







Medication Reconciliation in General Practice

2012/13 Safety Improvement in Primary Care Pilot 2013/14 Scottish Enhanced Services Programme

2014/15 Addendum to SESP 94 teams Scottish Enhanced Services
Programme 2015/16

81 GP practice teams

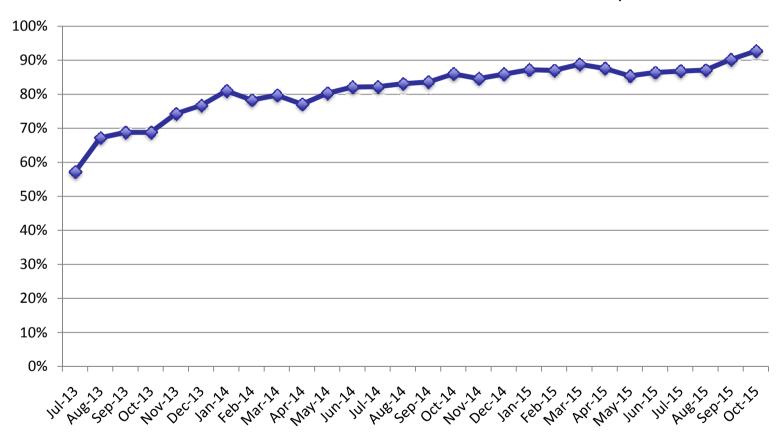
Focus on over 75s following discharge

Sample of 10 patients per month





NHS Lothian Medicines Reconciliation Bundle Overall Compliance







Examples of Improvements – the edited highlights!

- Addition of macros to Basic Consult to enable GPs to press a button saying: "medicines reconciliation" or "changes to meds discussed with patient" rather than having to type the information in individually.
- Enhance communication between surgery and local pharmacies. Local
 pharmacist came along to PLT to discuss their role. This was extremely
 helpful for all staff and for pharmacist too and has certainly improved
 communication both ways.
- Our IT Manager designed and produced a "Discharge Coding Guideline" for VISION. All clinical and admin staff now confident that correct codes being recorded correctly by everyone. Has facilitated better data for supported discharge work.





Successes and Challenges

Compliance consistently high – above 80% since June 2014

Evidence that processes are reliable and embedded within everyday practice

Difficult to identify how to improve compliance further

IDL issues exist out with the influence of General Practice

Primary / Secondary Care Interface Group in development





Failure Modes and Effects Analysis (FMEA) and improvement tools in medicines management NHS Lothian

Carolyn Swift
Service Improvement Manager
NHS Lothian





I've been asked to discuss...

- What is FMEA
- How we did it
- What we did with it





First Steps

TEAM
Executive Lead
Consultant
ST5
Pharmacist
Medical Nurse Practitioner
Patient Services Manager
FYs x 5 as placement allowed
Clinical Governance





What is FMEA?

A structured approach to:

- Identify the ways in which a process can fail
- Estimate <u>risk</u> associated with specific causes
- Prioritise the <u>actions</u> that should be taken to reduce risk





Identify the ways in which a process can fail

	Failure Mode: Each patient's medicines at the point of discharge are not complete and accurate on the IDL	Осс	Det	Sev	RPN
	Risks associated with TRAK				
2.1	1. EDDs and DDs inaccurate 2. Not able to say who prescribed 3.				
	Drop down meds lists increase risk of errors	7	7	8	392
2.2	Doctors not fully and accurately transcribing to the IDL from the Kard	4	5	6	120
2.3	Doctors not providing explanations for medicines changes during				
	admission	5	6	5	150
	Doctors not knowing how to fill in form, or its importance	6	6	6	216
2.5	Doctors not knowing what information GPs require and / or don't				
	provide it	4	5	6	120
[/ . <mark>)</mark>	Diagnosis is often not written in the notes so unable to put on the	/ _	_		2.42
	IDL notes generally vague	/	/	/	343
2.7	Unclear on what is necessary on IDL e.g. how much detail re	4	_	_	120
	investigations	4	5	6	120
2.8	Patients do not review the Kardex prior to transcription to the IDL	7	4	5	140
	Discharge drugs late because they have to wait for results	3	3	7	63
	Total				1664





Estimate risk associated with

specific causes

2	Failure Mode: Each patient's medicines at the point of discharge are not complete and accurate on the IDL		Occ	Det	Sev	RP	N
	Risks associated with TRAK	7					
2.1	1. EDDs and DDs inaccurate 2. Not able to say who prescribed 3. Drop down meds lists increase risk of errors		7	7	8		392
2.2	Doctors not fully and accurately transcribing to the IDL from the Ka	rc	4	5	6	-	120
2.3	Doctors not providing explanations for medicines changes during admission		5	6	5		150
2.4	Doctors not knowing how to fill in form, or its importance		6	6	6		216
2.5	Doctors not knowing what information GPs require and / or don't provide it		4	5	6		120
2.6	Diagnosis is often not written in the notes so unable to put on the IDL, notes generally vague		7	7	7	,	343
2.7	Unclear on what is necessary on IDL e.g. how much detail re investigations	1	4	5	6		120
2.8	Patients do not review the Kardex prior to transcription to the IDL		7	4	5		140
2.9	Discharge drugs late because they have to wait for results		3	3	7		63
	Total					16	564







A Risk Priority Number (RPN) was calculated:

Likelihood of event occurring

X

Likelihood of detection



Severity of harm

1 = not likely

10 = very likely

1 = likely to detect

10 = not likely to detect

1 = not severe

10 = very severe

The higher the RPN the higher the risk





Prioritise the actions that should be taken to reduce risk

	Fell a Made Factoralization of the call the call of				
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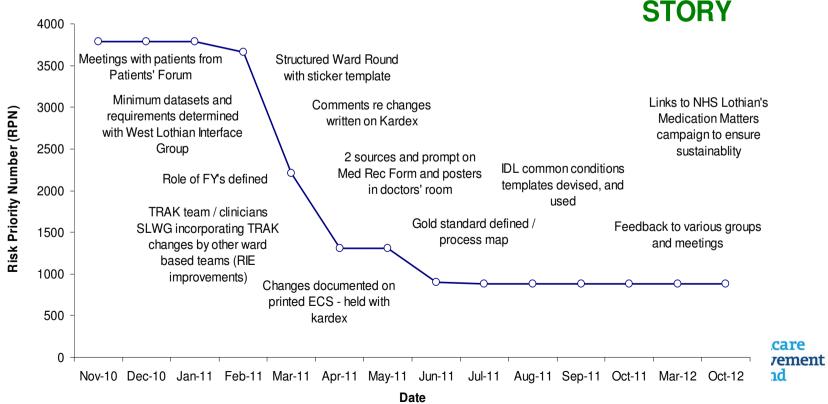




Total Risk Priority Number (RPN) as per Failure Modes and Effects Analysis (FMEA)

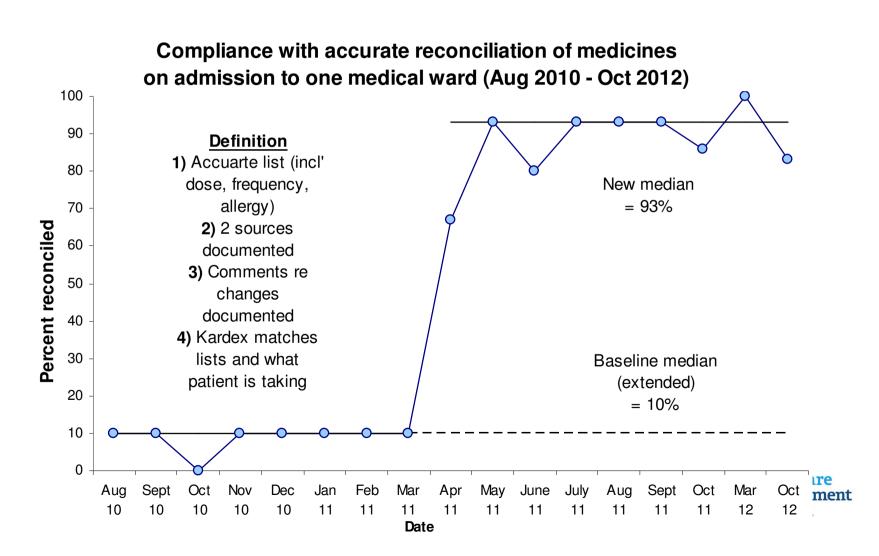
shows a 77% reduction in the risk that medicines will not be reconciled safely

THE STORY



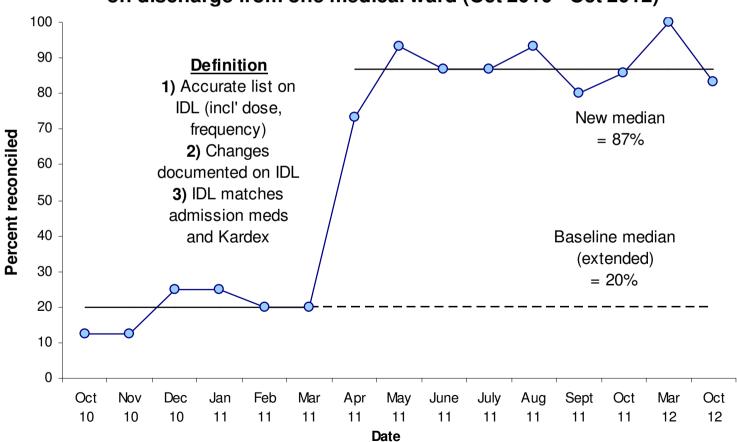


Results on Admission





Compliance with accurate reconciliation of medicines on discharge from one medical ward (Oct 2010 - Oct 2012)



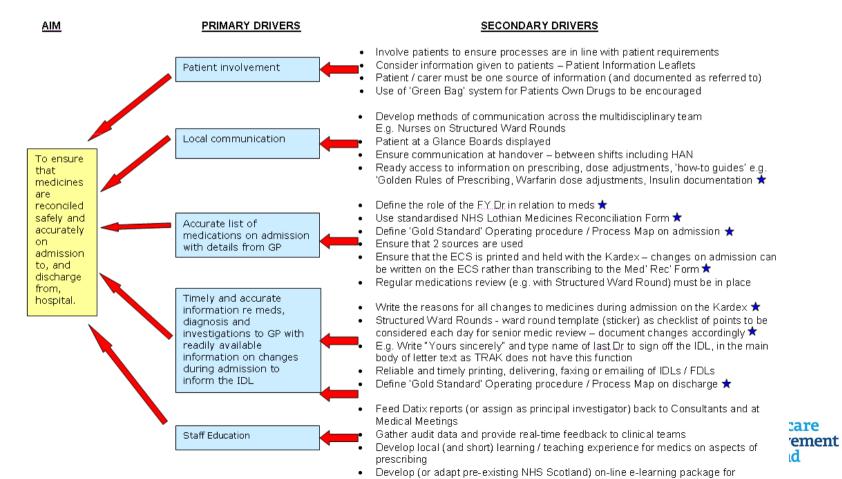
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The Driver Diagram

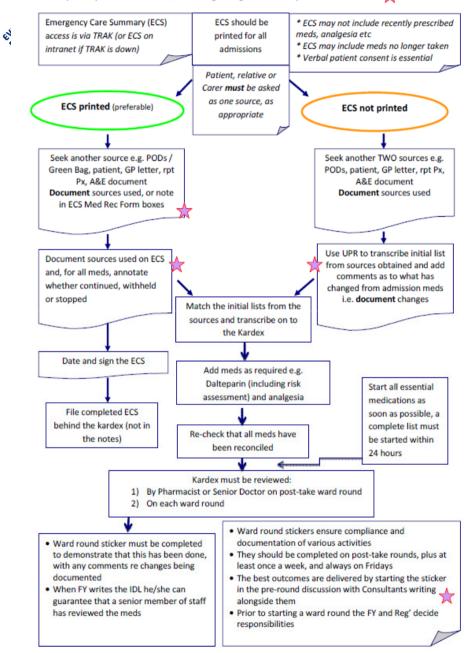
MEDICINES RECONCILIATION IN NHS LOTHIAN

★ Examples available on intranet



medicines reconciliation

MEDICINES RECONCILIATION on Admission: to ensure that all medications are reconciled accurately from an initial list of primary care medications, reflecting changes, to the in-patient Kardex



Basic process mapping for med rec on admission

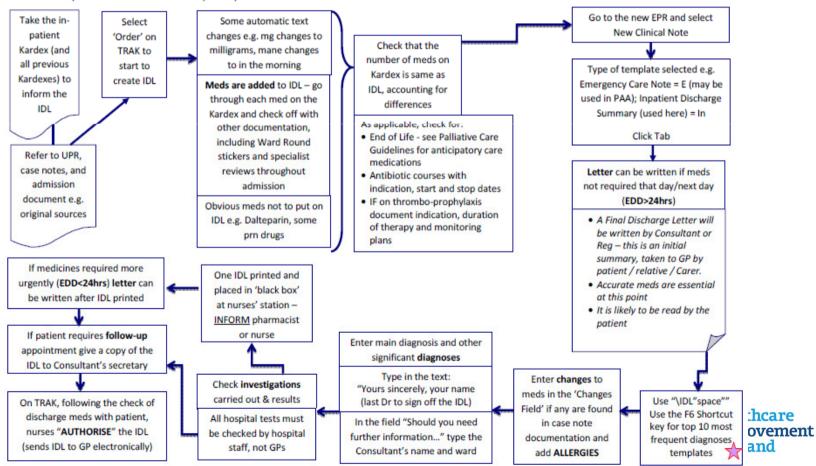




MEDICINES

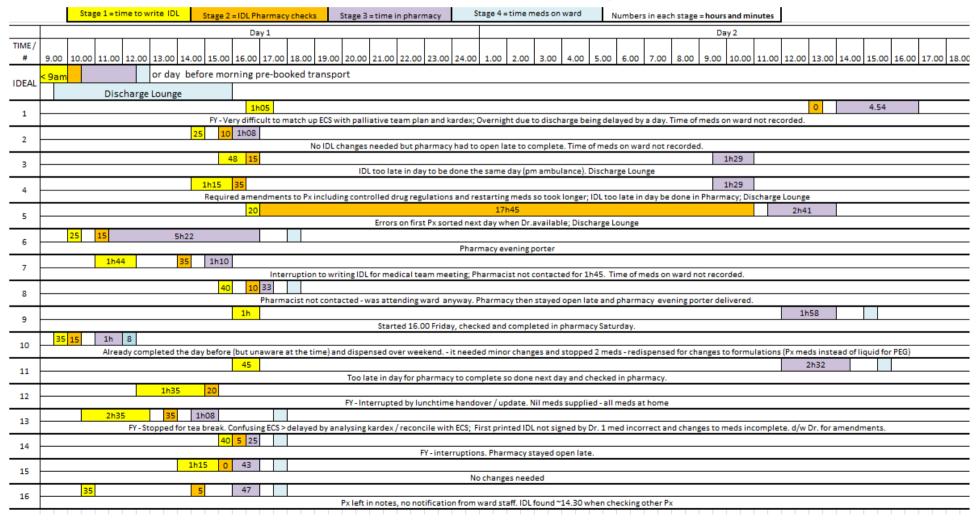
Basic process mapping for med rec on discharge

MEDICINES RECONCILIATION on Discharge: to ensure that all medications and the reasons for changes made as an in-patient, diagnosis and investigations are accurately communicated to GPs and primary care teams





Timeline of activity and delays MEDICINES in IDLs being written, checked, to pharmacy and back to patients





Cause and Effect

Cause and Effect Diagram – Main Themes Relating to the Administration of Medicines by the Ward Multidisciplinary Group

This diagram summarises the Failure Modes and Effects Analysis undertaken by 5 wards - details from each area, associated risk and action plans are available

Human Factors / General

- Forgetting to sign for meds given
- Nurses of varying skills and experience undertake med rounds (usually junior)
- Poor communication amongst all members of staff e.g. STAT doses, transfer info', changes
- Poor documentation of decisions, changes and additions in notes and/or kardex
- Double-checking is often ineffective and / or increases the risk of errors
- Distractions on drug rounds, discharges and administering (despite tabards), in particular when nurse has to frequently return to drug cupboards
- Time issues staffing levels, patient acuity, patient activity
- Patients may not be involved in decisions about changes to their meds and cannot assist staff to prevent errors

Discharge Process

- Nurses undertake many varied and complex tasks in relation to discharge meds e.g. checking IDL, counting tabs, checks with patients, matching PODs, writing labels, add/change TRAK re what is given, dispensing, rechecking with patient etc (separate process map using observation of real-time practice covering Mon - Fri as well as evenings and weekends)
 - Issues in the use of pre-packs e.g. checking against IDL, not knowing when to use IPS
 - PODs left in locker or not sent back due to volume of paperwork required by pharmacy
 - . Discharge policy not adhered to or started soon after admission lack of clarity of policy
 - · Pharmacy checks are retrospective so that there is no Clinical Professional check until after the patient has been discharged and the error has occurred

administration of medicines

- · Staff are unaware of importance of never omitting certain meds
- · Unavailable meds are not followed up
- Meds not available from pharmacy
- Incomplete list of meds on admission

- · Meds are not reviewed on Ward Rounds
- Meds requiring pre-prescribed (insulin, warfarin) not prescribed in time
- Medicines are inaccurately or incompletely reconciled on admission. discharge and transfer. This includes an accurate IDL with any changes communicated
- Dose calculations, including changing routes e.g. from oral, NG, IV or IM
- · Kardex prescriptions not completed as per policy
- Similar named meds are written wrongly

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Errors in the

Omitted Medicines

Prescription errors



FMEAs for 10 ward areas

Linked to PDSAs

	FMEA Ward	54 WGH November	29c 2011, 16th Jan, 13th Feb, 5th Mar 2012)					
Failure Mode		Cause / Effect	Осс	Det	Sev	RPN	Actions	Notes and Outcomes
1					G	eneral		
	Forgetting to sign that meds have been administered (and distractions)	double-dosing / omitted meds	5	5	5	125	INDW ctarte and it an arror hac hadh mada -	PDSA(1.1)B - in place; Team to look at Datix info at next meeting (CS to bring)
1.2	Errors can be made when there have been increases in patient activity, acuity and time constraints	Errors in reading kardex	2	7	2	28	Lockers during round - responsibilities defined as for last person to do round - highlighted at Safety Briefing (SBrf), ward meeting, induction	By Feb 2012 PDSA(1.1)A not 100% success - next test PDSA(1.1)B: Night shift to undertake top-up, and continue with SBrf
1.3	Oxygen may not be prescribed (note: Nurse Guidelines in Emergency patients) and may not be administered properly (devices and concentration)	Over / under	9	7	8	504	medics and nurses to introduce new policy (Mar 12); PDSA(1.3)B: Example kardex to be	Physios (Nicola) to audit use before and after (DM checking). FY/Reg to come to next meeting. Dates available for ward-based training

Ward work led to a whole programme of improvements, including mind mapping and pocket cards





Questions

