SCOTTISH PATIENT SAFETY PROGRAMME

MEDICINES

SPSP Medicines

Prepared by: Elouise Johnstone
NHS Lothian

Medicines Reconciliation in General Practice

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Medication Reconciliation in General Practice

Scottish Enhanced Services Programme 2015/16

81 GP practice teams

Focus on over 75s following discharge

Sample of 10 patients per month

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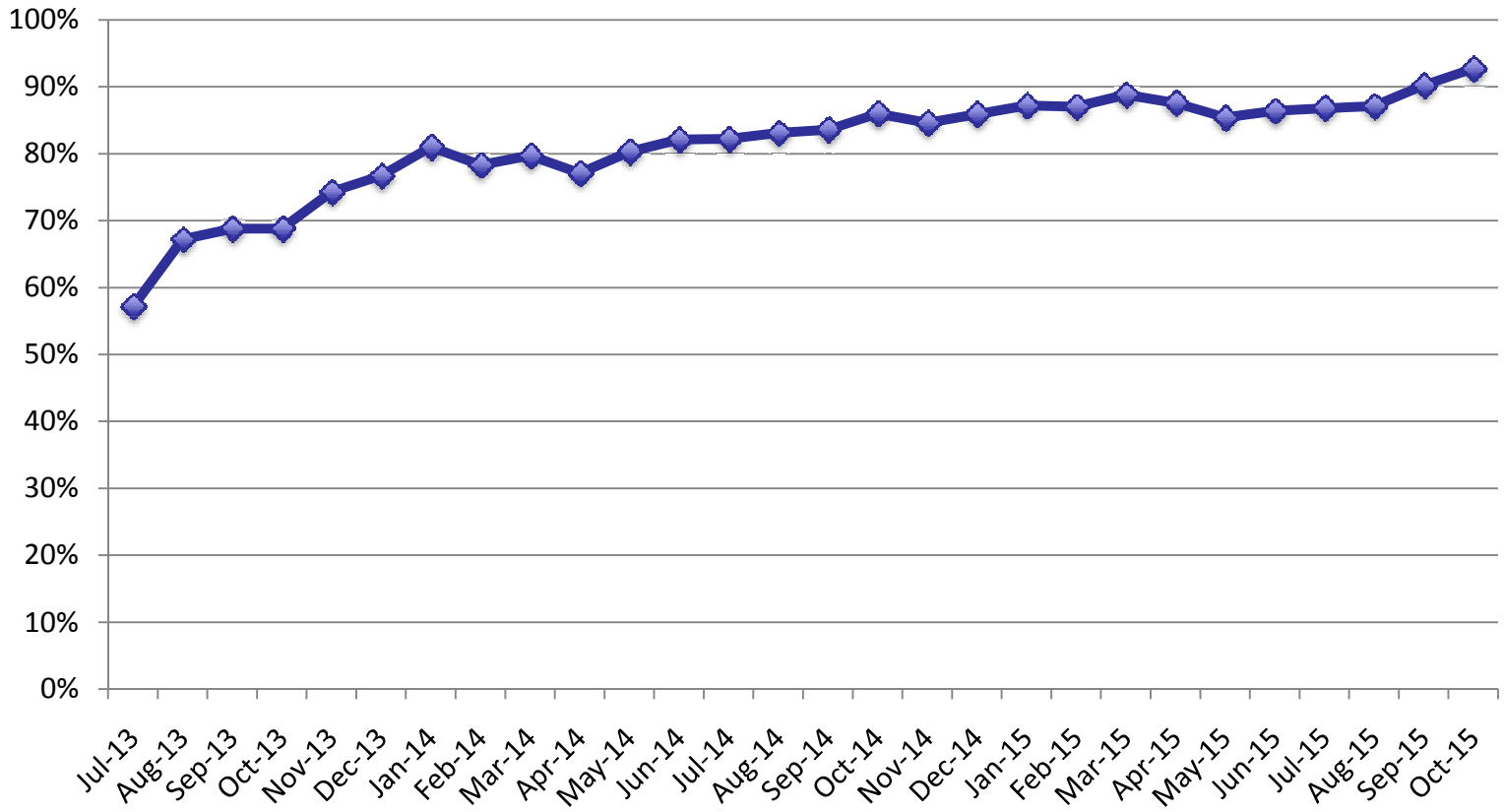
NHS Lothian Medicines Reconciliation Bundle Overall Compliance



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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.

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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

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

Carolyn Swift
Service Improvement Manager
NHS Lothian

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I've been asked to discuss…

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

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First Steps

TEAM

Executive Lead

Consultant

ST5

Pharmacist

Medical Nurse Practitioner

Patient Services Manager

FYs x 5 as placement allowed

Clinical Governance

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What is FMEA?

A structured approach to:

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

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Identify the ways in which a process can fail

2	**Failure Mode: Each patient's medicines at the point of discharge are not complete and accurate on the IDL**	Occ	Det	Sev	RPN
2.1	**Risks associated with TRAK** 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
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	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				1664

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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	RPN
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A Risk Priority Number (RPN) was calculated:

Likelihood of event occurring	X	Likelihood of detection	X	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

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Prioritise the actions that should be taken to reduce risk

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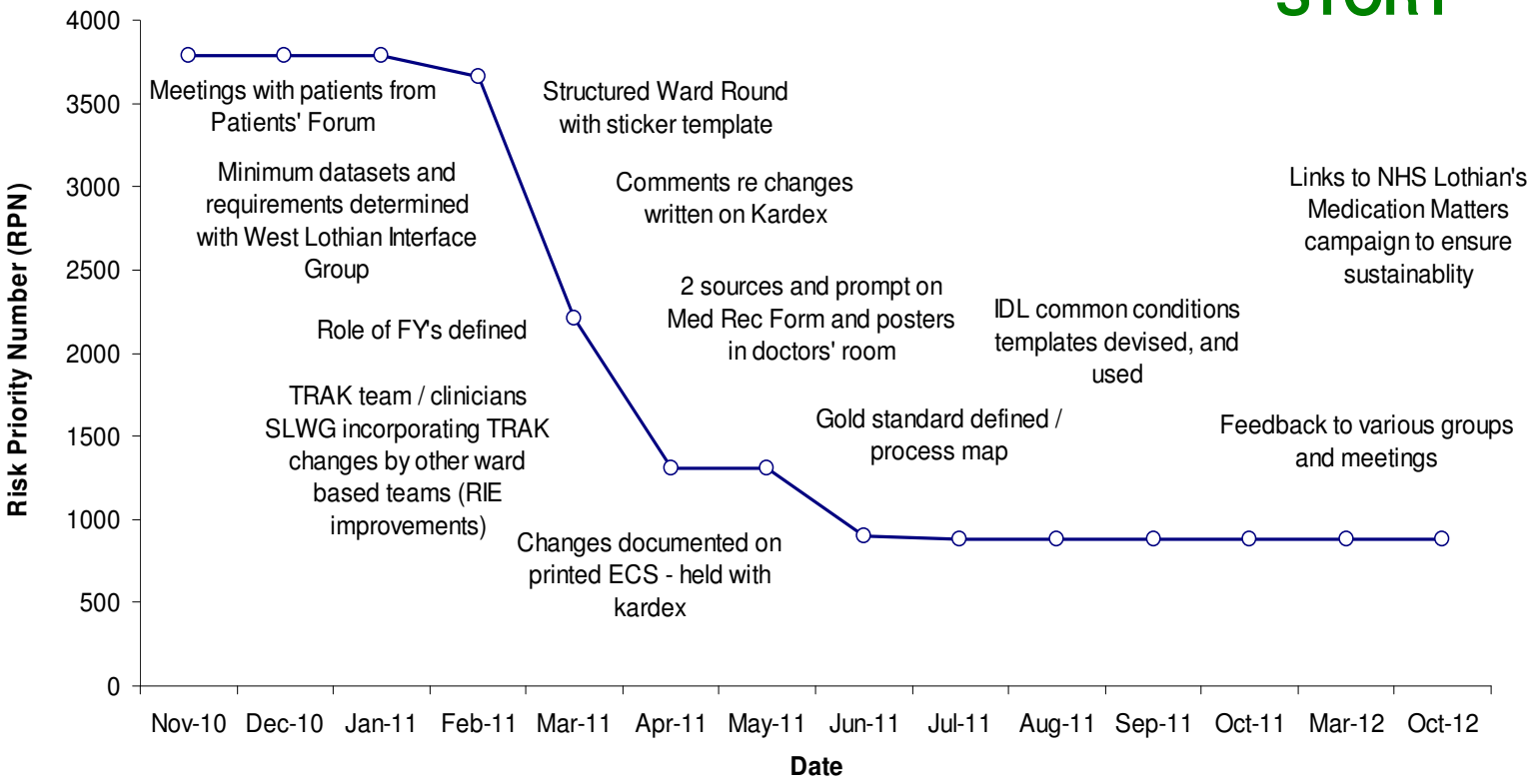
Total Risk Priority Number (RPN)
as per Failure Modes and Effects Analysis (FMEA)
shows a 77% reduction in the risk that medicines will not be reconciled safely

THE STORY



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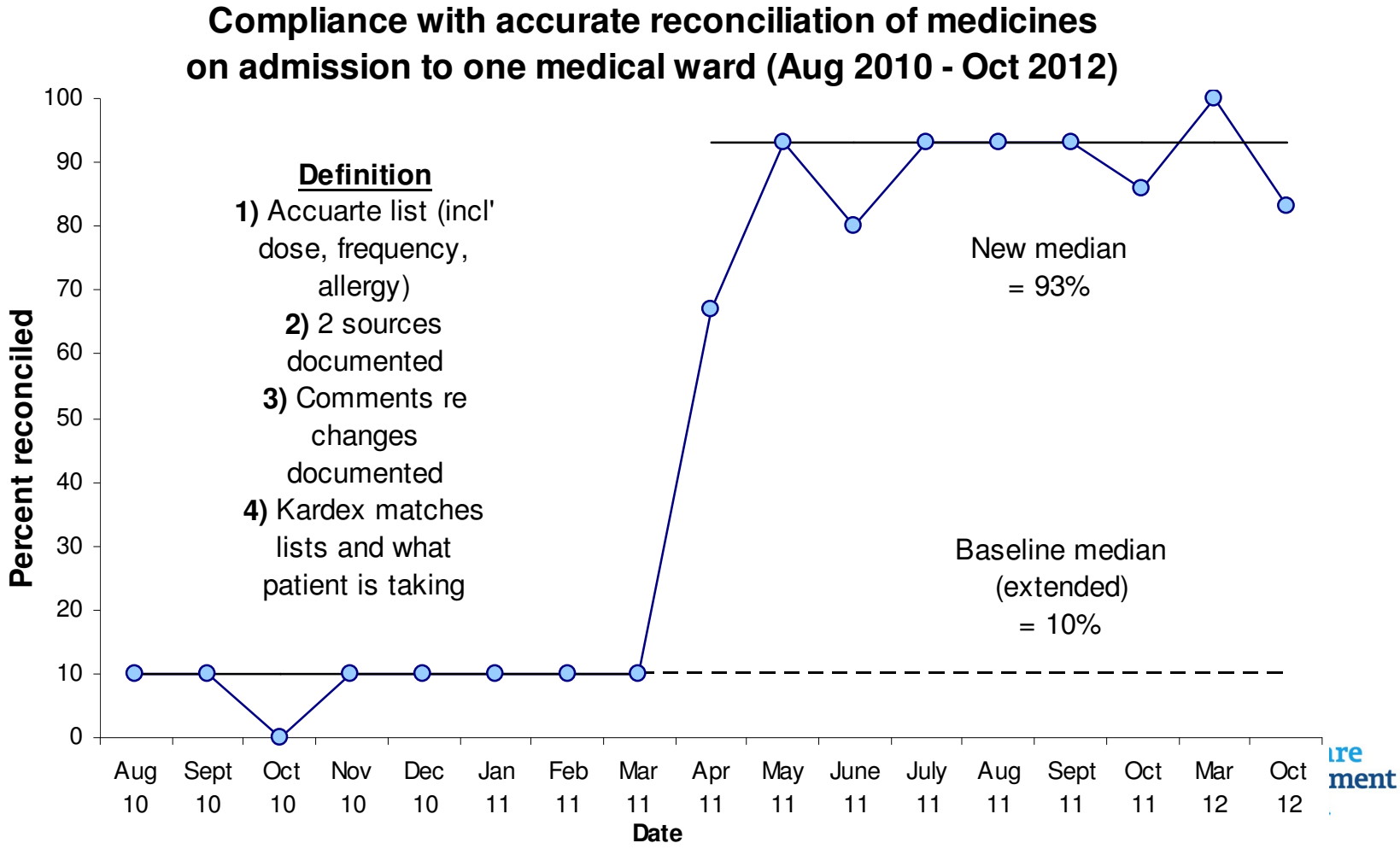
Results on Admission



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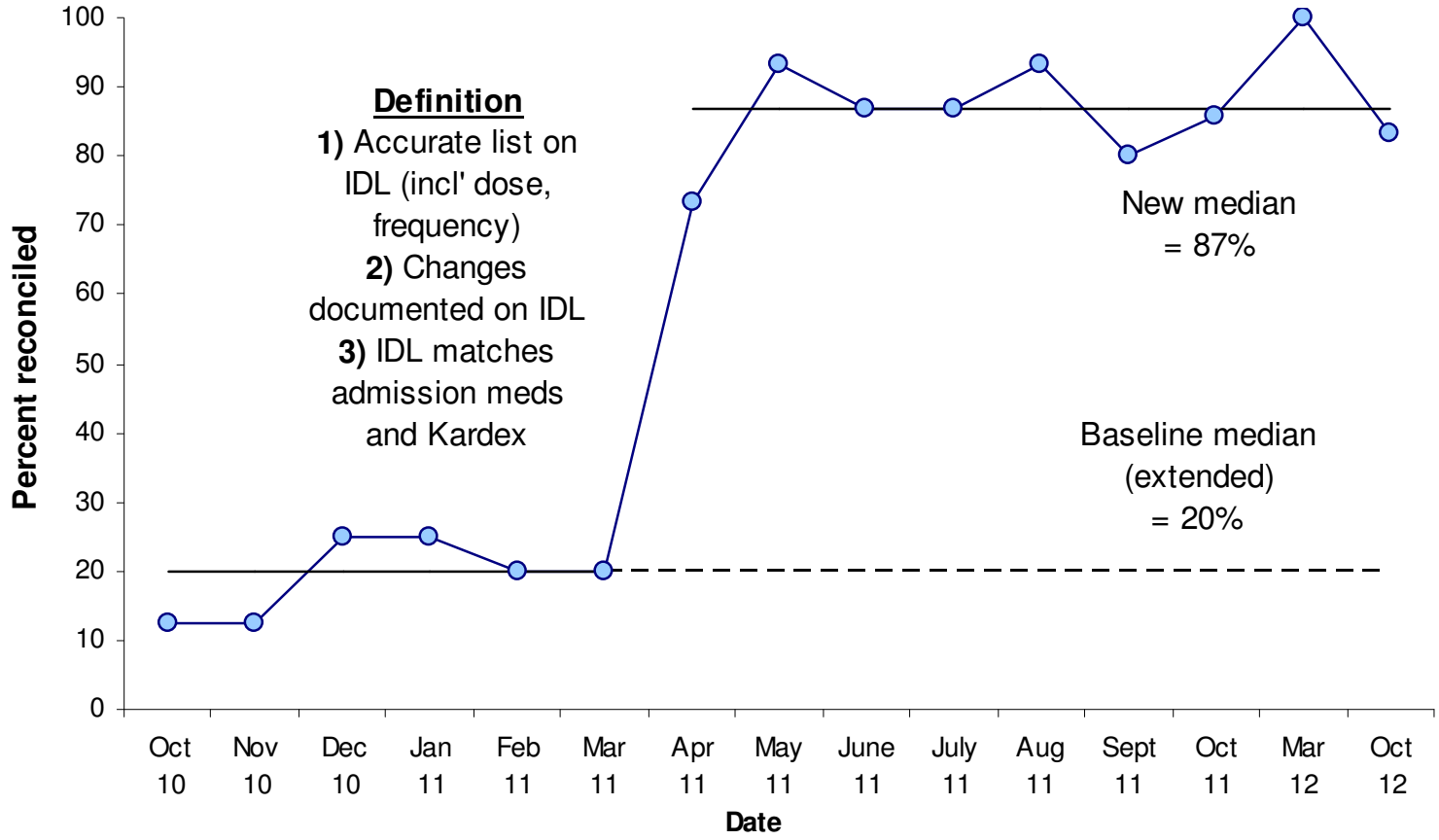
Compliance with accurate reconciliation of medicines on discharge from one medical ward (Oct 2010 - Oct 2012)



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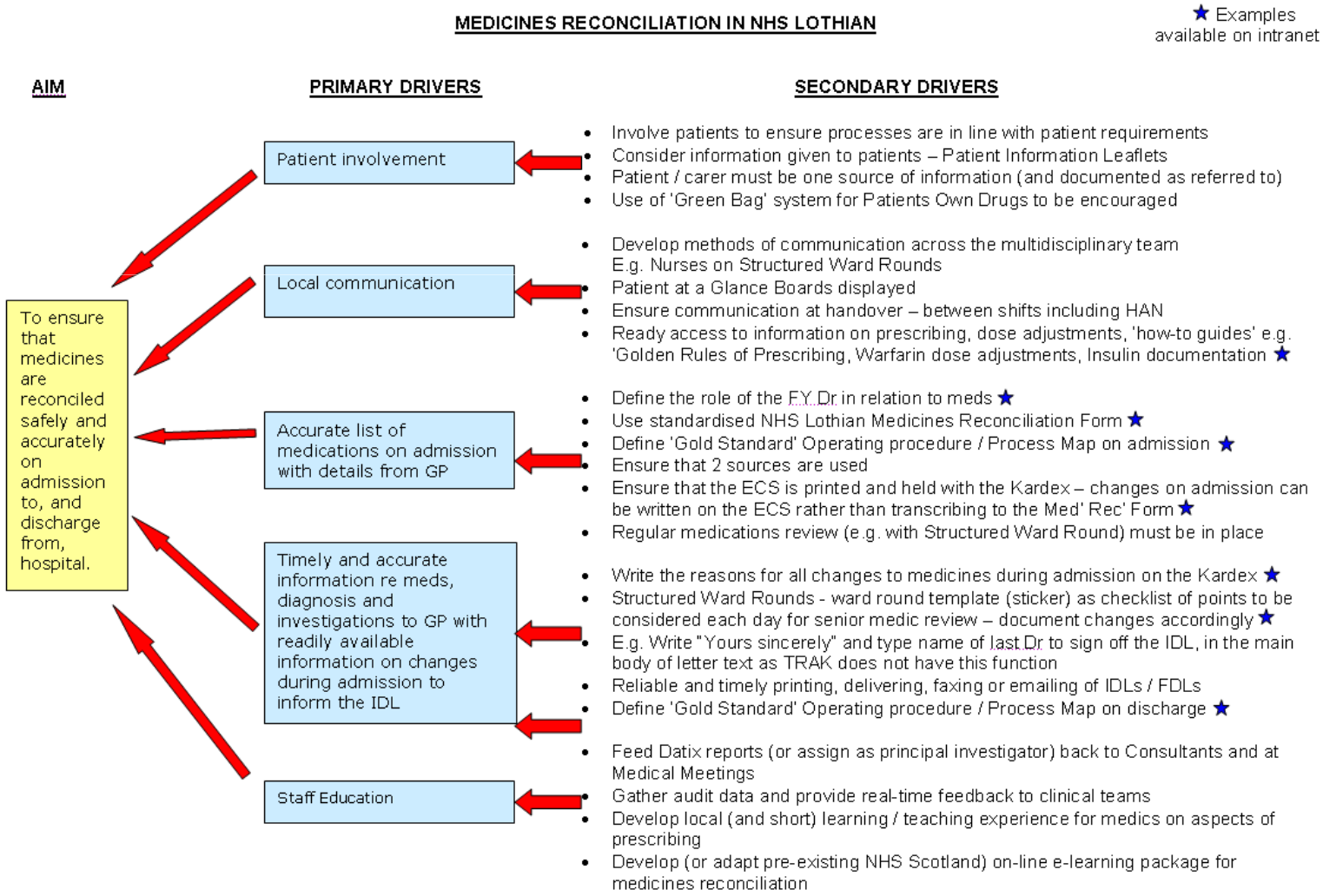
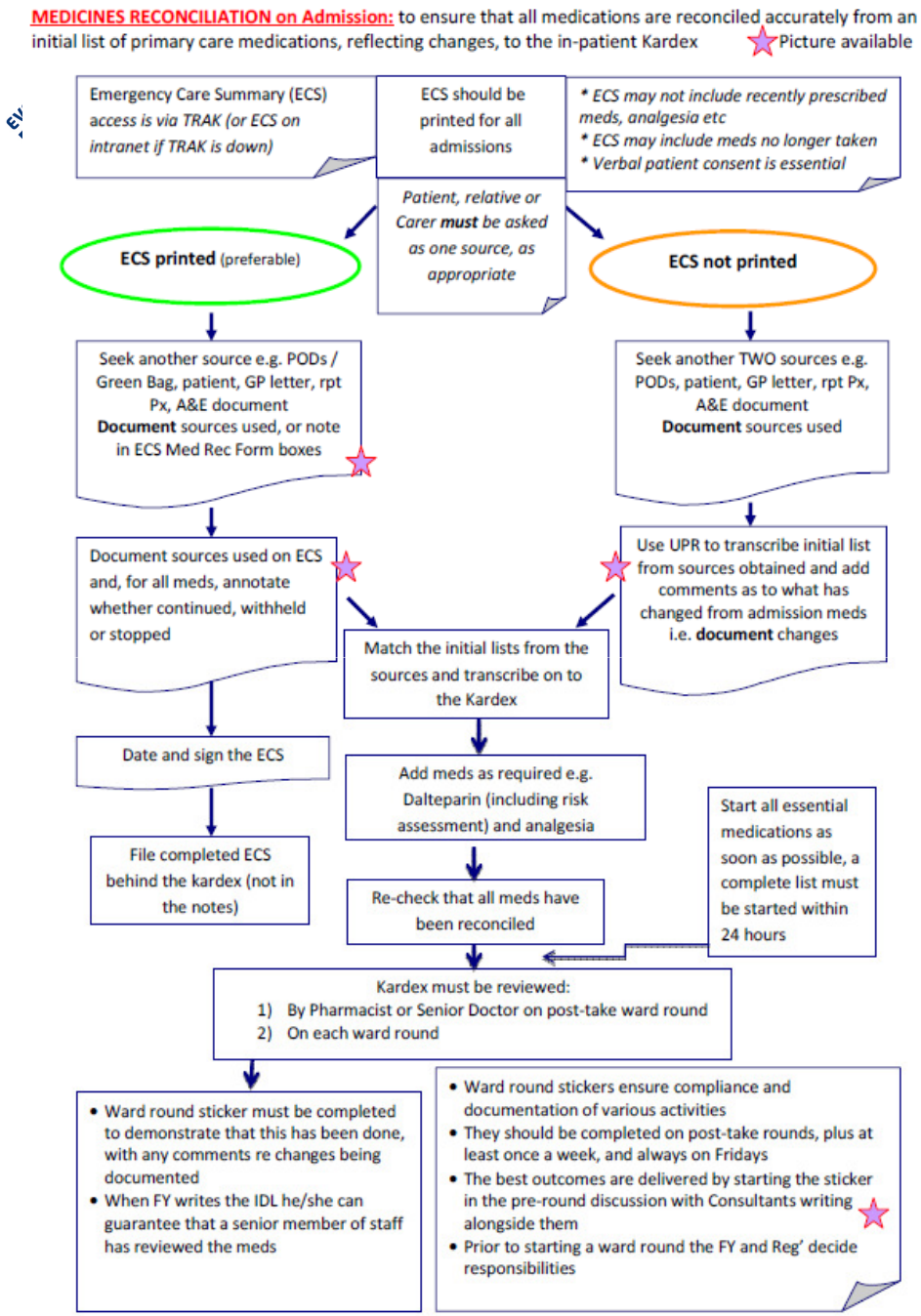
The Driver Diagram





Basic process mapping for med rec on admission

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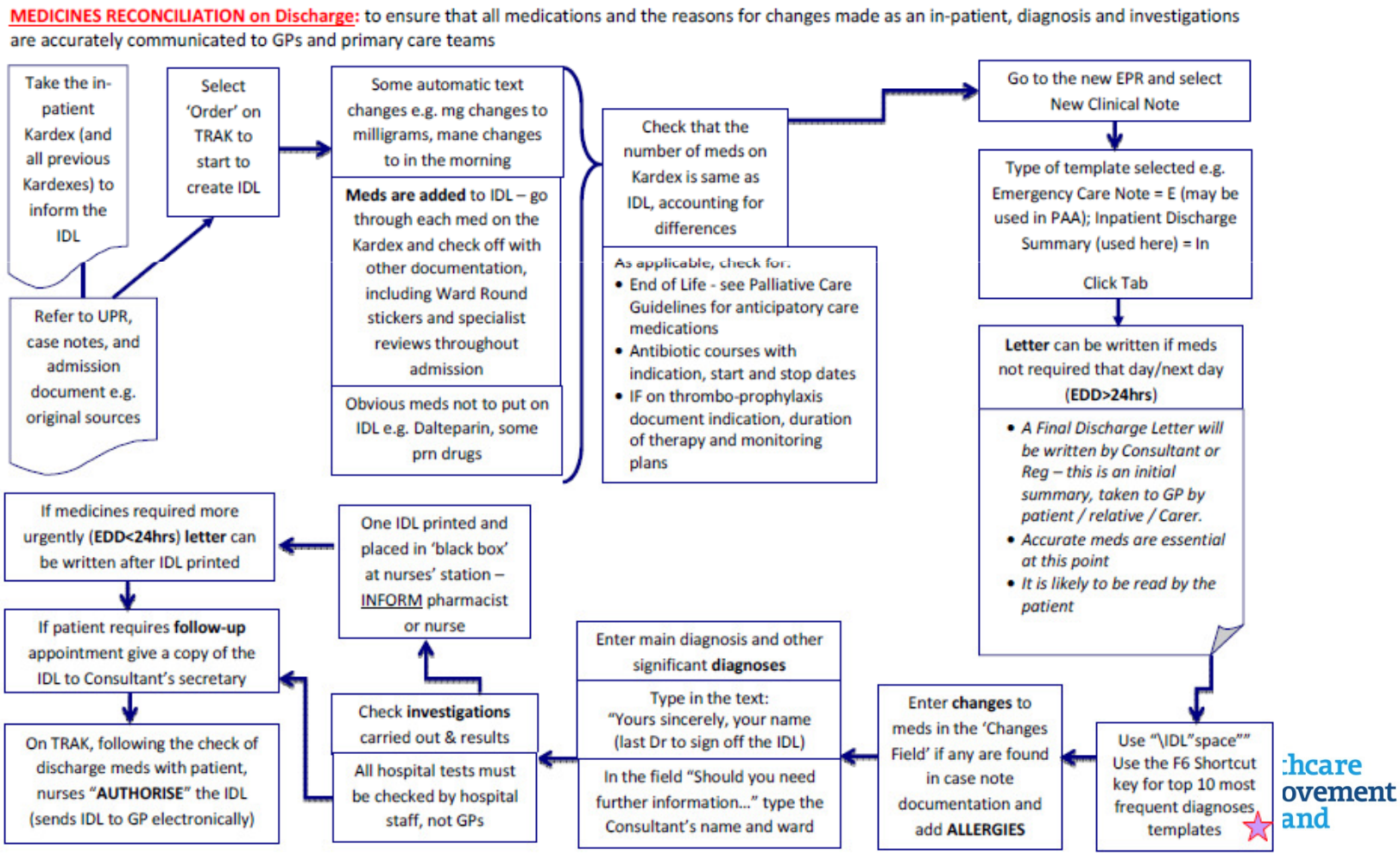
Basic process mapping for med rec on discharge



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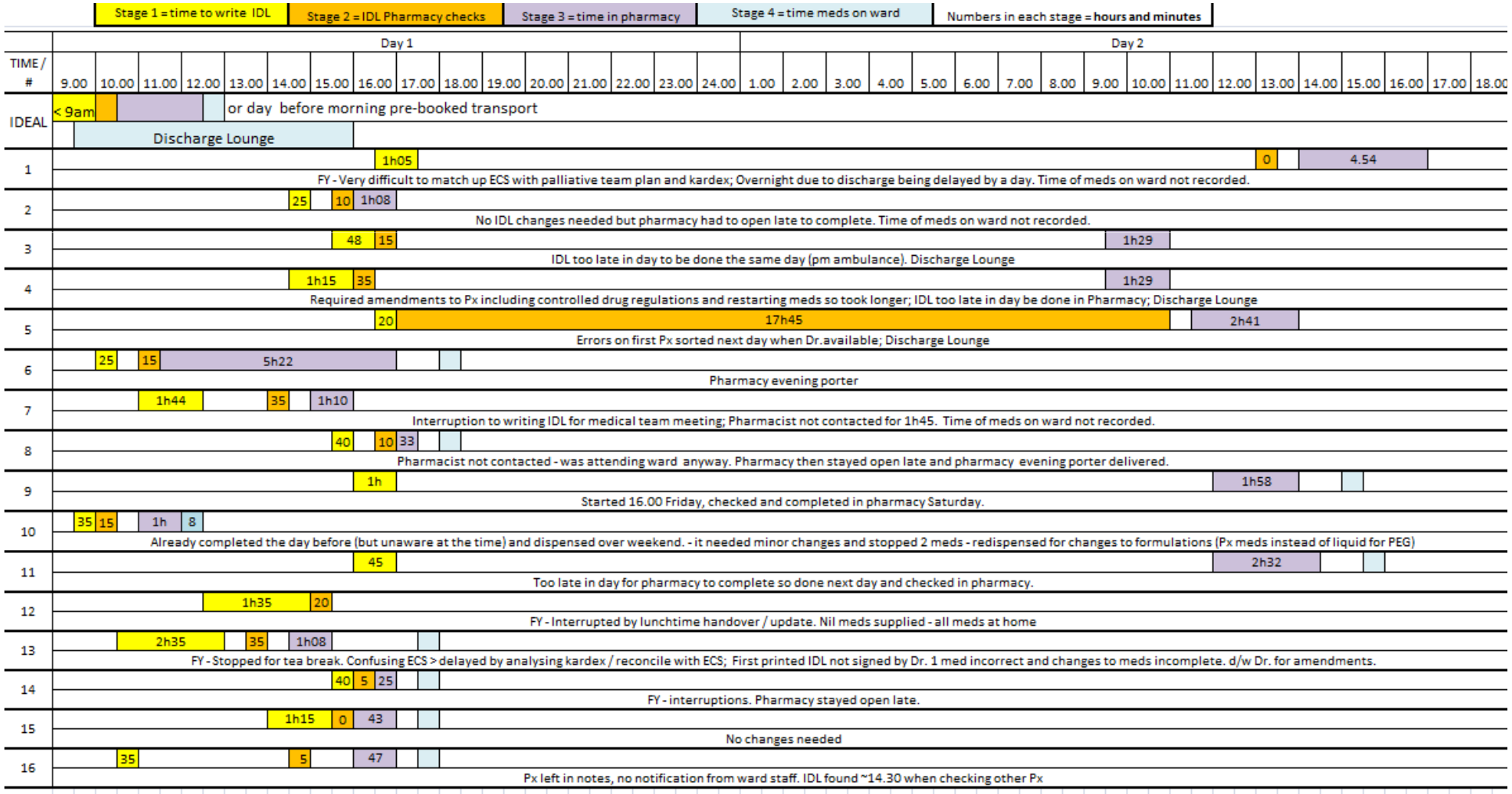
Timeline of activity and delays in IDLs being written, checked, to pharmacy and back to patients



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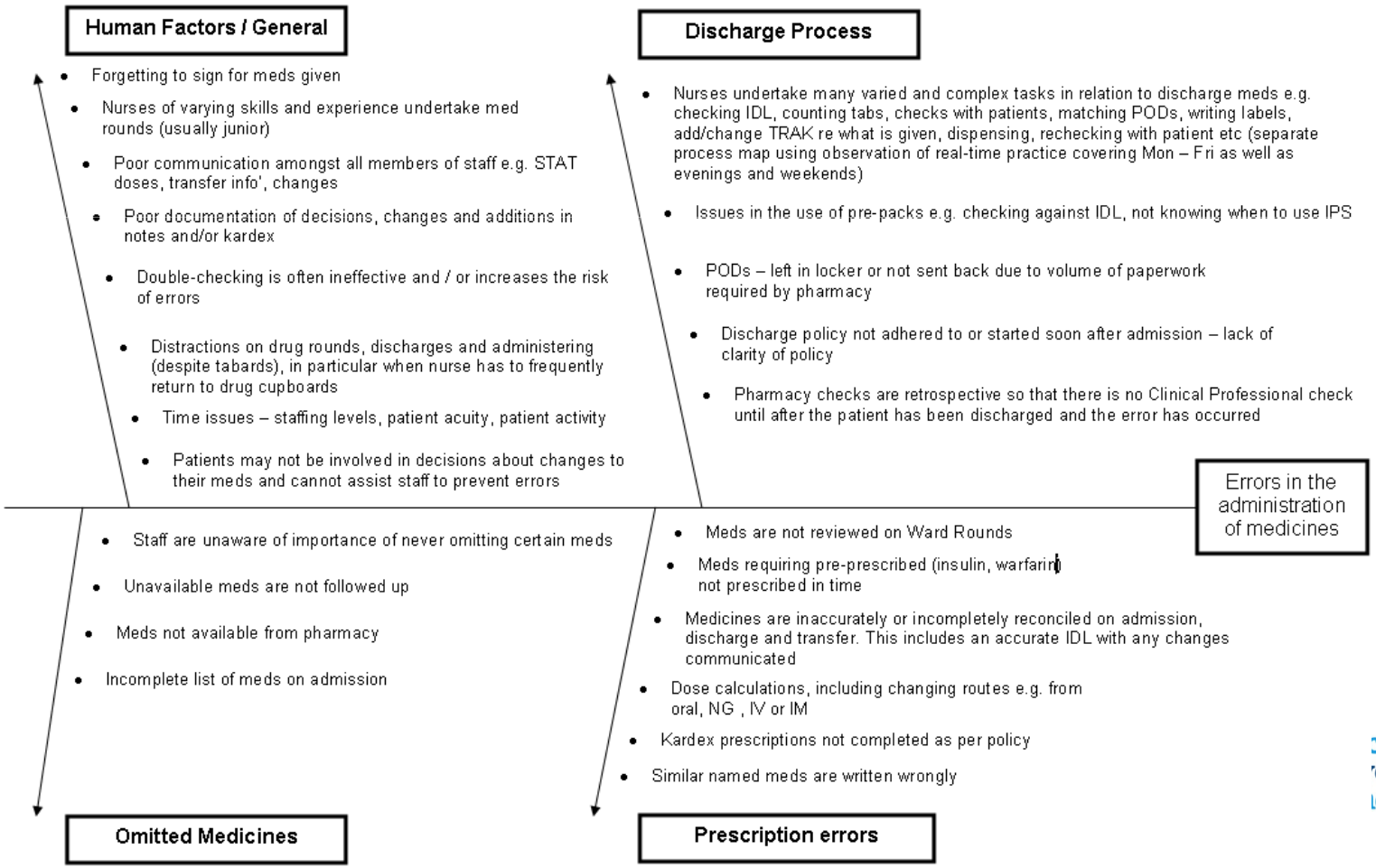
Cause and Effect

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



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FMEAs for 10 ward areas

Linked to PDSAs

FMEA Ward 54 WGH November 17th 2011 (updated 12th Dec 2011, 16th Jan, 13th Feb, 5th Mar 2012)								
	Failure Mode	Cause / Effect	Occ	Det	Sev	RPN	Actions	Notes and Outcomes
1	General							
1.1	Forgetting to sign that meds have been administered (and distractions)	double-dosing / omitted meds	5	5	5	**125**	PDSA(1.1)A: Tabards (variable success so far). PDSA(1.1)B: Supervised med rounds for all new starts and if an error has been made - SC/N or DC/N sign-off	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	PDSA(1.2)A: Time wasted topping up POD Lockers during round - responsibilities defined as for last person to do round - highlighted at Safety Briefing (SBrf), ward meeting, induction (back up by technician)	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 dosing	9	7	8	**504**	PDSA (1.3)A: Local training by physios to medics and nurses to introduce new policy (Mar 12); PDSA(1.3)B: Example kardex to be displayed in Drs room and induction folder	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

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Questions

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