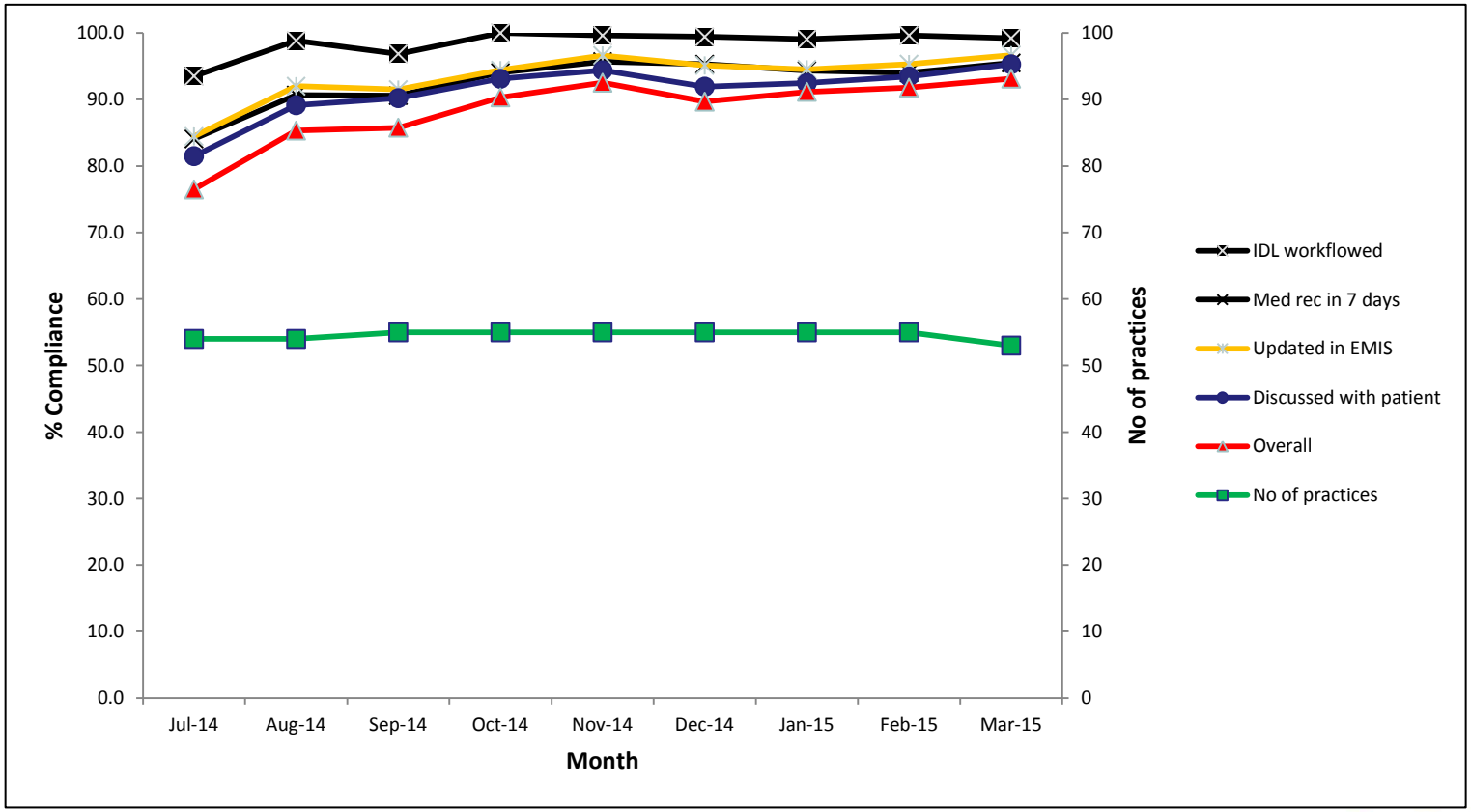
FV Aggregate Medication Reconciliation Bundle Compliance Jul 14 - Mar 15



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Successes

"Now a systematic approach to the immediate discharges, the practice is dealing with them more promptly - there is less confusion from the patient and the chemist regarding changes to medication "

"We are contacting patients more reliably and discussing medication changes"

"Also contacted the community pharmacy particularly when patients are on weekly dispensing using boxes"

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Issues at discharge

- Timeliness – especially community hospitals
- Accuracy
- Reason for stopping drugs
- Delayed Discharge
- Warfarin
- Contacting hospital
- Patient Understanding
- Requests for investigation could be highlighted
- Make GPs aware of specific drugs which need review and dose titrated
- Primary and secondary care interface group established
- HEPMA

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Key points for sharing

Understanding the value of involving community pharmacy in medicines reconciliation.

Gaining the engagement and support of leads (whether medical or nursing) is key.

Experience of implementing HEPMA.

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What we would like to learn from others

Gaining the engagement and support of the whole multidisciplinary team

How Boards are sharing discharge information with their Community Pharmacy contractors e.g. Community Pharmacist access to Clinical Portal.

Getting contemporaneous information from various specialist services (e.g. addictions) out of hours and available to front line staff

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WebEx Series

WebEx Schedule for 2016		
Date	**Time**	**NHS Board Presenting**
18th August 2016	3pm – 4pm	NHS Borders
15th September 2016	3pm - 4pm	NHS Lanarkshire
20th October 2016	3pm – 4pm	NHS Island Boards

..... the 3rd Thursday of each month between 3pm – 4pm

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hcis-medicines.spsp@nhs.net

www.scottishpatientsafetyprogramme.co.uk/programmes/medicines

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THANK YOU

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