PHO and Facilitator: ProCare, Waiana Collier

Team members: Clendon Family Health Centre clinical staff

Organisational "Buy - In"

Aim: To improve and standardise the medication reconciliation process to improve patient safety.

Buy-in:

- No standard method- all clinical staff had a different way of processing discharge summaries.
- Noticed a few avoidable errors, especially when repeat prescriptions were being requested.
- An area we all felt improvement was necessary for patient safety.

Change Ideas

- Standardise process
  - of reviewing discharge summaries, reconciling medication changes, and updating patient's files
- Synchronise decision making
  - around contacting and discussing medication changes with patients
- Weekly evaluation
  - of process at clinical team meetings

Safety in Practice

Safety in Practice

CFH Medication Reconciliation Process (as of August 2015):

Open CMDHB Discharge Summary within 5 days

Review:

- **Diagnosis** – and if a significant new diagnosis, add to patient Classification List
- **GP Advice** – action as appropriate and safe
- **Medication List** – look for new, stopped or changed medications. *

Assess if further contact required. If ANY medication change occurred with long-term meds – then assess whether patient contact required by either a nurse phone call, or a nurse consult or a doctor consult. This contact to be preferably within 7 days of discharge from hospital.**

***If Medication New :**

- **prescribe for patient**
- **write instruction of use**
- **leave quantity (mitte) as zero**
- **Tick External provider**
- **under Medication Status - tick New Med**
- **make long-term if for long-term use**

If Medication Dose Changed :

- **consider as a New Medication, but in Medication Status, code as increased or decreased**
- **make blue for long-term (change previous Rx with the old dose, to black)**

If Medication Stopped :

- **take off long-term**
- **change Medication Status to "stopped"**
- **delete instructions and write stopped with a date= mth/year**
- **add to medical warnings if appropriate**

****If Simple Medication Change - ask Nurse to call patient, to check patient aware of change**

If a Moderately Complicated Change – ask Nurse to invite patient to come in and see nurse, with all their medications

If Complicated Medication Change – ask Nurse to invite patient to come in to see Doctor, with all their medications.

NB. if simple or moderate medication change but at patient contact, the patient is very confused, advise a doctor consult, or consider another safe management plan. NB. forward these discharge summaries with request made- to Individual Nurse Provider Box: so BP patient to Nurse VM; RT patient to Nurse LB, and GJ patient to Nurse KR

What changes have been tested between June and September 2015:

	Change Tested	Outcome
1	Standardised process for recording that medication reconciliation had been done - Tested with 3 GP provider patients	'med rec done' written on only 40% of discharge summaries. Need to discuss at clinical team meeting and add to process algorithm.
2	Trialed drop down box in medication list with 5 options to help with recording when changes had been made - Tested with 3 GP provider patients	90% usage. All 5 options were found useful.
3	Created algorithm to help GP decide how patient should be contacted to discuss medications changes - Tested with 3 GP provider patients	Algorithm used in 100% of cases.

Most Successful PDSA Cycle:

PLAN

Drop down box in medication list with 5 options (as below) to help with recording when changes had been made:

- New medication
- Dose increased
- Dose reduced
- Medication stopped
- Medication list updated but script not issued

Most Successful PDSA Cycles?

DO

Review 10 results from 3 different GP provider's patients

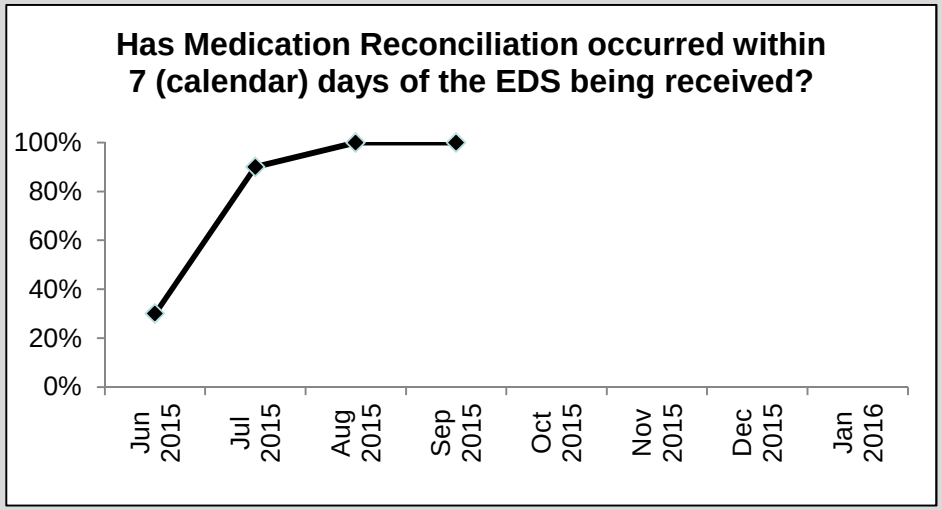
STUDY

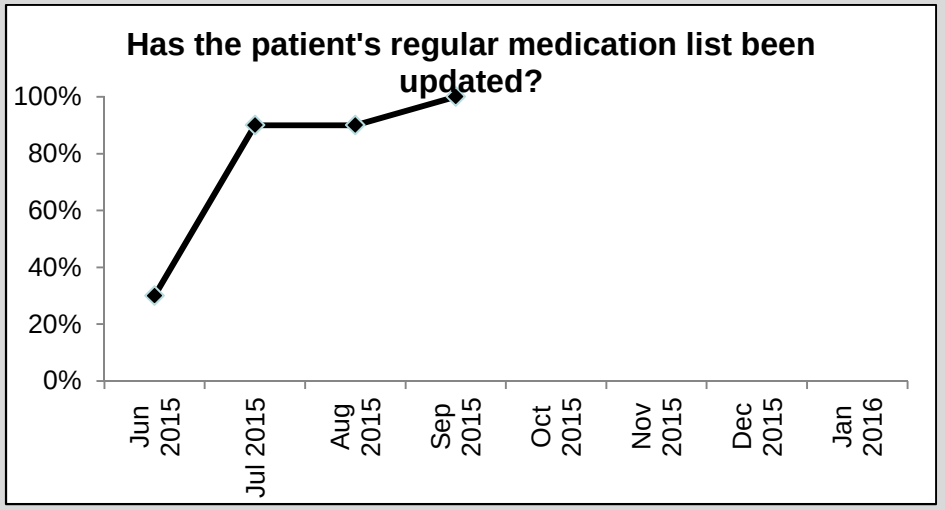
- Drop down box used in 90% of cases

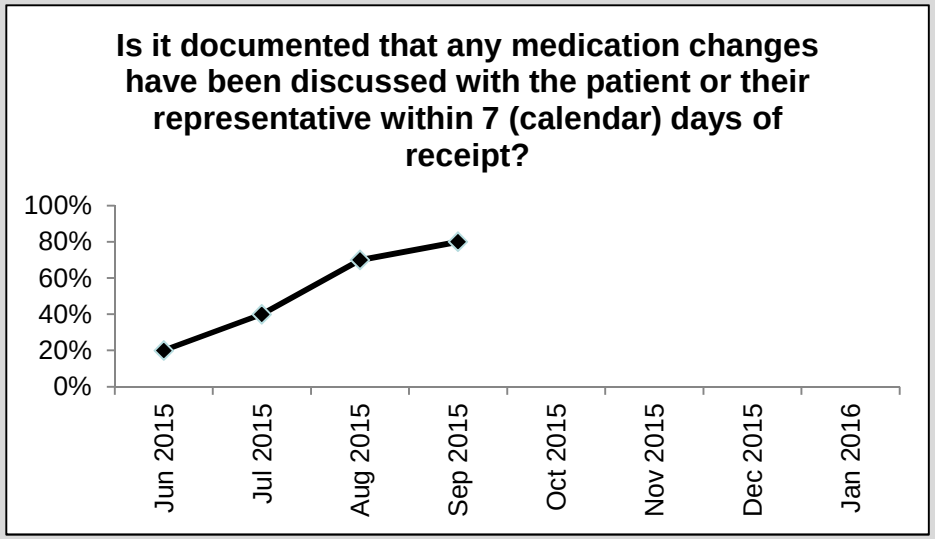
ACT

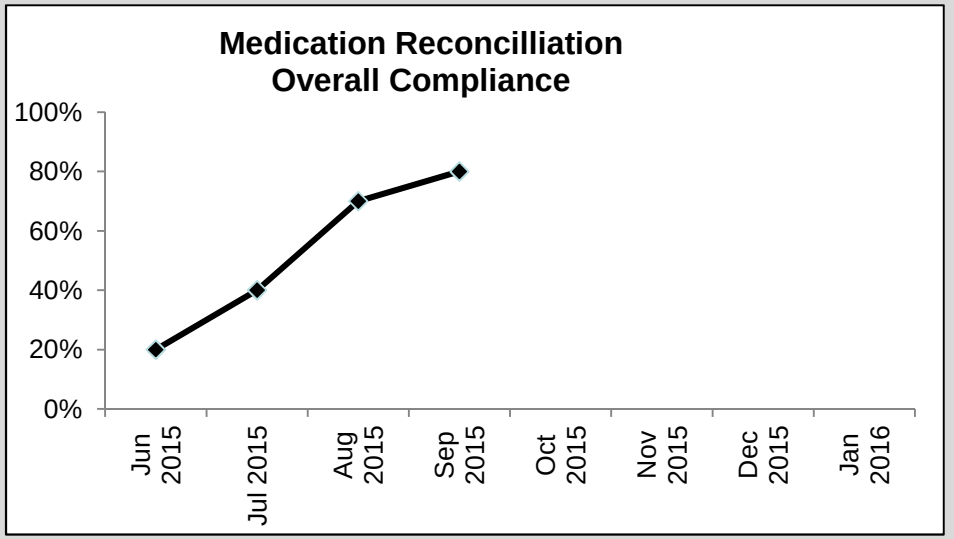
- Writing explanatory comment in instruction section of the medication would be helpful, especially when repeat prescriptions requested.
- Repeat PDSA in two months

Measures Summary









Highlights and Lowlights

HIGHLIGHTS:

-Good buy-in by whole team early in the process

-Team found standardised process worked well early on, especially use of drop down box for recording medication changes

LOWLIGHTS:

- Practice has locum doctors who don't attend weekly clinical team meetings so communicating process was challenging and is ongoing

- New process creates additional work load for whole clinical team, especially with other ongoing projects eg. ARI

- Challenging to find time to complete audit process

Achievements to date

- Uniformly well-received and implemented by all clinical staff
- Effective change package implemented early in process
- Identified need for measurement plan