Healthcare Improvement Scotland's Improvement Hub

Reducing Medicines Harm Across Transitions

Medication Reconciliation WebEx Series 2016

Thursday 15 December 2016
3pm–4pm

Presented by:
NHS Lothian

#SPSPMeds2016 @SPSPMedicines

NHS SCOTLAND
Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

MEDICINES

SPSP Medicines

December 2016 WebEx

NHS Lothian

Reducing medicines harm across transitions

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SCOTTISH PATIENT SAFETY PROGRAMME MEDICINES

Welcome

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

What is our theory for improvement?

What tests of change have resulted in improvement?

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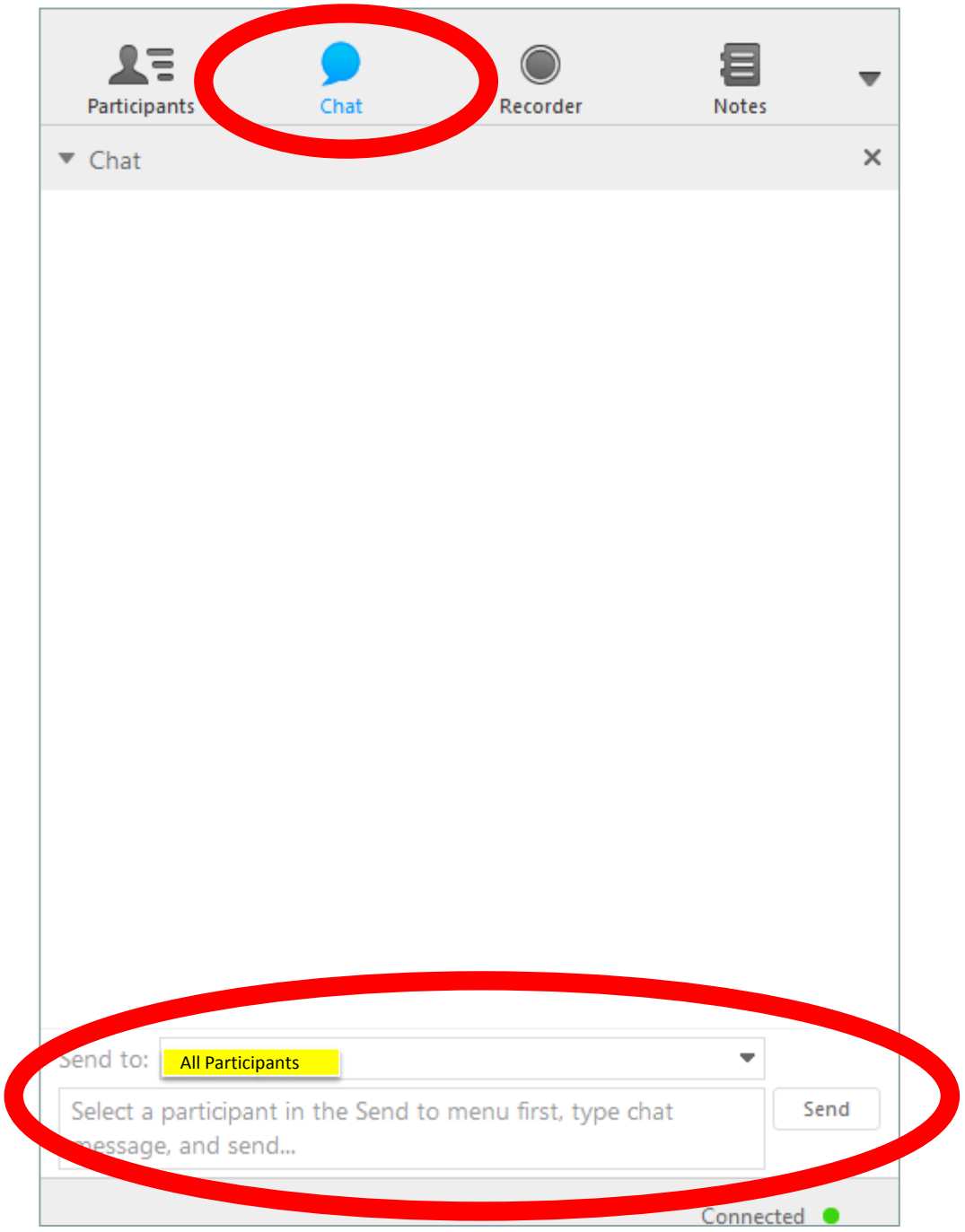
If you want to get involved in the conversation, please click on the Chat icon circled in red.

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

This WebEx is being recorded as a resource for SPSP teams



Ambition and Aims	Primary Drivers	Secondary Drivers	Change Ideas
Ambition: All patients will have their medicines accurately reconciled on admission to and discharge from hospital, including primary care. This information will be communicated to patients and healthcare professionals. **Aims:** 95% of patients will have their medicines accurately reconciled within 24 hours of admission (+ accurate Kardex) 95% of patients will have their medicines accurately reconciled on discharge (+ accurate IDL) 95% of patients will have an accurate GP medication list within 2 working days of IDL being received. Community pharmacy aim (TBC)	**Person-Centred Care**	- Patients are responsible for their own medicines - Patients are actively involved in medication reconciliation processes	- Medication Passport (app and booklet) - Patients represented on medication reconciliation implementation groups - Links with medication self-management programmes - Prompts for patients to take a meds list to all appointments/admissions - Green bags (SAS/ ?Primary Care / ?preop) - 'Tell me how you are taking your medicines' - Ensuring involvement of informal carers in MR discussions, they are often the ones giving medication to the patient. - Reminders to return unused medication stored at home. - Teach back with whoever is giving out the medication to ensure safety and understanding. - Risk assessment process to identify patient/carer understanding and ability re medication management.
	Leadership and Culture	- MR is integrated with other key strategic policies - A single system approach supported by senior leadership - MR is a named priority by NHS leaders at all levels - CMO letter (18/2013)	- Policy to support MR across the continuum of care - Establish MR group with oversight of acute and primary care services that reports to senior management - Education of senior leaders regarding impact of MR - Awareness of local data regarding MR processes - Dashboard linking data from acute and primary care - MR leads are named for key health disciplines
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www.scottishpatientsafetyprogramme.scot.nhs.uk/Media/Docs/Medicines/MR-DD.pdf

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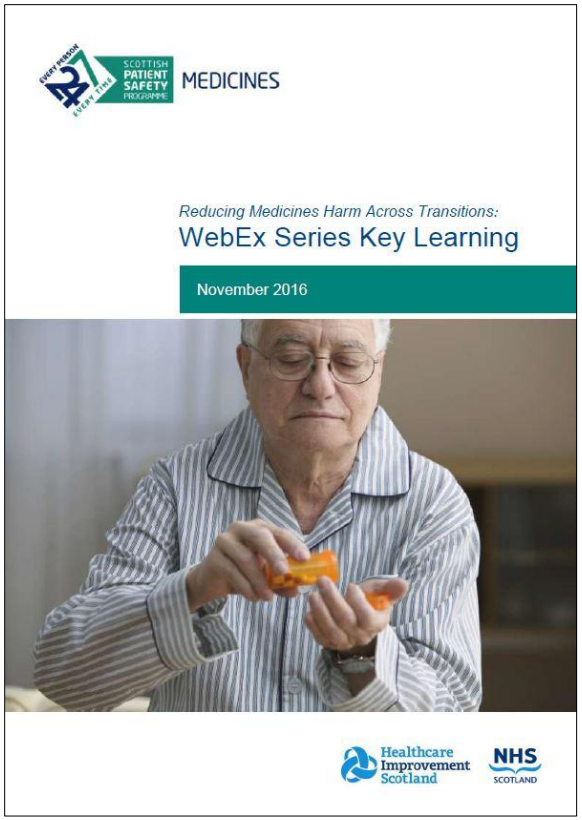
From previous 3 WebExes:

- September 15th (NHS Lanarkshire)
- October 20th (NHS Orkney and NHS Shetland)
- November 17th (NHS Highland)



NHS Highland (November 2016)
Medicines reconciliation process in community pharmacy
My Medicines wallets

NHS SCOTLAND Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

MEDICINES

SPSP Medicines

December 2016 WebEx

NHS Lothian

Reducing medicines harm across transitions

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Medication Reconciliation: Story so far

Data is being collected within the following settings in NHS Lothian:

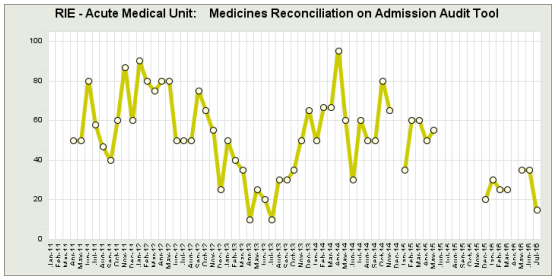
- Acute Adult, Paediatrics, Mental Health, Primary Care and Community Pharmacy.

Acute Adult - RIE

- Variable journey over the years – key individuals changing.
- RIE has one of the busiest medical admission units in Scotland – over 80 admissions per day, average LOS of 17 hours and very high turnover of staff.
- Have ECS Med Rec embedded in TRAK but our MR paperwork in UPR is no longer fit for purpose and ECS is often difficult to locate in the notes.
- MR highlighted as priority for improvement in recent OPAH inspection.

SCOTTISH PATIENT SAFETY PROGRAMME MEDICINES

Medication Reconciliation: Story so far



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Medication Reconciliation: Story so far

- Attended the SPSP Medicines Safety Event in Glasgow, Feb 2016
- Felt inspired to do something differently – encouraged to apply for the SQSF
- NHS Lothian Safer Medicines Network established by AMD Patient Safety
- Site wide MR working groups being re-established across Lothian to report into Medicines Safety Network and ADTC.
- Consultant and Pharmacist led training for undergraduates, FY1s and FY2s.
- Data now being collected on **admission, transfer and discharge** in acute Medicine
- Increased measurement from 20 patients per month to 10 patients per week in each area – more dynamic data
- Fortnightly MDT meetings established

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Chief Medical Officer and Public Health Directorate
Chief Nursing Officer, Patients, Public and Health Professionals Directorate
Finance, eHealth and Pharmaceuticals Directorate
Clinical Director, The Quality Unit

The Scottish Government
Riaghaltas na h-Alba

LEGACY 2014
XX COMMONWEALTH GAMES SCOTLAND

Dear Colleague

Safer Use of Medicines
Medicines Reconciliation: Revised Definition, Goals and Measures and Recommended Practice Statements for the Scottish Patient Safety Programme

Purpose

From the Chief Medical Officer
Chief Nursing Officer
Chief Pharmaceutical Officer
Clinical Director, The Quality Unit
Sir Harry Burns MPH FRCS(Glas) FRCP(Ed) FFPH
Ros Moore RGN RNT BSc (Hons) Nursing MA
Professor Bill Scott BSc MSc DSc (Hons) FRPharm S
Professor Jason Leitch

MATCH UP medicines

Guide to using the Medication Management Plan

1. **On admission all patients require a best possible medication history**
   - Prescriber, pharmacist or nurse to document medicines taken prior to admission including non-prescription and complementary medicines.
   - Include previous adverse drug reactions and allergies, and any recently ceased or changed medications.
   - Pharmacist/nurse to refer to list and clarify or add additional information obtained from patient/carer.
2. **Doctor's plan**
   - Prescriber to document plan for each medication i.e. handover of medication management decisions (continue, withhold, cease) or pharmacist/nurse to confer with prescriber and document plan.
3. **Confirm history with at least two sources**
   - Prescriber, pharmacist or nurse to confirm with at least two sources (e.g. GP, pharmacist, patient's own medicines) that the information is correct.
   - Record source of confirmation.
4. **Medication reconciliation**
   - Pharmacist/nurse to compare medicines listed with medication chart. This should take place as soon as possible after admission. Consider doctor's plan and clarify any discrepancies with prescriber.
   - Tick when reconciled.
5. **GP & community pharmacy details**
   - Pharmacist/nurse to record details of community healthcare providers.
6. **Medication risk identification**
   - Pharmacist/nurse to assess patient and complete this section.
7. **Checklist**
   - Use to assist to obtain a best possible medication history.
8. **Medication issues**
   - Nurse/pharmacist/prescriber to record issues identified during medication review and action required by appropriate clinician.
   - Identifier to record contact details.
9. **Document date and result of action**
   - Clinician performing the action to document this.
10. **Medication changes during admission**
    - Prescriber/pharmacist/nurse to document any changes made during admission which may need to be communicated on discharge.
11. **Comments (e.g. medication administration and supply notes)**
    - Pharmacist/nurse to document any administration or supply notes e.g. patient requires dose administration aid or patient to return to hospital for future supply.
12. **Discharge checklist**
    - Pharmacist/nurse to complete this section.
13. **Referral for Home Medicines Review**
    - Pharmacist/nurse to complete and follow local processes for referral if a Home Medicines Review is required.

AUSTRALIAN COMMISSION on SAFETY AND QUALITY IN HEALTHCARE

Medrec
matching medicines at transitions of care

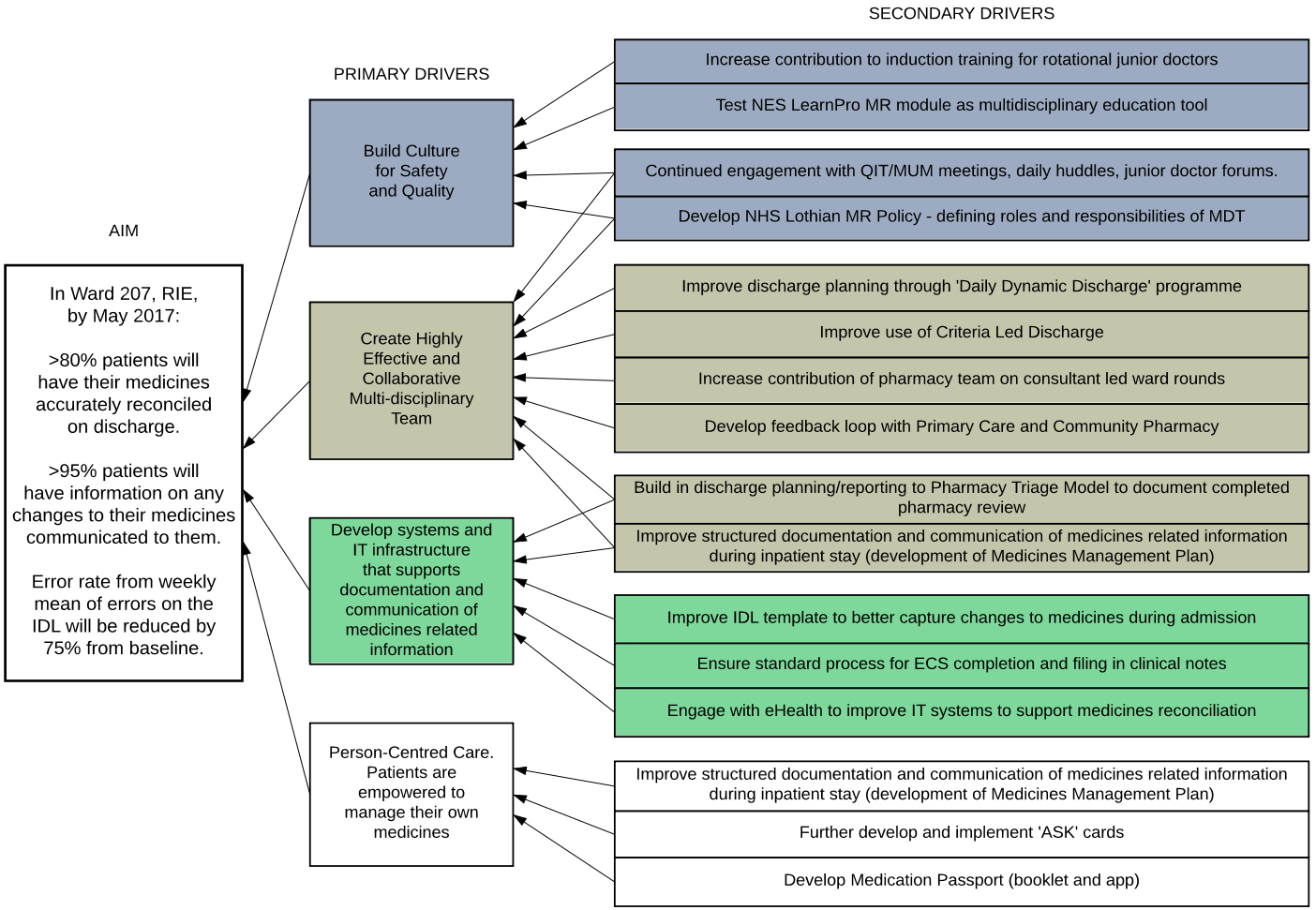
Specialist Pharmacy Service
Medicines Use and Safety
NHS

Improving the Quality of Medicines Reconciliation

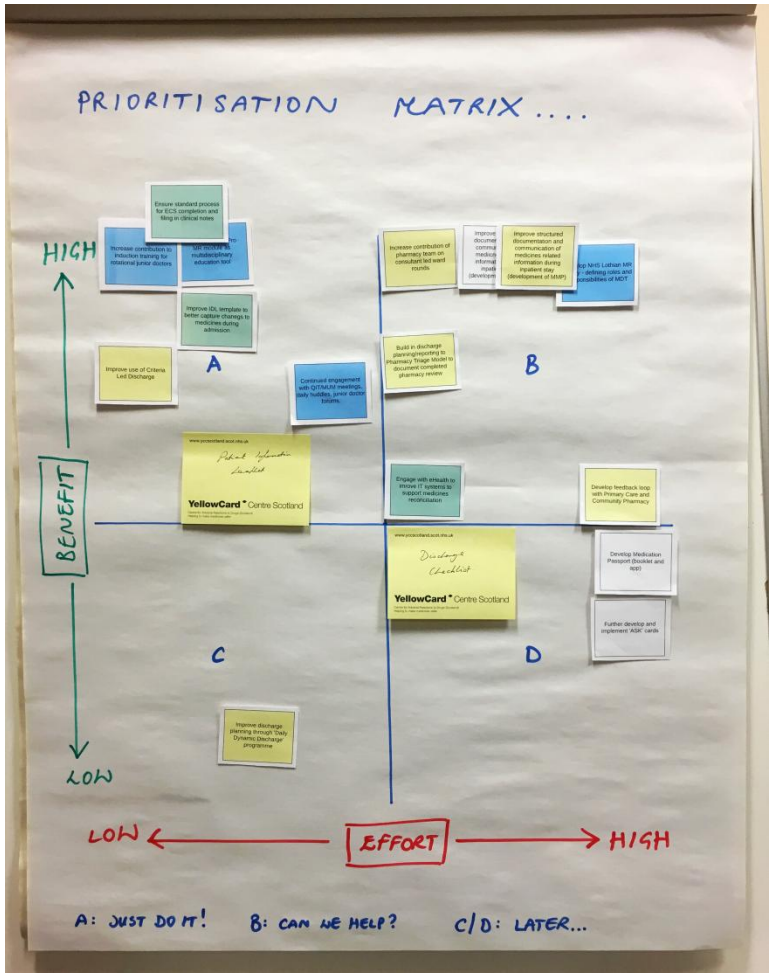
A Best Practice Resource and Toolkit

Med Rec on Discharge Driver Diagram

OUR AMBITION: ALL PATIENTS WILL HAVE THEIR MEDICINES ACCURATELY RECONCILED ON DISCHARGE FROM HOSPITAL, AND THIS INFORMATION WILL BE RELIABLY COMMUNICATED TO PATIENTS AND HEALTHCARE PROFESSIONALS.



Back to Basics. Prioritisation. Team Work



- TRAK IDL Update
- NES LearnPro Module
- Induction Training
- Improving structured documentation and communication of medicines related information (MMP)

Innovation: Medicines Management Plan

Affix patient identification label here or Name/CHI

NHS Lothian - Acute and General Medicine - RIE

Medicines Management Plan (MMP)

Keep with active prescription chart(s)
DO NOT REMOVE

ALLERGIES/ ADVERSE DRUG REACTIONS
Document on:
Front page of the UPR and on Front of Prescription Chart
Include details of reactions.

Medicines Reconciliation on Admission

1. Generate ECS (with consent). Print and complete manually. ☐
2. Document 2 sources for each medicine. Sources must be NUMBERED & NOT TICKED ☐
3. Decide and document plan for each medicine Tick – Continue / Withhold / Stop ☐
4. Document ALL CHANGES to medicines overleaf ☐
5. File this plan and ECS with completed Prescription Chart ☐
6. If unable to fully complete ALL steps - document outstanding issues below for review ☐

Over the counter / Medicines prescribed out-with GP practice / Illicit substances / Herbal / Homeopathic drugs: None ☐

Pre-admission Insulin	Dose				Source(s) Used for Dose:	Admin-istered at home by:	Own supply available	If **not** suitable to self-administer or supply not available: **Refer to Ward Insulin Guide**
	Breakfast	Lunch	Teatime	Bedtime				
Device: Pen / cartridge / vial	UNITS	UNITS	UNITS	UNITS			Y / N	
Device: Pen / cartridge / vial	UNITS	UNITS	UNITS	UNITS			Y / N	

Warfarin: Indication: Target INR: Usual dose: INR on admission:

Medicines Reconciliation completed on admission by: Ensure ECS also signed on completion.

Date: Time: Sign: PRINT: GMC: Contact:

Pharmacy Verification: Accurate prescription chart on review: Yes ☐ No ☐ If No, enter discrepancies below.

Technician: Date: _____ Time: _____ Sign: _____ PRINT: _____ Contact: _____

Pharmacist: Date: _____ Time: _____ Sign: _____ PRINT: _____ Contact: _____

Medicines Reconciliation Discrepancies / Medicine Issues for Review

Date Time	Issue(s) Identified	Identified by:	Date of Action	Result of Action

Changes to Medicines During Admission

Date	Medicines Withheld	Reason / Comments	Review Prior to Discharge: STOP	RESTART	GP to R/V

Date	Medicines Stopped	Reason / Comments

Date	Medicines Changed e.g. formulation, dose	Reason / Comments

Date	Long-term Medicines Started	Indication / Comments

Medicines Reconciliation on Discharge / Discharge Planning

Supply of Patient's Own Medicines Brought In: Yes ☐ No ☐ Own Supply Stored in: Fridge ☐ CD cupboard ☐

Compliance Aid: Dosette / Community MAR Chart / Installment Dispensing

Community Pharmacy Details: _____ Phone No: _____ Email CP: _____

Usual Day(s) of Supply: _____ Notified of Admission ☐ Email Sent on Discharge ☐

Comments:

Education Required:

Discharge: **Match up medicines on IDL with medicines on Prescription Chart AND admission ECS or MR Form**

IDL sent to Pharmacy (if needed): Sign: _____ Date: _____ Time: _____

Changes to Medicines Identified and Communicated to Patient: Sign: _____ Date: _____

Fridge Items / Controlled Drugs Returned to Patient on Discharge: Sign: _____ Date: _____

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Test of Medicines Management Plan in AMU

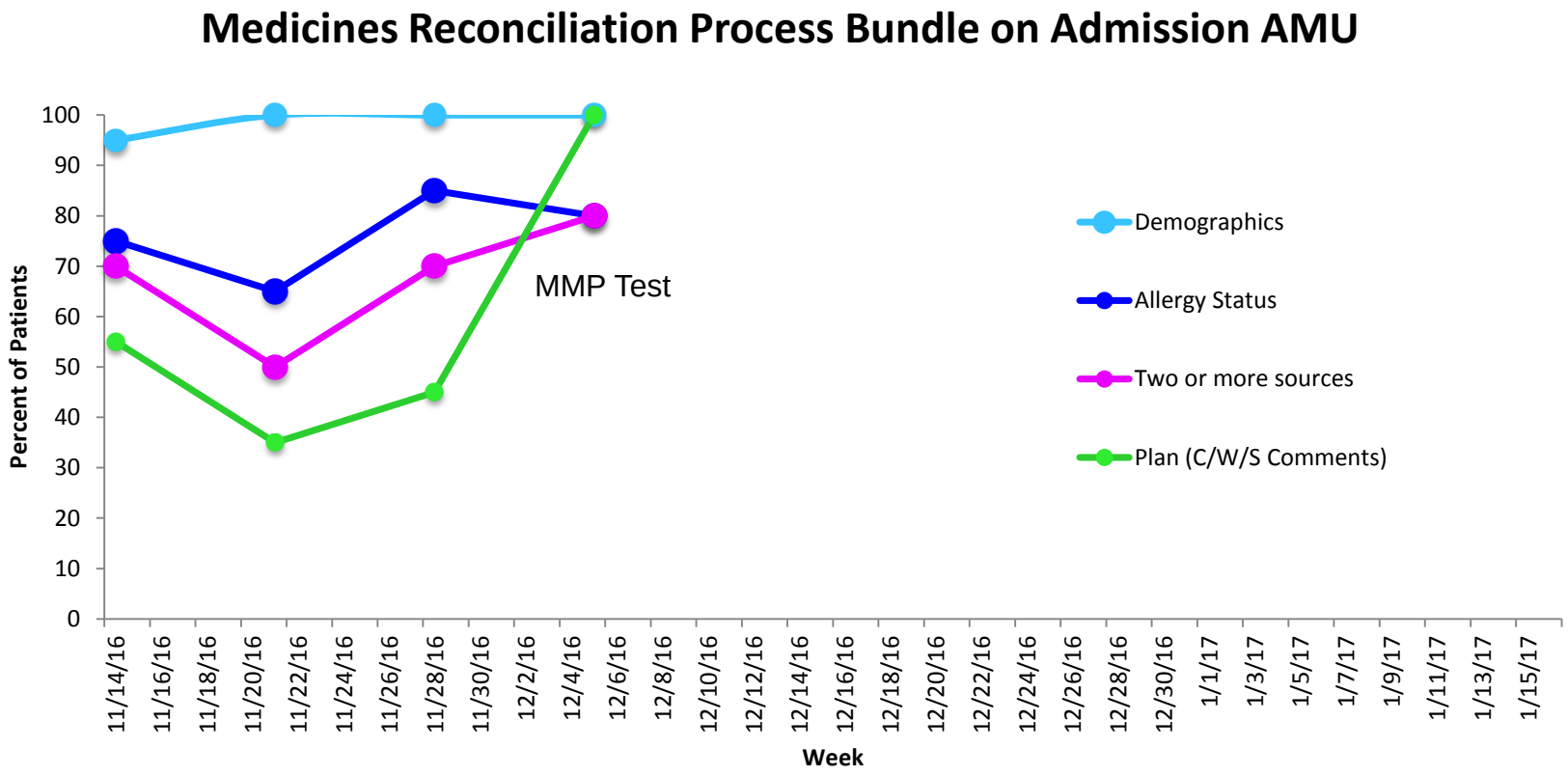

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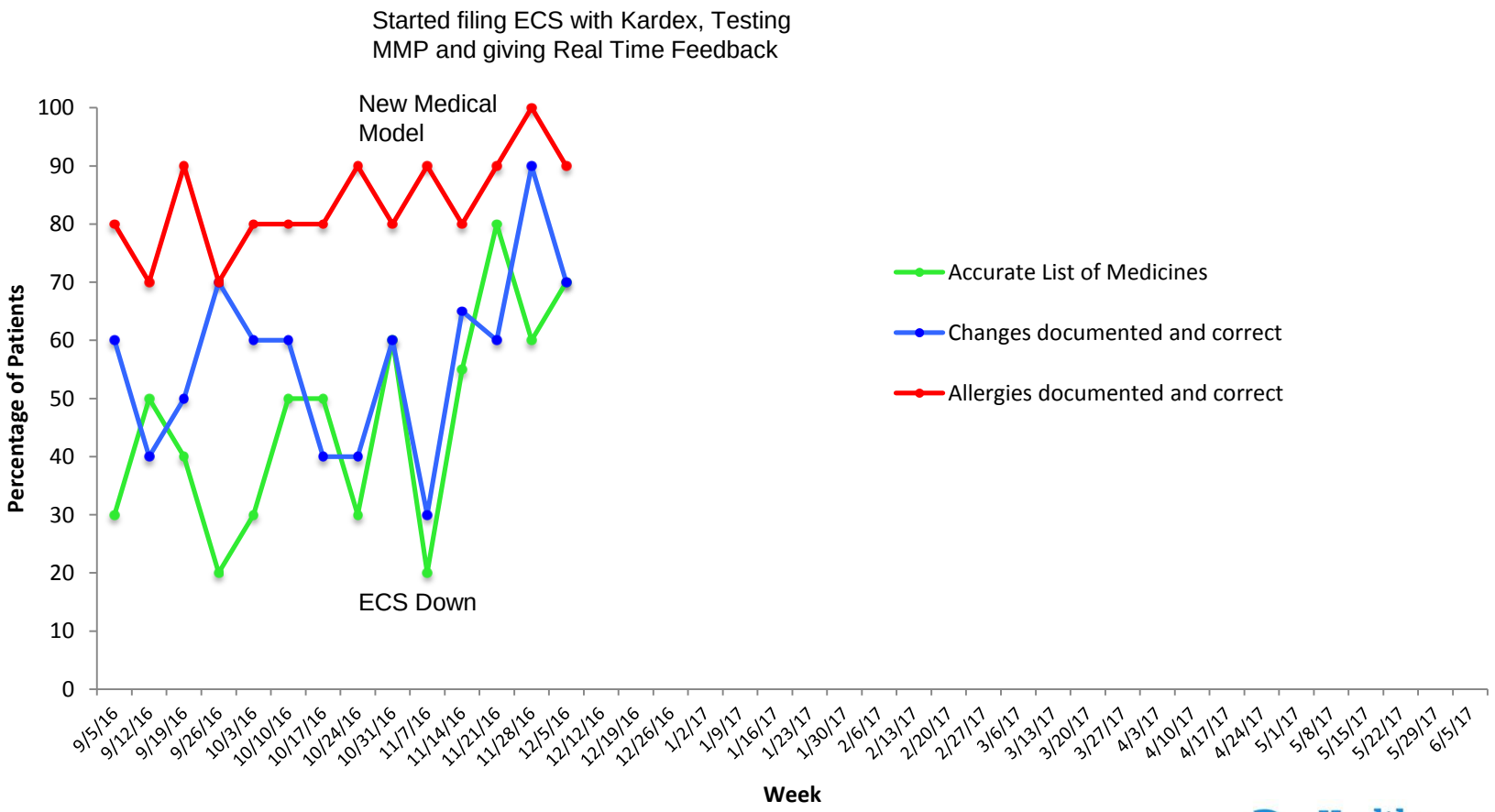
Chart PM3: Medicines Reconciliation on Discharge Element Compliance - Ward 207



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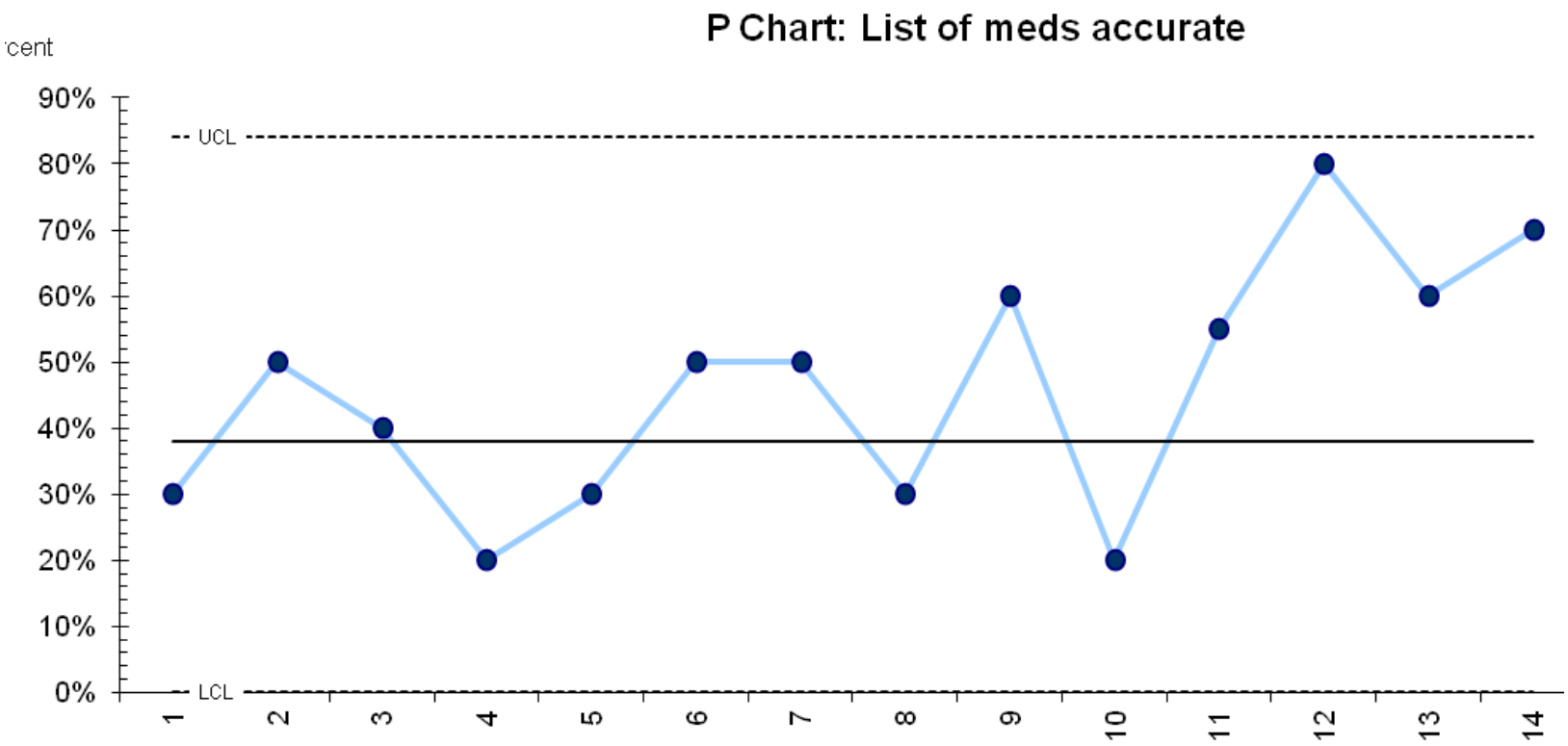
Accurate List of Medicines on the IDL



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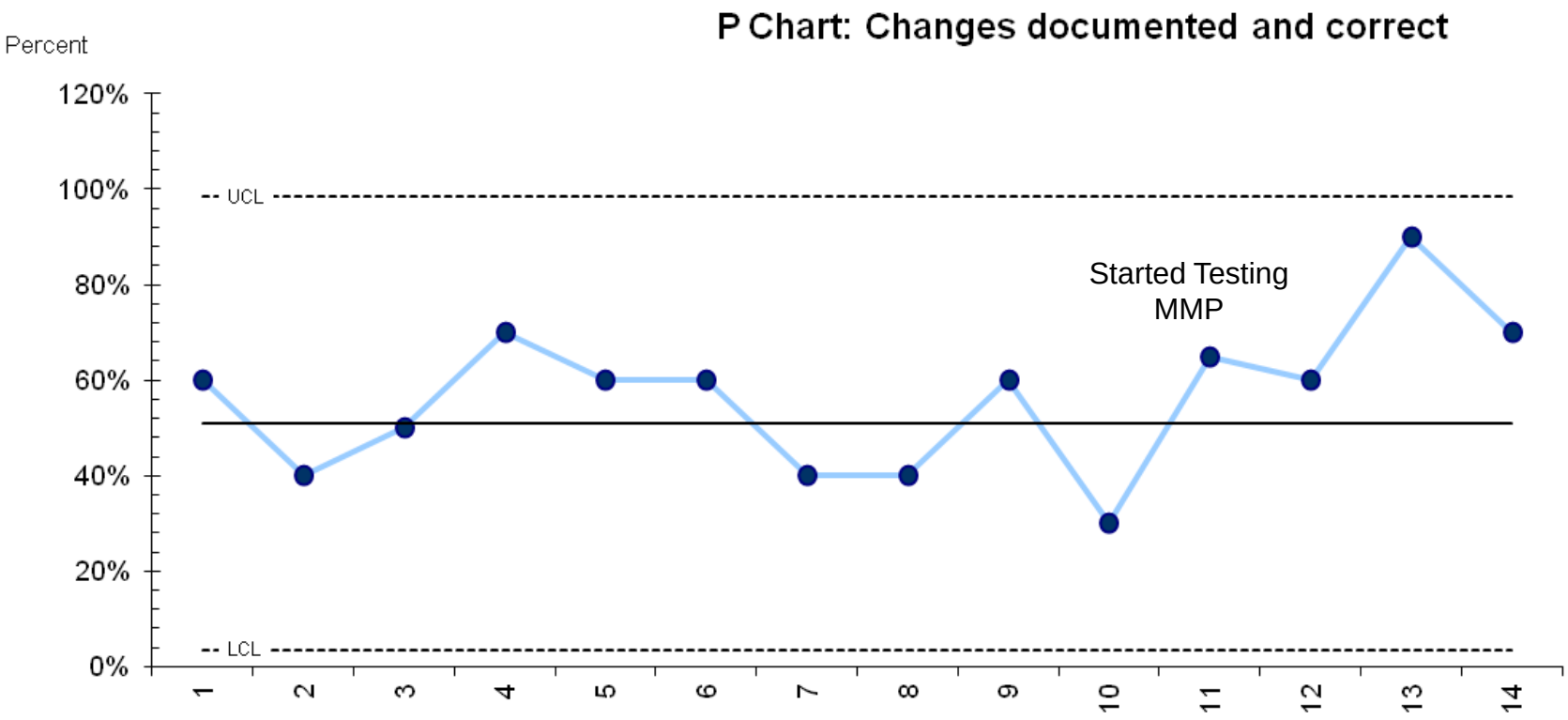
Changes to Medicines Documented and Correct on the IDL



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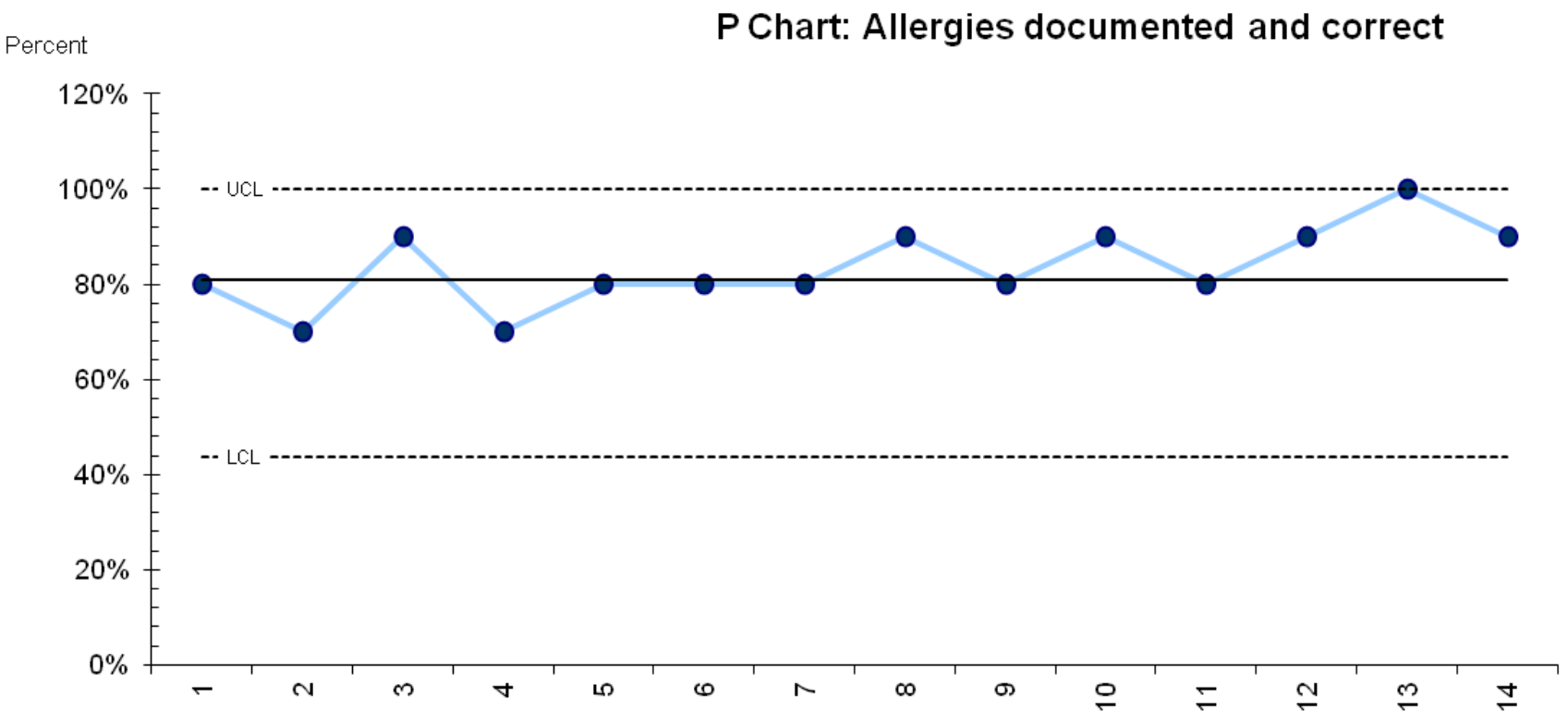
Allergies Documented and Correct on IDL



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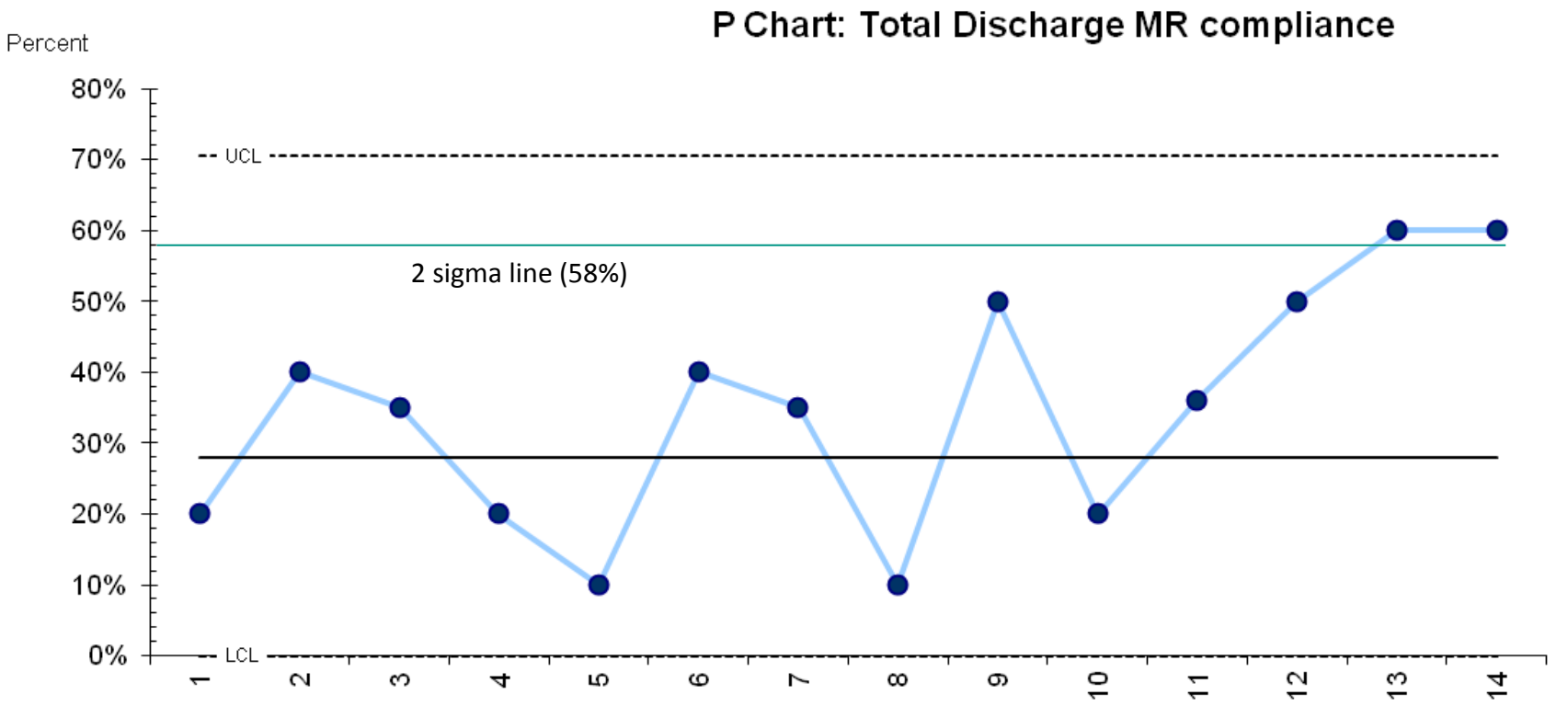
Overall Compliance on Discharge – Starting to see Improvement??



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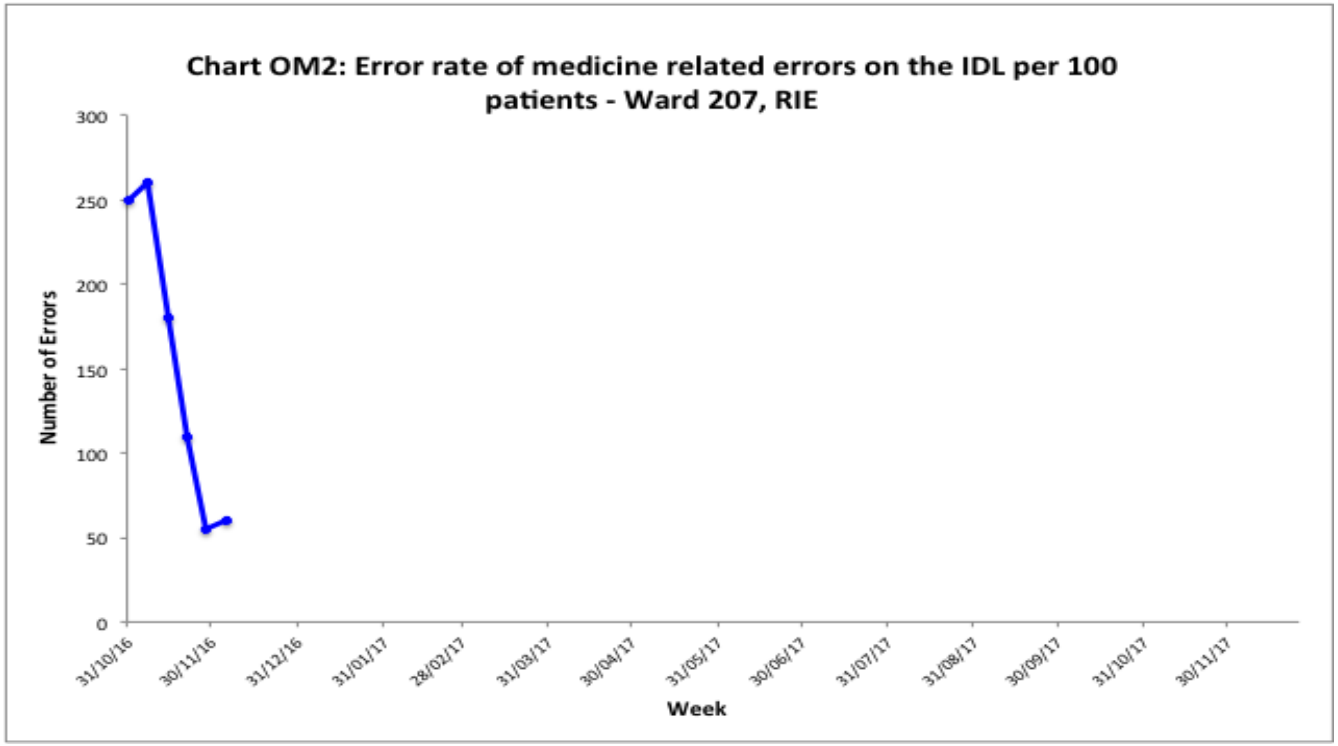
SCOTTISH PATIENT SAFETY PROGRAMME
MEDICINES

Medicines reconciliation Error Rate on the IDL



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SCOTTISH PATIENT SAFETY PROGRAMME MEDICINES

Successes

- Development of NHS Lothian SPSP Safer Medicines Network to share learning and encourage collaborative approach across Lothian.
- Multidisciplinary engagement particularly from senior clinical leaders.
- **Feeling empowered to own our data and do something differently**

Challenges

- Sustainability and spread.
- Sharing of Data – QiDS
- Collaborative Working
- Lack of formal Med Rec Policy in Lothian

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SCOTTISH PATIENT SAFETY PROGRAMME MEDICINES

Key Points for Sharing:

- **Ask NHS Lothian about:**
  - Work with TRAK IDL templates
  - Development of Medicines Management Plan to improve the documentation and communication of medicine related issues across transitions.
- **NHS Lothian would like to know more about:**
  - Have other boards made the NES LearnPro module compulsory for junior doctors and/or other HC professionals? If so what has been the success of this?
  - How other boards that operate a One Stop Policy ensure that medicine changes are reliably communicated to patients?
  - How have other boards involved patients in MR working groups?

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IF YOU CANNOT DO
GREAT THINGS
DO MANY SMALL THINGS
IN A GREAT WAY

SCOTTISH PATIENT SAFETY PROGRAMME

MEDICINES

SPSP Medicines

Prepared by: Ailsa Howie
Eleanor Morrison
Claire Gordon
Sandra Nash

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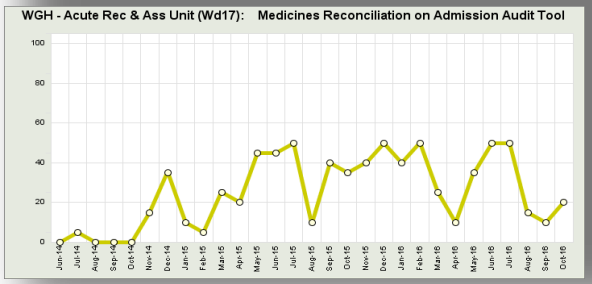
Journey So Far!

- Developed a short code: **“\medrec”**
- Med Rec sources (2 minimum): (delete as appropriate) 1: ECS 2: GP referral letter 3: Repeat Prescription 4: GP Practice conversation 5: Patient’s own drugs 6: Patient 7: Patient’s relatives 8: Recent discharge letter 9: Care home drug chart 10: Other (specify)
- Drugs on admission: (Include Recent Acute Medicines / relevant recent medications (e.g. antibiotics), Dose, Frequency, Route, Decision by each one to STOP/WITHOLD/CONTINUE (if all, can write this at top))
- Over the Counter Medicines:
- Recreational Medicines:

Medication Reconciliation: Starting Point

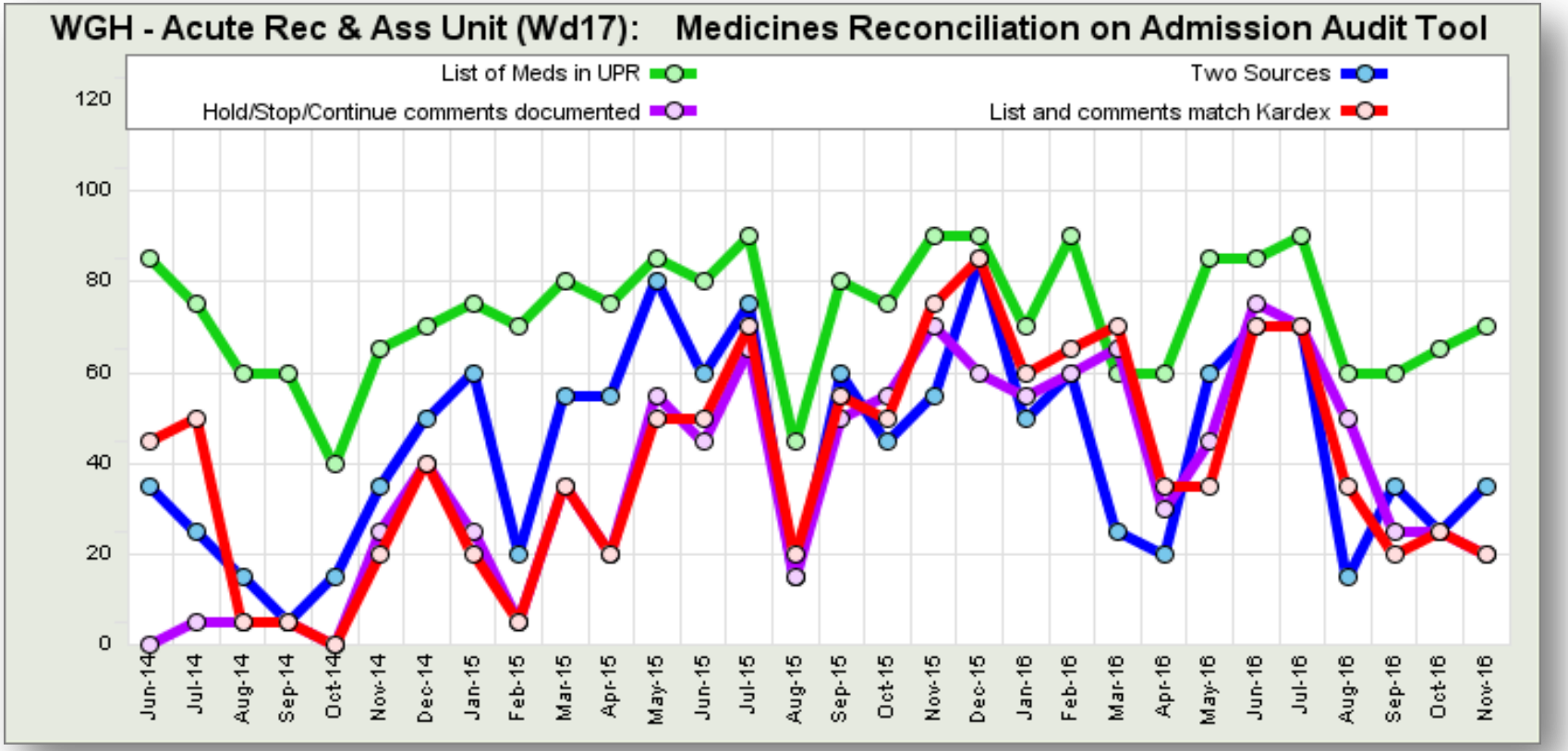


Med Rec. QI priority set

Junior Dr rotation change

Short Code Introduced

Medication Reconciliation: Breakdown



SCOTTISH PATIENT SAFETY PROGRAMME MEDICINES

Medication Reconciliation: Reduction in Drug Errors

Aim: **To produce an accurate, simplified and acceptable IDL.**

- facilitate effective transition from acute to ongoing care
- reduce the incidences where errors can occur
- safer medicine reconciliation at time of transition.

We "listened" and "learnt" and asked the questions!

- *Paisley does it!*
- *Trolleys do it!*

Proposal*:* ARU / WGH site will implement a new Abbreviated IDL for all patients who have been an inpatient for less than 48 hours with less than 4 medication changes >98% of the time.

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What is the potential gain?

48 hr Discharge Analysis (over 1 weekend) in ARU	**No.**
Patients discharged within 48 hours of admission	19
IDL medication error	21
Medication errors avoided if Abb. IDL available	**20**
Pt's who would have met Abb. IDL criteria	11
No. of paper IDLs missing for pharmacy review	6

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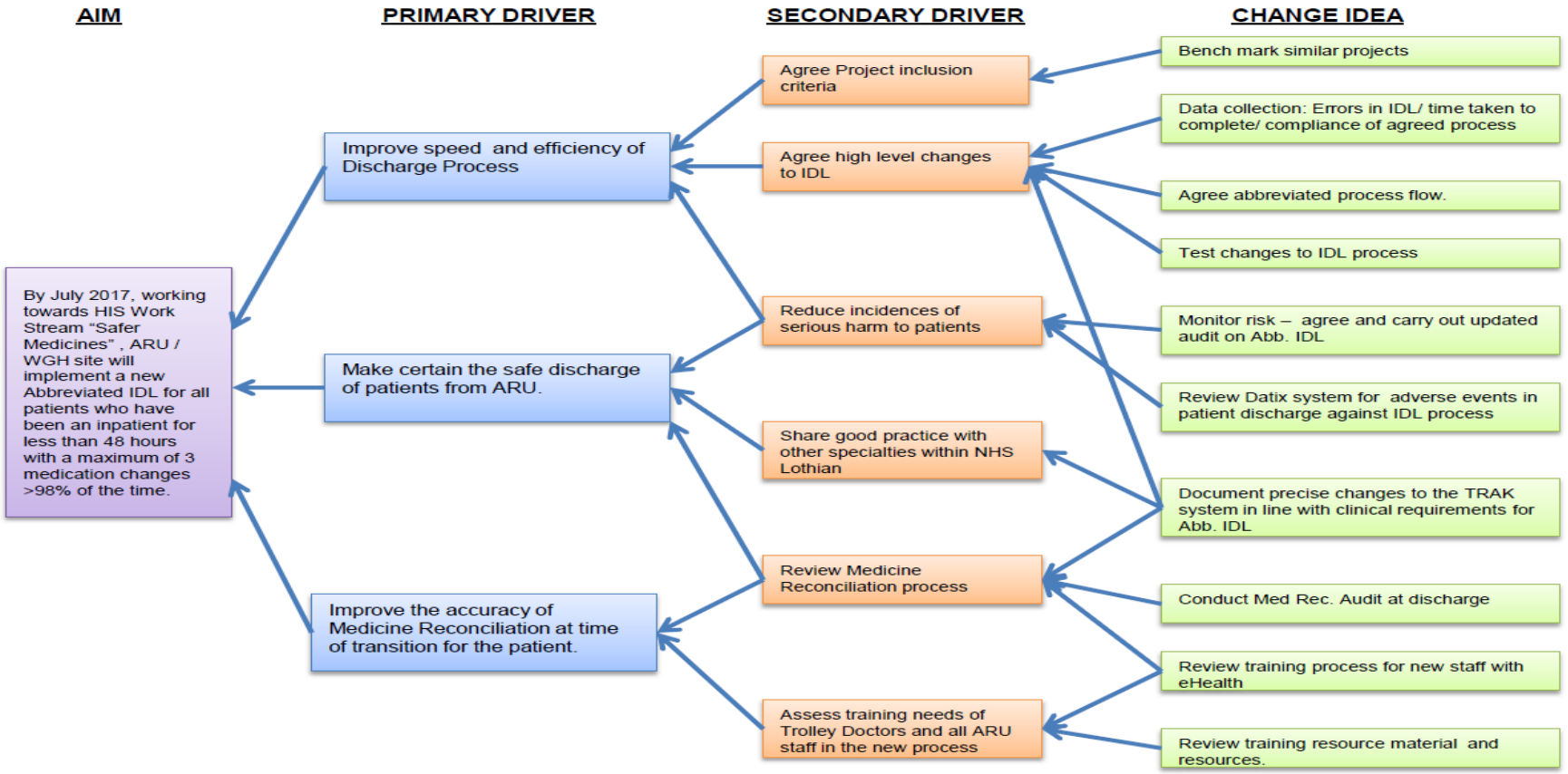
Main Drivers:



ABBREVIATED IMMEDIATE DISCHARGE LETTER (ABB. IDL) DRIVER DIAGRAM

What Drives the Abb. IDL Project

Drivers	Balancing
Reduce medication errors	Speed up the production of IDLs
Reduce medication errors	Less adverse incidents to review
Reduce medication errors	Improved staff morale, feel more competent
Reduce opportunity for error in Med Rec.	Improved Med Rec through conduit of care including transition
More relevant information for patient / carer and GP	Patient / carer better informed improving compliance
Medication changes more obvious	ECS easier to keep up to date for GP's
Improve patient flow – increased pre 12 o'clock discharges	Contributes to improve 4 hour compliance

SCOTTISH PATIENT SAFETY PROGRAMME MEDICINES

What are the Questions?

- What are the errors that occur?
- How often do errors occur?
- How long does it take for a IDL
- What is Med Rec. on admission?
- What is it on discharge?
- How valuable is the IDL for patients and GP's.

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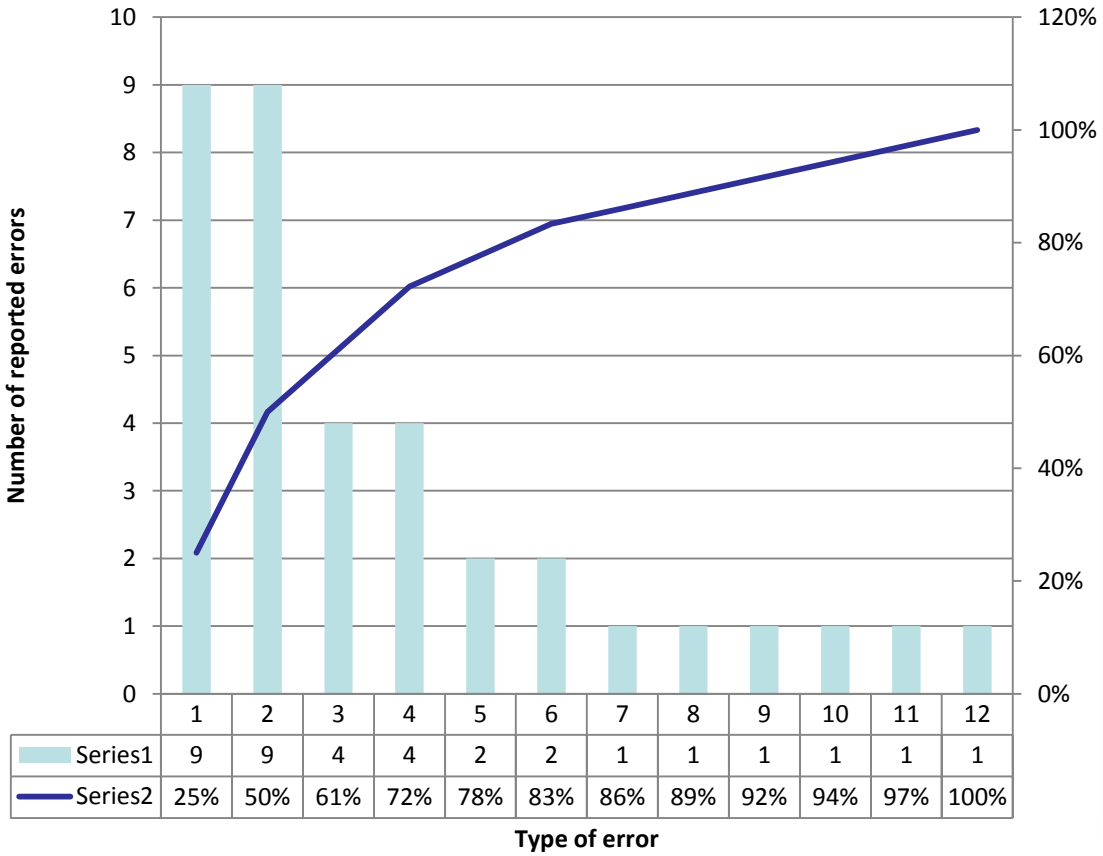
What are the errors and how often?

Reported Errors on IDL



	1	2	3	4	5	6	7	8	9	10	11	12
Series1	9	9	4	4	2	2	1	1	1	1	1	1
Series2	25%	50%	61%	72%	78%	83%	86%	89%	92%	94%	97%	100%

	Type of error	Number of errors
1	Dose missed/not prescribed	9
2	Errors in Med. Rec. on Admission	9
3	Dose/strength miss prescribed	4
4	IDL not checked out of hours	4
5	Change of drugs not on IDL	2
6	No IDL in Discharge Lounge	2
7	Patient allergy	1
8	Wrong drug prescribed	1
9	Draft IDL home with Pt	1
10	IDL not complete by treating Dr	1
11	Duplicate Drug Kardex	1
12	Error in medications in TRAK	1

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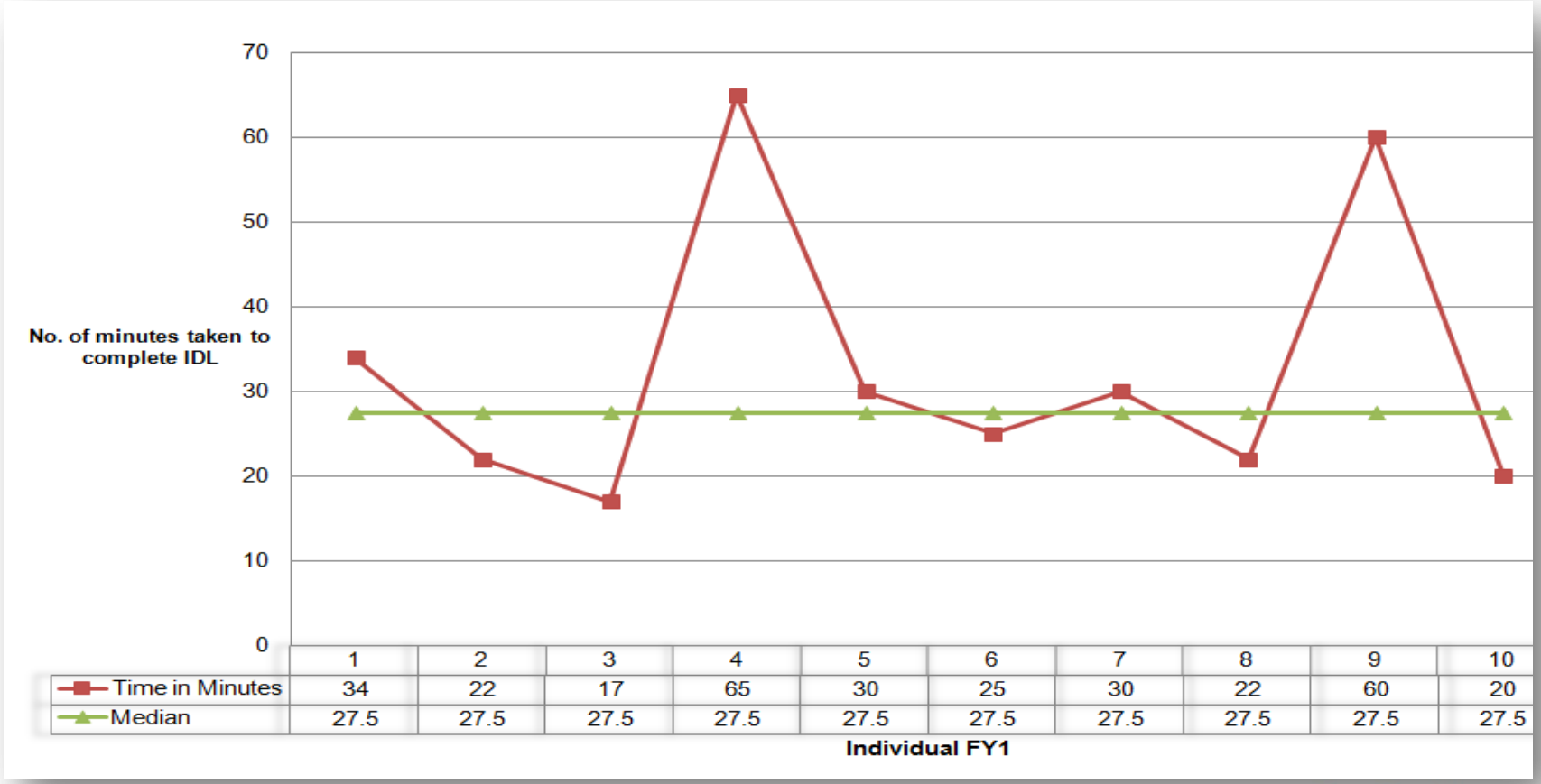
How long does it take for a IDL?



	1	2	3	4	5	6	7	8	9	10
Time in Minutes	34	22	17	65	30	25	30	22	60	20
Median	27.5	27.5	27.5	27.5	27.5	27.5	27.5	27.5	27.5	27.5

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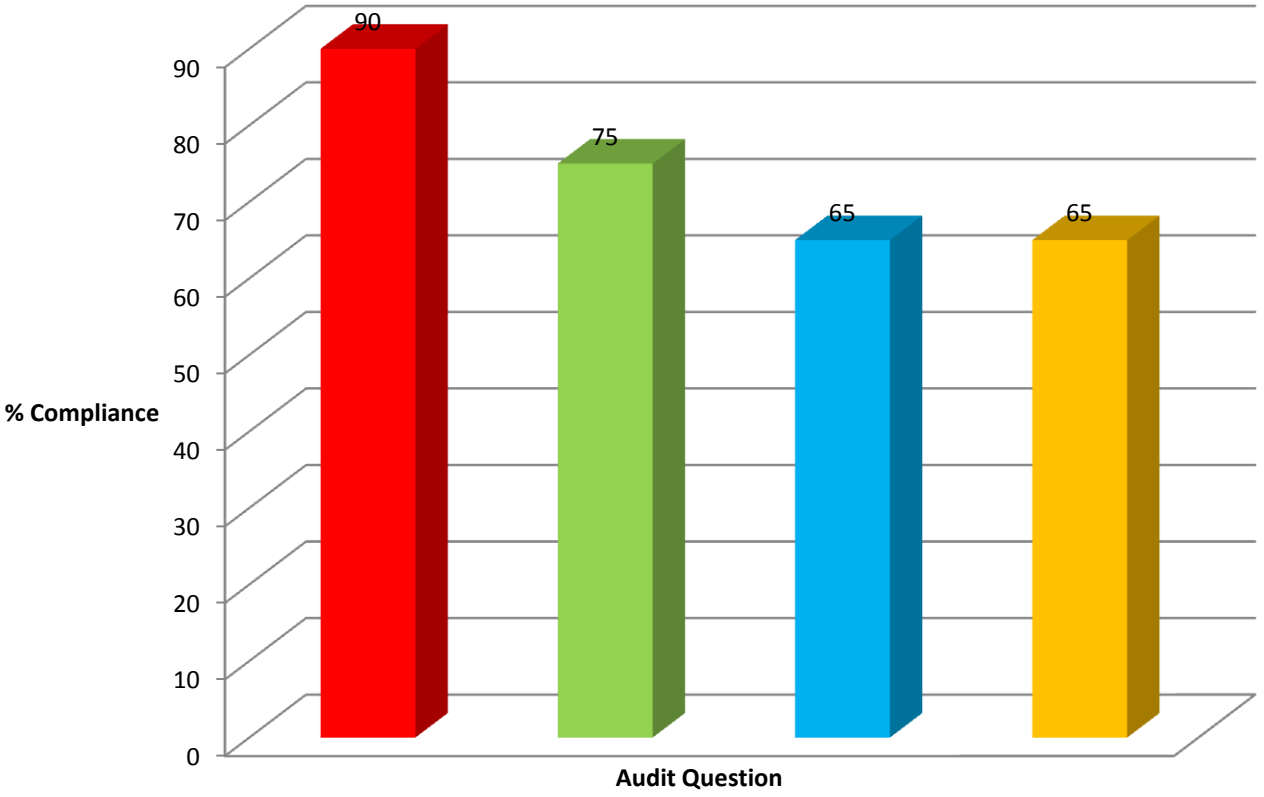
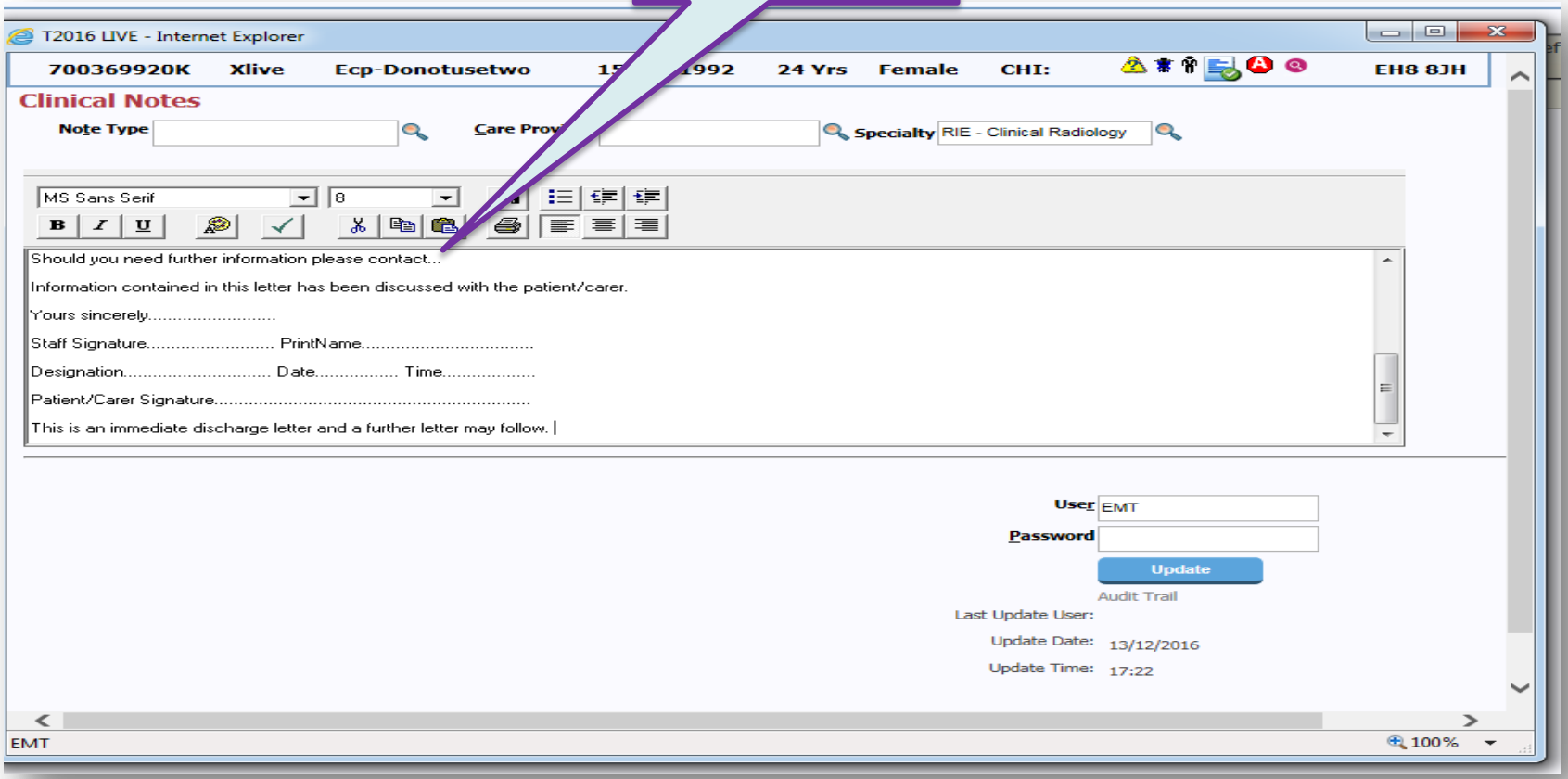
Med Rec: On Discharge



Innovation: Changes made to Process

Enter \48IDL and press space bar



MEDICINES Abb. IDL Template:

Safety Brief

This abbreviated IDL that is being tested as part of Quality Improvement work in the Western General Acute General Receiving Unit. Only new drugs, or those that have been changed, are included in the list. Any medicines discontinued will be detailed. All other medicines are to continue as before.
This letter will only be generated for patients that are in hospital in the Acute receiving Unit for less than 48 hours and have less than 4 medication changes. That includes stopping, changing the dose, withholding a drug or starting a drug.
If you have any questions or issues with regard to this or if any errors have been made with regard to the medication document please contact us immediately: ailsa.howie@luht.scot.nhs.uk Sandra.nash@luht.scot.nhs.uk Claire.gordon@nhslothian.scot.nhs.uk

PRINCIPLE DIAGNOSIS / PROCEDURE

TREATMENT

FURTHER INVESTIGATIONS AND FOLLOW UP BEING ARRANGED BY HOSPITAL

CHANGES TO DRUGS SINCE ADMISSION
Stopped:

Started:

Changed:

Withheld:

PREVIOUS ADVERSE DRUG REACTIONS

PREVIOUS ADVERSE DRUG REACTIONS

SIGNIFICANT CHANGES TO CARE ARRANGEMENTS

CHANGES TO DNACPR STATUUSOR ANTICIPATORY CARE PLANNING

GP to please consider the following……

Should you need further information please contact……

Information contained in this letter has been discussed with the patient/carer

Yours sincerely

Staff signature…… Print Name……

Designation…… Date…… Time……

Patient / Carer Signature……

This is an immediate discharge letter and further a letter may follow.

SCOTTISH PATIENT SAFETY PROGRAMME MEDICINES

Innovation: Impact of \48IDL Code

- The code when creates the 48hour IDL Template in TRAK Clinical Notes
- A step by step approach for staff to follow
- Helps medical staff complete the agreed process
- No information is missed
- Patients/ Carers are not bombarded with information

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Next Steps

- Data Collection – impact on Nursing Staff
- Develop training material
- TEST Change: TRAK (does it work?) and Clinical Staff
- Assess Impact for all disciplines involved i.e. Pharmacy – review SOP
- Collate feedback from clinical and Primary Care staff
- Collect patient comments
- Conduct agreed Audit
- Collate post change data – contrast and compare

SCOTTISH PATIENT SAFETY PROGRAMME MEDICINES

Successes

- Sharing good practice with other specialities within NHS Lothian
- Working collaboratively to consider all team members and the impact on their service
- Enabling staff to work safely, person centred and effectively

Challenges

- Constantly changing workforce
- Competing priorities in a Front door environment
- Compliance from clinical staff
- Sustaining change throughout NHS Lothian
- Agreeing a formal Med Rec NHS Lothian process, policy and procedure

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SCOTTISH PATIENT SAFETY PROGRAMME MEDICINES

Key Points for Sharing:

- Analyse your systems and ask:
    1. What do I need you to do?
    2. How can you help me?
    3. Who can help me to achieve this?
    4. How can we make it safe?

- NHS Lothian would like to know more about
  - Have other Health Boards a policy on Med Rec.
  - How do others see the management of Med Rec in the future
  - How can we influence other supporting systems i.e. KIS, ECS

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WebEx Series

WebEx Schedule for 2017		
Date	**Time**	**NHS Board Presenting**
19th January 2017	3pm – 4pm	NHS Dumfries and Galloway
16th February 2017	3pm – 4pm	NHS Tayside

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Healthcare Improvement Scotland's Improvement Hub

Medicines Reconciliation Summit

Thursday 2 March 2017

COSLA Conference Centre
Haymarket, Edinburgh

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@SPSPMedicines

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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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