SCOTTISH PATIENT SAFETY PROGRAMME

MEDICINES

SPSP Medicines

Prepared by: NHS Tayside

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Medication Reconciliation: Story so far….

For us it began in 2005!

Successes

- Reliable systems in acute admissions units
- Process spread to over 85% of in-patients areas but reliability not yet achieved
- NHS Tayside Medicines Reconciliation Policy
- Development of single measurement tool based on measures in CMO letter
- Engagement with all SPSP programmes (except Community Pharmacy)
- Beginning to involve junior doctors and medical students in data collection/improvement

Challenges

- key messages engagement
- PSN/Wags – meds identified as priority, pr/cg accountability
- Welcome refresh & re-branding, collaboration with ADTC
- Interface examples

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Challenges

- -Sustaining momentum
- -Linking work together
- -Defining accountability
- -“Medrec burnout!”

- NHS Tayside Patient Safety Network and Workshop Action Groups- medicines safety identified as priority by stakeholders
- Changing accountability – embedding medicines safety data in performance review dashboards for directorates and community health partnerships
- Refresh/re-branding of medicines reconciliation as “harm at the interface” is welcome

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Mental Health Story

- First introduced medicines reconciliation in 2009 when we participated in the Mental Health Safety Collaborative
- Education of MDT on need for medicines reconciliation and process
- Following initial testing the med rec form was included in admission paperwork
- Data collection by pharmacy with feedback to ward areas
- Marked improvement which was sustained
- Training on medicines reconciliation was embedded in Junior Dr induction- training was delivered jointly by Consultant Psychiatrist and Pharmacist with local examples of harm where med rec had not been completed
- Monitoring of Junior Dr 'performance for 1st month on site with individual feedback (SBAR format)

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Challenges

- Unable to be sustained
- Too pharmacy dependent
- Challenges with spreading to other sites
- SPSP-MH programme –struggled to get further engagement

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Need to do something different

- Tested national data collection tool in the substance misuse ward – MDT approach (Nurse, Dr and pharmacist)
- Marked improvement by involving Dr in data collection
- Developed guidance based on feedback from this test
- Aim to spread use of MDT tool to all areas

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New Opportunity - Monitoring and Measurement Of Safety

- Interactions
- Allergies
- Wrong medicine
- Adverse reactions to medicines
- Side effects
- toxicity
- Stopped medicines but then restarted

- Everyone's business
- Learning form incidents e.g at daily safety briefings
- Feedback to junior doctors
- Learnpro module

- Adherence to policy
- Med rec form e.g paper or MIDIS
- Using 2 or more sources
- Pharmacist/Peer verification
- MDT approach

- Med rec audit tool - feedback
- Sources OOH e.g ECS and access to IT systems
- Induction – junior docs and nurses
- Locums understanding their responsibility
- Zero tolerance to allergy status not being recorded

- Interruptions
- Staffing levels
- Business of the ward e.g answering bleeps
- Handovers e.g ward, across interface, ward to ward
- Conversations with patients e.g are patients taking prescribed dose?
- Quality of information
- Consent e.g to use ECS

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Current activity…..

Two Senior trainees undertaking a QI project on med rec

- Use of MDT audit tool for checking accuracy of med rec on admission within 24 hours
- MDT approach to med rec
- Access to systems e.g ECS

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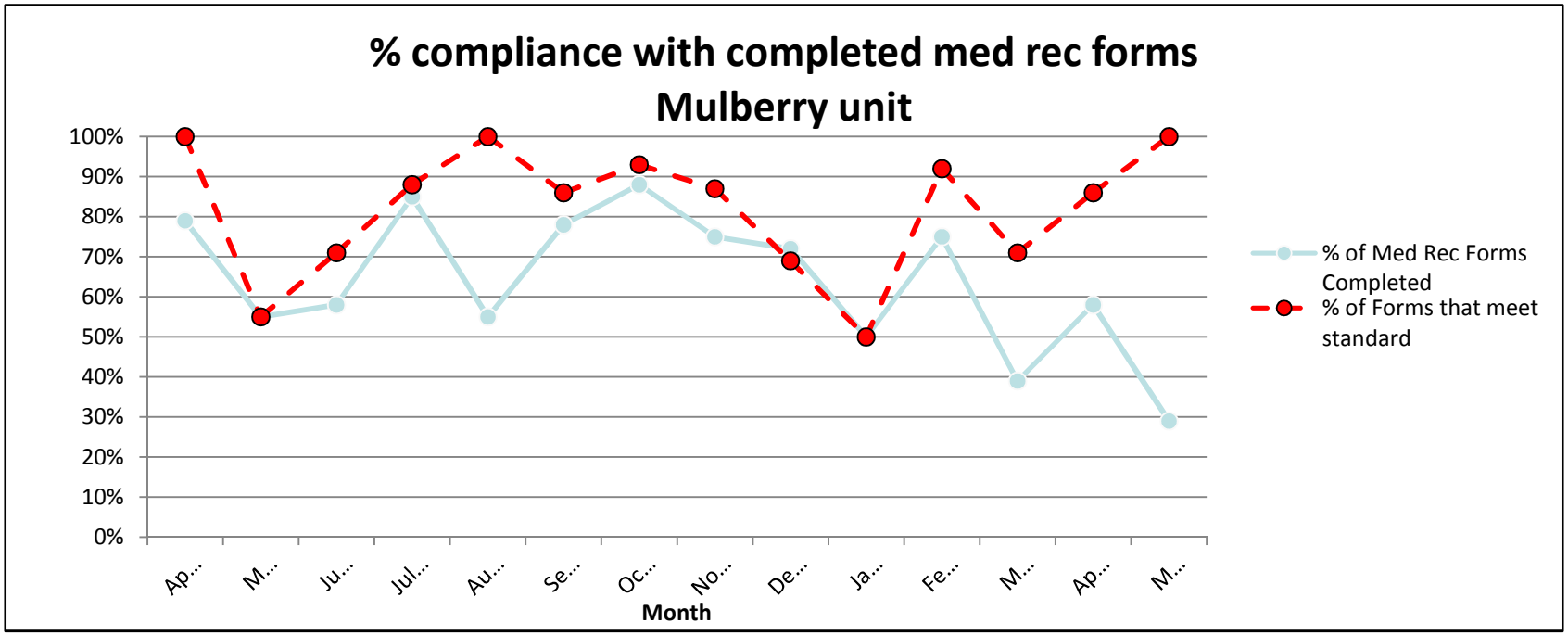
Data


% compliance with completed med rec forms
Mulberry unit
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Ap...
M...
Ju...
Jul...
Au...
Se...
Oc...
No...
De...
Ja...
Fe...
M...
Ap...
M...
Month
% of Med Rec Forms Completed
% of Forms that meet standard

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MEDICINES

Medicines Reconciliation on discharge…..

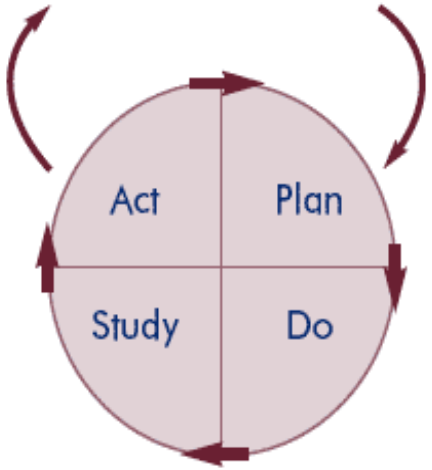
- Anecdotal evidence
- Base line data over 4 weeks
- Take 5, Ask 5

The Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in the improvements that we seek?



Testing Changes

Improve patient safety on transfer from secondary to primary care by 50%

Sustained improvement in the accuracy of discharge prescriptions

Promote accurate & reliable medicines reconciliation on discharge by encouraging doctors to,

1. Review the patient's reconciled list of medicines on admission and use it as a vital source when completing the discharge document

2.Clearly communicate any changes in the patient's drug history to the GP as part of the discharge document

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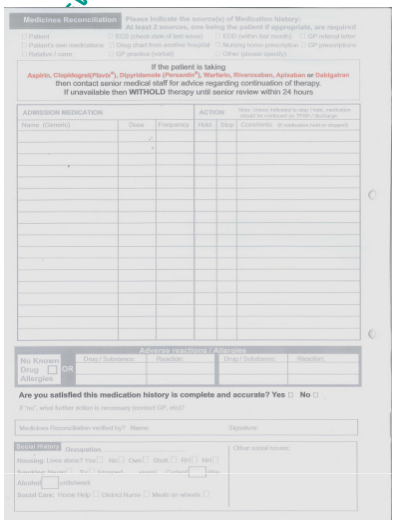
MEDICINES Data – Upper GI Surgery Pilot ward



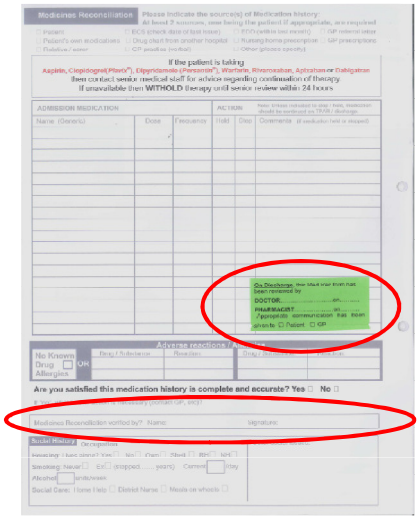
Pre Test of Change

On Discharge, this Med Rec form has been reviewed by

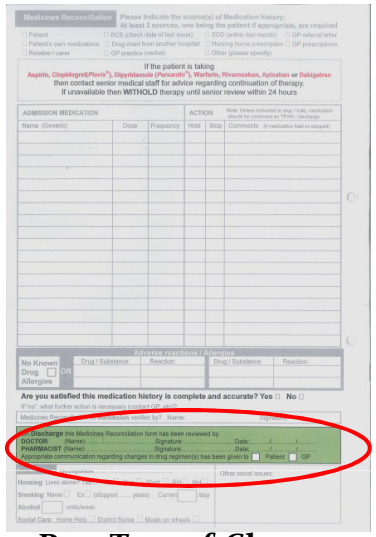
DOCTOR ..... On .....

PHARMACY ..... On .....

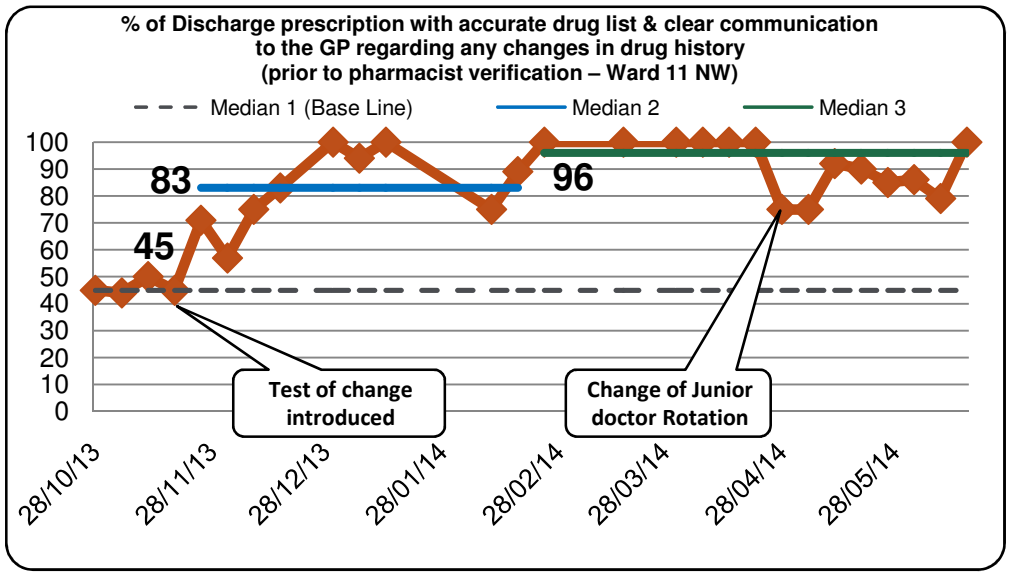
Appropriate communication has been given to ☐ patient ☐ GP

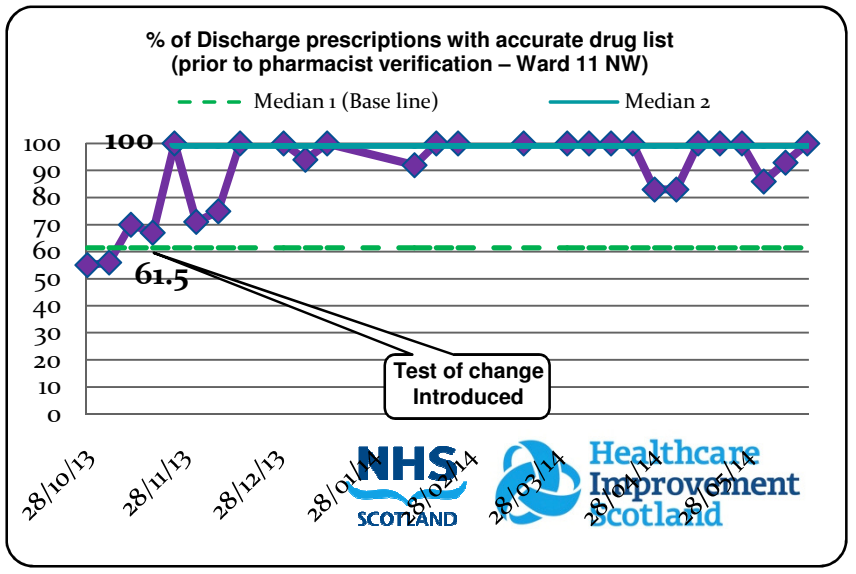


Test-Of-Change



Post Test-of-Change





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Successes

- Goal Achieved & Sustained at > 90%
- Waste, Harm & Variation
- Replicated in Orthopaedics
- Spread across Surgery & Orthopaedics
- Engagement & commitment from Primary Care

Challenges

- Benefits out with Surgical wards?
- Impact on Med Rec in Primary Care?

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Medicines reconciliation of Patients Own Medicines Brought in by Ambulance

Aim:

By December 2015, 95% of patients brought in by Ambulance from their own home admitted to Ward 4 of Perth Royal Infirmary arrive with their own medications.

Goals:

- Decrease the number of missed medication doses in ward 4 of PRI
- Improve Medicines reconciliation for patients admitted to ward 4 of PRI
- Decrease the number of prescribing errors
- Reduction in waste and additional supply of medicines

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MEDICINES

PROCESS:

% OF PATIENTS BROUGHT IN BY AMBULANCE (BIBA) WITH MEDICINES

% OF PATIENT'S MEDICINES BROUGHT IN BY AMBULANCE

OUTCOME:

% OF ACCURATE MEDICINES RECONCILIATION PRIOR TO PHARMACY INTERVENTION FOR THOSE PATIENTS BIBA

% OF PATIENTS BIBA WITH NO MISSED DOSES PRIOR TO PHARMACY REVIEW

COST OF ONE STOP DISPENSE SUPPLY AND MEDICINES SUPPLIED ON DISCHARGE FOR WARD 4

BALANCING:

% OF DRUG HISTORIES COMPLETED BY PHARMACY TECHNICIANS DUE TO THE INCREASE OF PODS BROUGHT INTO HOSPITAL

NUMBER OF MEDICINES ORDERED FOR INPATIENT STAY

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MEDICINES

Data Collection on the ward by the Pharmacy Team

Version 13: March 2015 NHS Tayside Perth Royal Infirmary Pharmacy Service

Date..... Ward..... Pharmacy Patient Log Sheet Pharmacist.....

Patient's Name	Consultant	Ward Activities				Priority code	No of PODS brought in	How many meds do they take?	N° missed doses	Did they come by ambulance?*	Med rec interventions?	Notes / Med. Rec. Audit	Date Rx Checked
		Ward Round	Care Plan	Drug History	TPAR								

Version 13: March 2015 NHS Tayside Perth Royal Infirmary Pharmacy Service

Pharmacy Patient Log Sheet

TODAY'S TAKE

Patient's Name	Consultant	Ward Activities				Interventn Y/N	Priority Code	Notes / Med. Rec. Audit	Date Rx Checked
		Ward Round	Care Plan	Drug History	TPAR				

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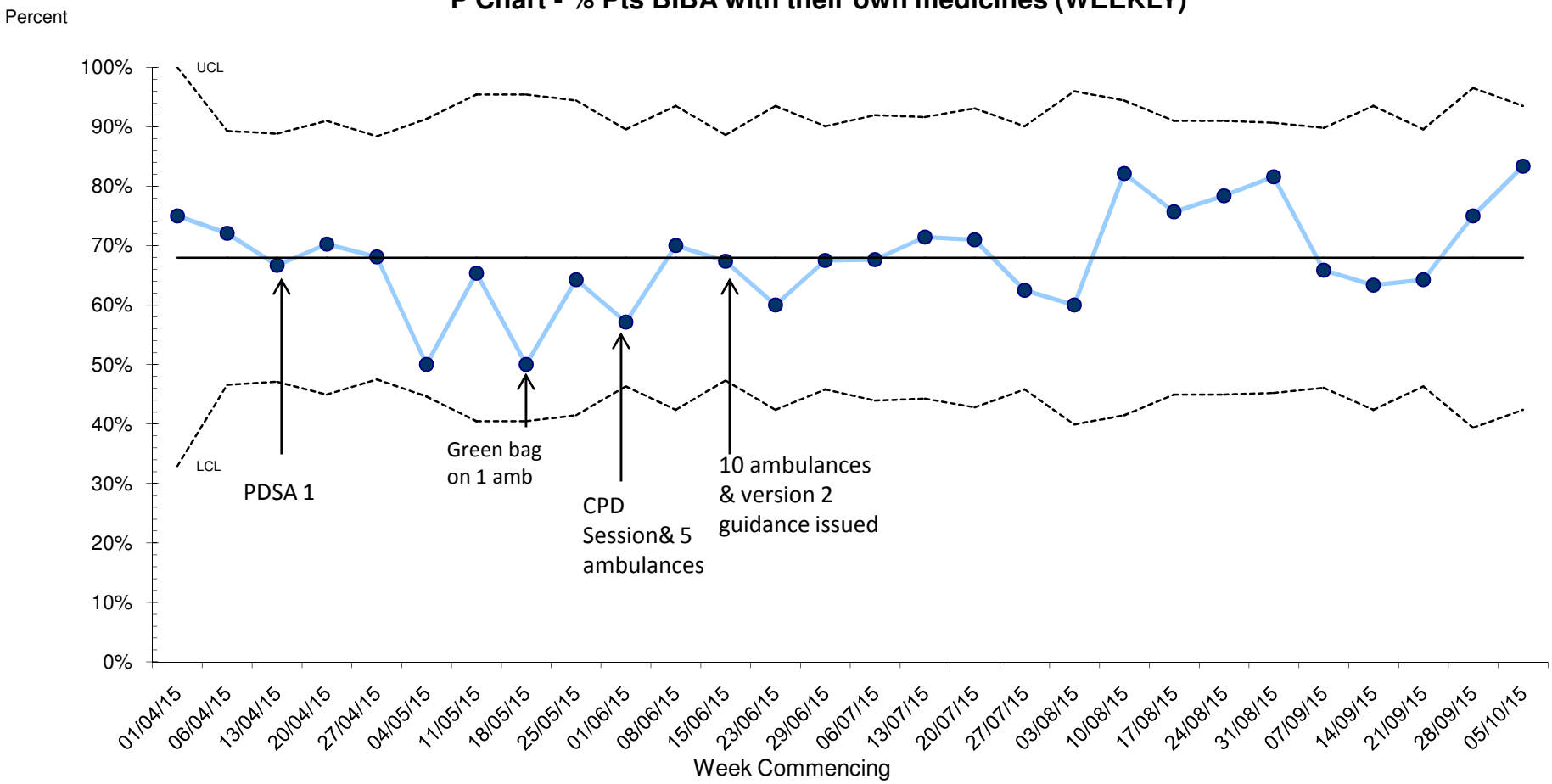
MEDICINES

P Chart - % Pts BIBA with their own medicines (WEEKLY)



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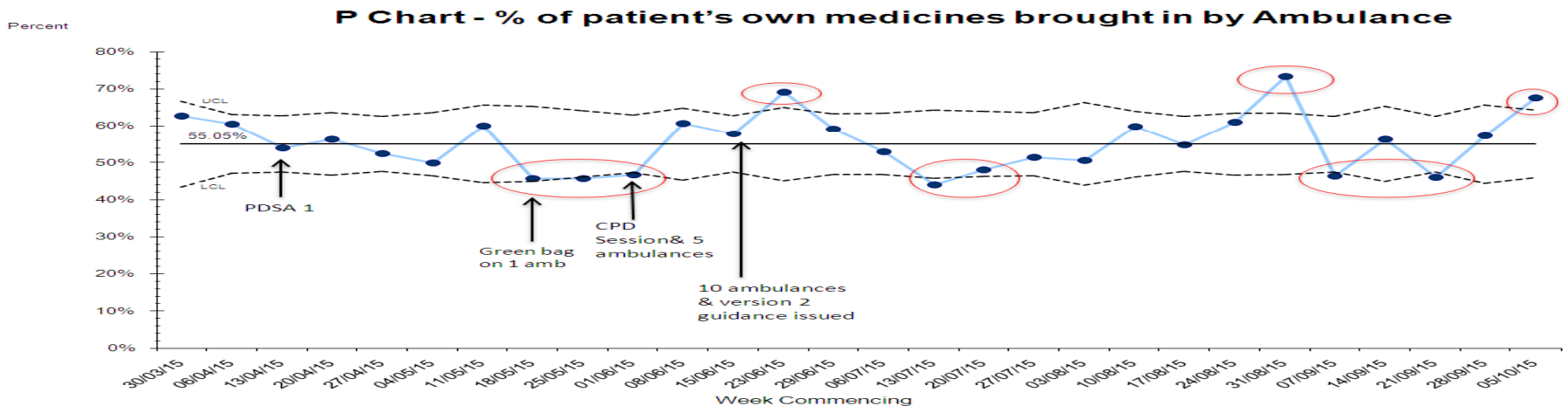
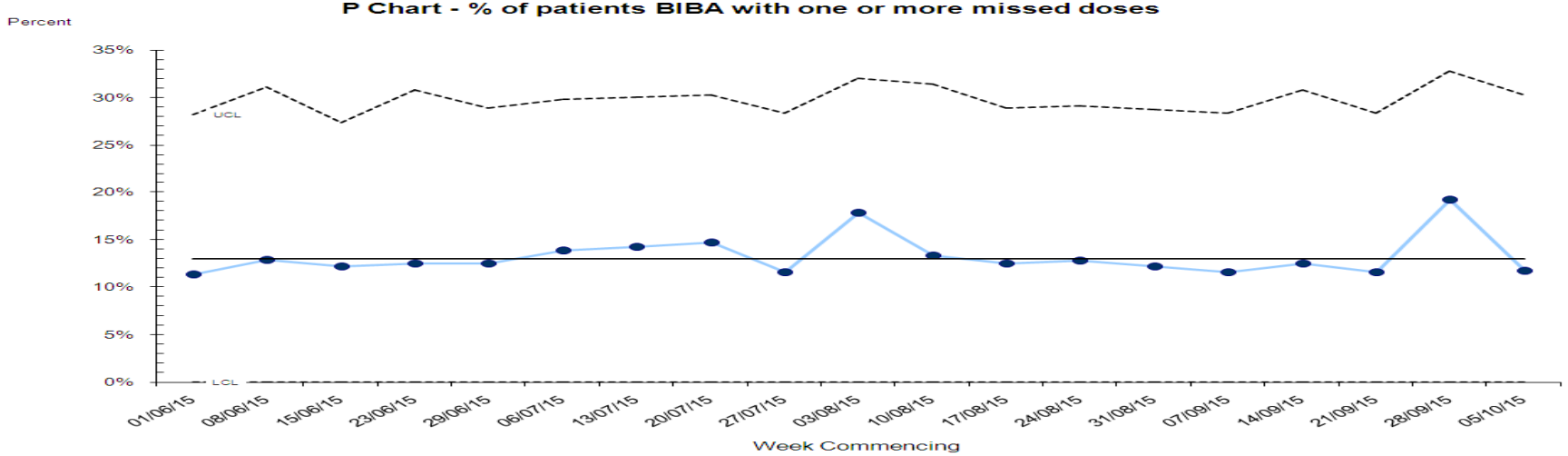
P Chart – % of patients own medicines BIBA



P Chart – % of pts BIBA with one or more missed doses



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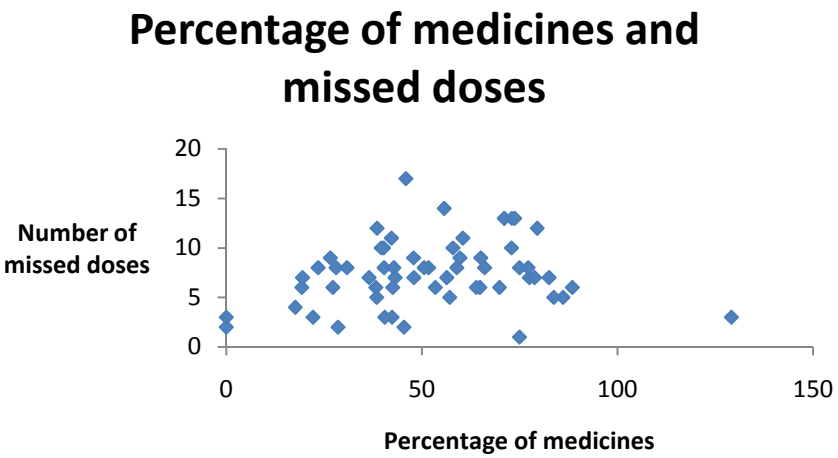
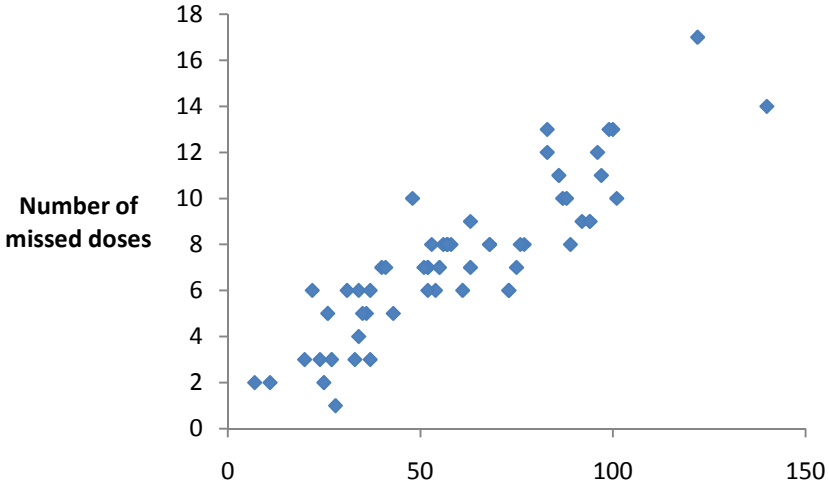
Looking for correlation





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Next steps……Planned Experimentation!

Planning Form

1. Objective:

To establish if changes to the ward round will improve medicines reconciliation.

2. Background Information

A previous exercise with one of the consultants on Ward 4 at Perth Royal Infirmary anecdotally showed improvements in the medicines reconciliation process of their patients. There are recognised tools to support medicines reconciliation with the tool for this exercise being a check and correct tool.

Experimental Variables:

	A: Response Variables	**Measurement Technique**
1	% pts requiring med rec intervention by Pharmacy	Measure is the percentage of the number of patients requiring med rec intervention with the numerator being the number of patients requiring med rec intervention and the denominator being the number of patients accepted for admission by the consultant 'on take' that day (approx 15 - 30 patients)

	B: Factors Under Study	**- Level**	**+ Level**
1	Med rec tool	No	Yes
2	Stamp	No	Yes

	C: Background Variables	**Method of Control**
1	Consultants	Hold Constant
2	patients	Measure and Potentially Adjust
3	POMs	Measure and Potentially Adjust

Learning and next steps

- Reduced variation and signs of improvement in patients with their own medicines brought in by Ambulance
- System learning shows that the number of medicines in the system has a stronger correlation than the % of medicines BIBA in relation to Missed doses.
- Missed doses despite all medicines with patient – Consideration to Handover PDSAs
- Med rec intervention by Pharmacy is fairly consistent across all of the Consultants – Planned Experiment!
- National Guidance for Ambulance Staff

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Thank you and questions.....