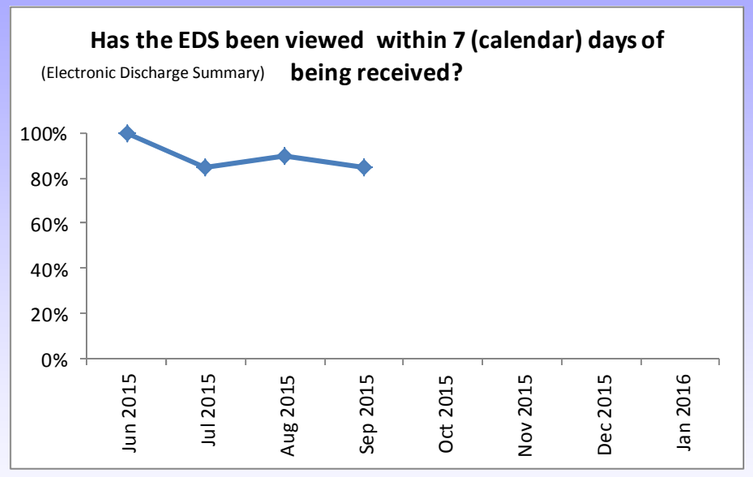
Safety in Practice

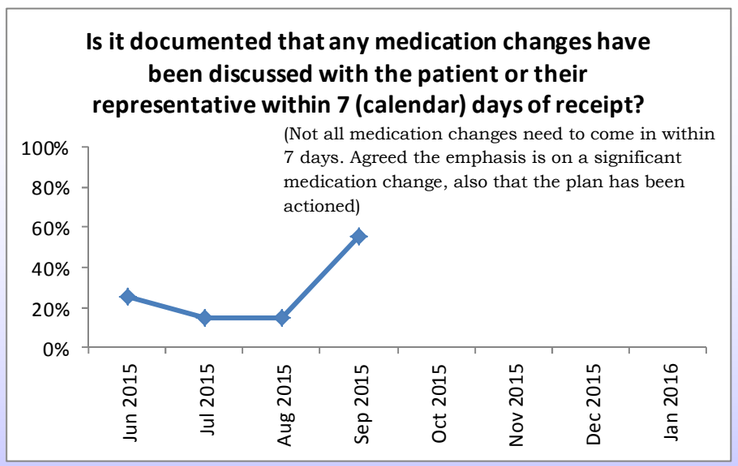
Medication Reconciliation

Medication Reconciliation is defined by the Institute for Healthcare Improvement (IHI) as: "The process of obtaining an up-to-date and accurate medication list that has been compared with the most recently available information and has documented any discrepancies, changes, deletions or additions resulting in a complete list of medication accurately communicated.



Criteria used to identify patients more likely to have had a medication change:

- First audit looks at the discharge letters from Gen Medicine and patients over 65 years.
- Second and following audits looked at a range of departments in and out patients over 45 years



Possible solution to Doctor's inbox:

MA's will go through doctor's inbox including:

- Shorecare/Whitecross Discharge summaries
- Acceptance of referral to secondary services
- Transfer of notes
- Immunisations
- New-born Referrals
- New enrolments

The Safety in Practice program was initially developed in Scotland in 2010 looking to reduce avoidable harm to people from healthcare delivered in the primary care setting.

Process for Medication Reconciliation:

- Doctor views EDS and identifies any long term medication changes
- Reconciles drug list and updates prescription
- Links to a classification
- Hotkey inserted to comment box in EDS
- Medication change discussed with patient
- Whole process to be completed within 7 days

Identified Problems with Medication Reconciliation:

- Doctor's inbox cluttered
- Multiple discharge summaries sent to inbox for the same patient creating more work and confusion
- Different hospital departments have different formats for discharge summaries
- Difficult to identify relevant information in discharge summary and very time consuming.

Actions:

Implemented hot keys in July to enter in to the discharge comment box so that it can be seen if the discharge summary has been read and actioned with regard to medications.

- .ch - change in long term medication
- .nch - no change in long term medication

Added new hot key in August:

- .tci—change in long term medication patient to come in

Adjusted hot keys in September:

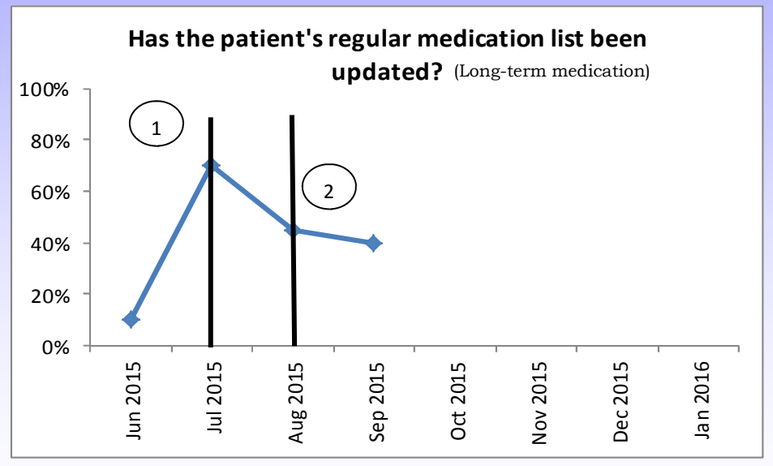
- **.chna—**change in long term medication no action required
- **.chtci—**change in long term medication patient to come in
- **.chph—**change in long term medication, patient phoned
- **.nch—**no change in long term medication

Chtci = If a patient needs to come in after a change in long term medication, the doctor can send a letter, text or task their MA to contact the patient and book an appointment with their regular doctor.

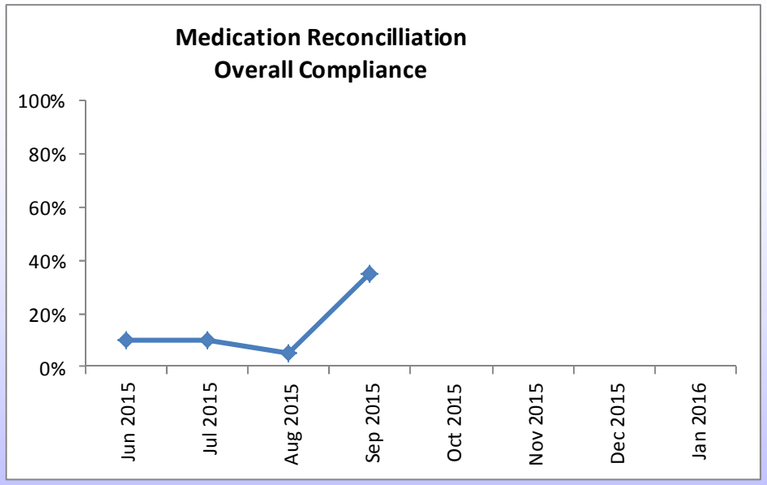
Chph = If a patients needs to be phoned regarding a change in long term medication, the doctor will send a task to Nurse Admin to phone the patient.

Why Medication Reconciliation?

- Often issues around communication & understanding
- Poor communication of medical information at transition points is responsible for as many as 50% of all medication errors.
- Acknowledged as a cause of patient harm:
  - Causes readmissions
  - Near Misses
  - Significant events



1. 70% of patients regular medication list had been updated in July (60% increase from June after introducing hot keys .ch and .nch)
2. 45% of patient regular medication list were updated in August (25% decrease from the previous month). Zero conversion to hot keys in August



Added comments during audit to note what aspect caused the overall failure.

Most common reasons for failure were:

- Medication Added
- Long Termed
- Highlighted ext
- Classified
- Old Medication Removed

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