Learning Session 3

Avondale Family Doctor

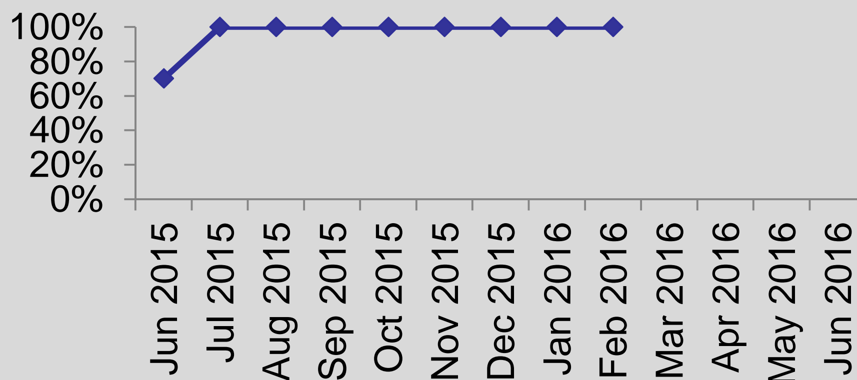
Medication Reconciliation

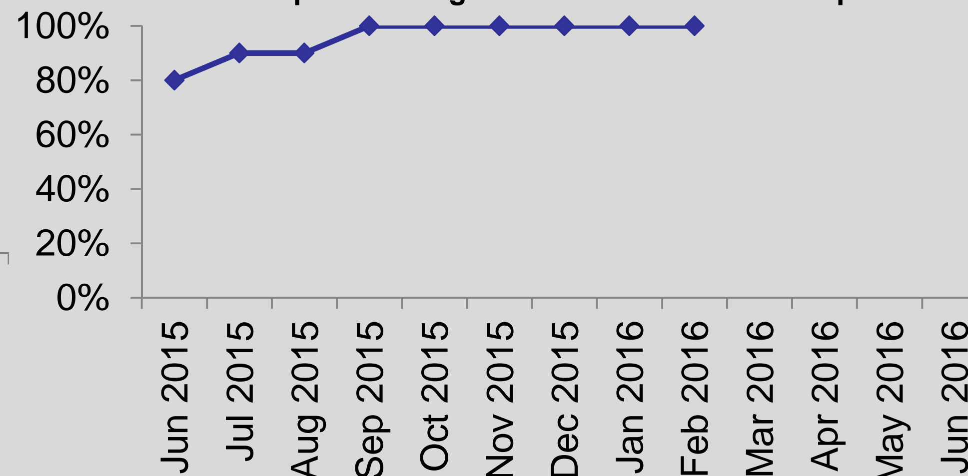
SiP Team Members: Dr Rob Stewart
Pam Hart, Jenny Littlewood (PN)
Gail Osborn, Margaret-Ann Stewart (Admin)
APHO Facilitator: Louise Goodall

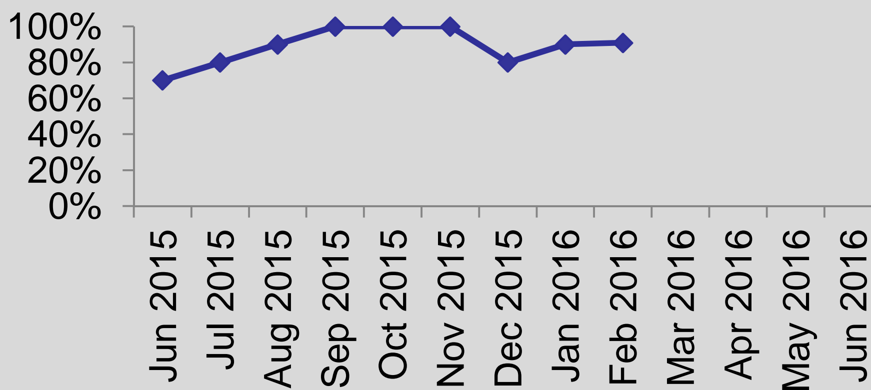
Safety in Practice

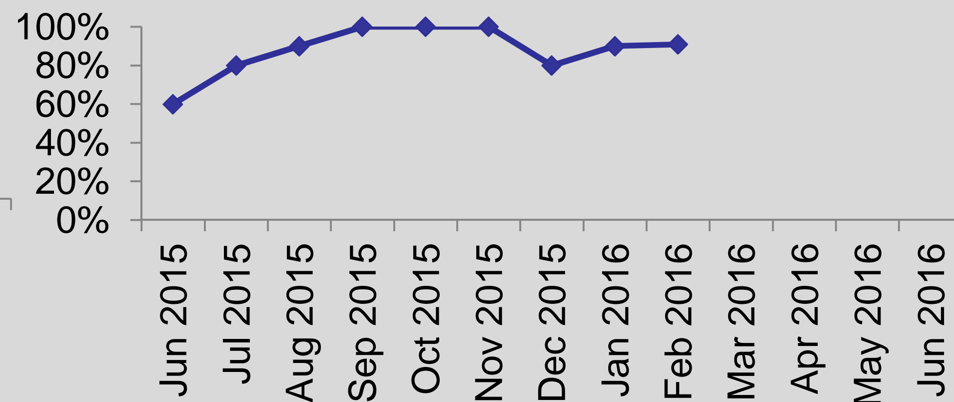
Safety in Practice

Measures Summary









Change Package

	Change Tested	Outcome / Evidence of Improvement
1	Identify and record medications prescribed and managed by specialists which may have possible potential harm with drug interactions with any current or future medications prescribed.	Five patients with specialist medication had these loaded on the patient's electronic health record.
2	Code created SPEC	At 25/11/15 staff meeting there was a 'code' discussion. Decision for amending Med Tech •Medication status SPEC (specialist) •tick box to prevent printing and repeating •load medication with spec status and tick long term This will then show if there is an interaction with another drug that is prescribed.
3	As hospital and specialist letters are received they will be reviewed by Rob and then transferred to nurse's in-box for any medications noted as specialist only to be coded, and other medication reconciled and updated.	Rob is noting and then forwarding specialist letters with both specialist medications and changes for reconciliation to nurse inbox.

Trigger Tool

- Rob (doctor), Pam (practice nurse) and Louise (Auckland PHO nurse) all reviewed clinical notes in order to get a broader perception of our strengths and weaknesses in record keeping.
- We had 2 patients with 2 or more visits in a week but we do not consider a trigger as our patients are welcome any time and are encouraged to return if there is no improvement in their symptoms.
- 19 records were reviewed to find 5 incidents.
- It was a valuable experience for the team to discuss the incidents, acknowledge the errors and explore ways we can all improve our record keeping.
- The main focus is ensuring patient medications are reviewed at every possible opportunity.
- The clinical staff all set a personal goal to improve record keeping and as a team we are embracing using the medication status drop down consistently.
- It was rewarding that our incidental findings were mostly positive.

Highlights and Lowlights

- Reconciling medication for patients with poly pharmacy and those with long term conditions (often these are one and the same) has made the task of repeat prescriptions more effiecient and less time consuming.

- Discussion with patients and their family re discharge medications and medication change has led to more patients choosing to use blister packs.

- Medication codes help to determine when a medication has been commenced, stopped, altered etc and this is helpful when communicating with pharmacists in both primary and secondary care.

- All staff on board and medication reconciliation is now “normal” part of our workload.