Orewa Medical Centre

PHO and Facilitator:

Team members: Dr Sally Simpson, RN,Linda Ingles, RN, Rachel Liddel, Practice Administrator Carlee Robinson and Business Administrator Nurse Leader Stephanie Watson.

Organisational "Buy - In"

Aim: To reduce the risk of medication errors by reconciling discharge summaries from WDHB General Medicine and WDHB Home and Older Adult services for all patients whom have been discharged from their care.

Buy-in: A small project team whom are representatives of the practice teams, have come together to define the problems related to reconciliation of discharge summaries post discharge from WDHB General Medical and Home and Older Adult services. This team has been involved in mapping the process of reconciliation and in meeting with the PHO and Project Facilitators in developing and clarifying a clear process to ensure reconciliations are completed.

Change Ideas

Driver Diagram

Although our data showed a high level of patient discharge summaries reconciliation we did have area of improvement in relation to:

- Medication changes have been discussed with the patient or their representative within 7 days?
- Has the patients regular medication list been updated?

Both of these areas were identified as needing quality improvement.

What Changes have you tested?

	Change Tested	Outcome
1	Identification that we are reconciling our discharge summaries but we are not always notifying patients within the 7 day timeframe.	Clarification of the process: • Identification of the diversity of processes being used • Collective agreement about the process that should be followed • Defined process which still has the doctors as central to the decision making in relation to how a medical reconciliation can be completed • Defined use of the nursing team or reception team to ensure patients aware of medication changes.
2	Identification that the discharge summary would not always require a change to the medication list. It may require a change in screening or no change at all.	• Change the parameter that we are auditing to ; Has the Plan Been Enacted as Intended in the Patient Discharge Report.
3	Development of a Policy and Procedure to support standardisation of approach to Medication Reconciliation from discharge summaries	• New policy generated with clarity in relation to expectations of patient engagement once they have been discharged back to our care. • Policy circulated and signed off by each team member • Audit down to individual clinical team members to identify adoption of new process.

Most Successful PDSA Cycles?

Model for Improvement

Practice: Orewa Medical Centre **Date:** 15. 9.15

Step 1.
The 3 Fundamental Questions

Before completing the 3 fundamental questions and the PDSA cycle sheet, consider the Change Principle that your work will relate to.

Topic Area: Minimise Handoffs, Optimise maintenance,

1. What are we trying to accomplish?

This becomes the GOAL

To reduce the risk of medication errors by reconciling discharge summaries from WDHB General Medicine and WDHB Home and Older Adult services for all patients whom have been discharged from their care.

2. How will we know that a change is an improvement?

This will develop MEASURES to track the achievements of the goal

Reduction in tasks to the nursing team about:

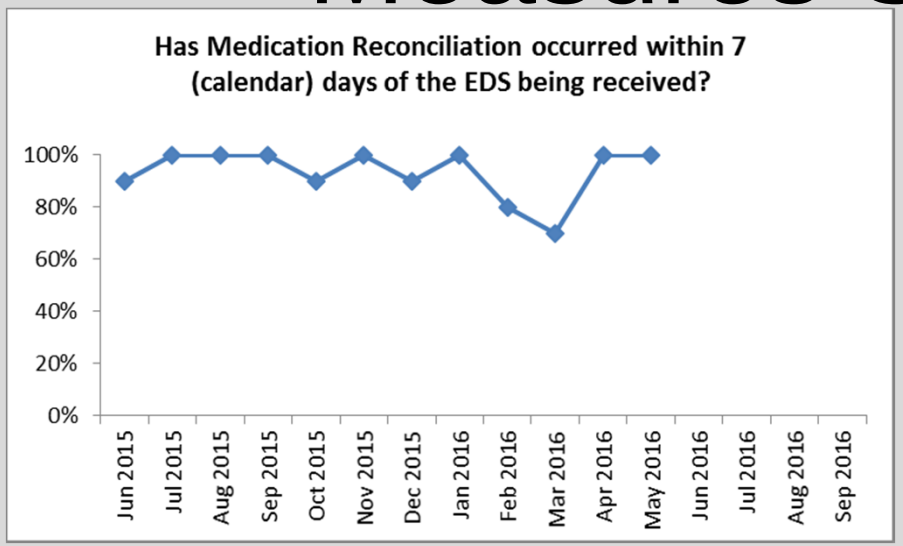
Medication errors such as:

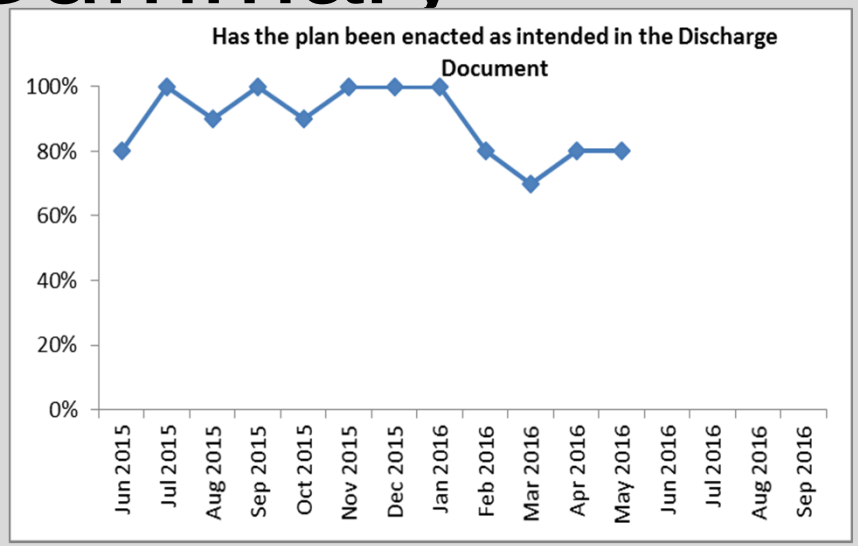
- Changed medications from that documented on the repeat prescription
- Changed dose of medication from that documented on the repeat prescription
- Medications continued that were stopped when in the hospital setting

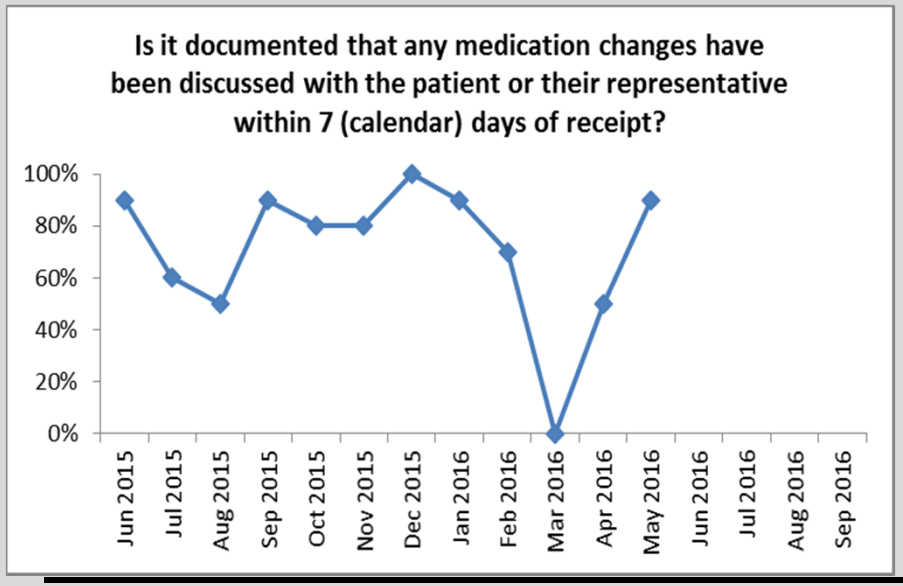
Most Successful PDSA Cycles?cont

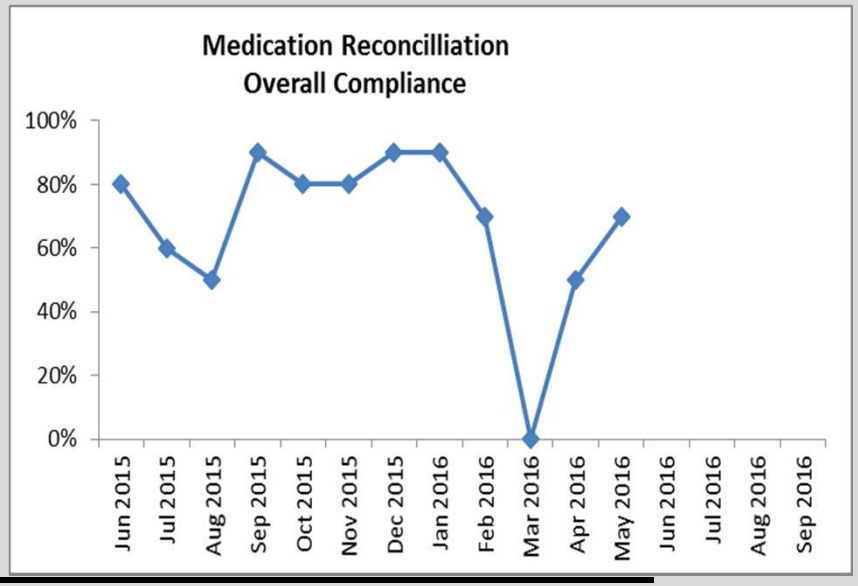
3. What changes can we make that can lead to an improvement? *By answering this question you will develop the IDEAS you would like to test to achieve your goal*	
Idea 1	Reconciliation of the discharge summary and clear update information documented in patient notes to assist the nurses generating the repeat prescription
Idea 2	Identify those patient whom require a higher level of communication to ensure they a aware of the changes to their medication or changes to their plan of care.
Idea 3	70% No action required Utilise multiple mediums of communication: Texting/SMS, email, and letters to ensure patient aware no change is required post discharge.
Idea 4	For those patients in the 20% category the nursing team can be activated by a Doctor t to contact the patient. For those patients in the 10% category the nursing and reception team can assist the doctor to facilitate a consultation with the patient

Measures Summary









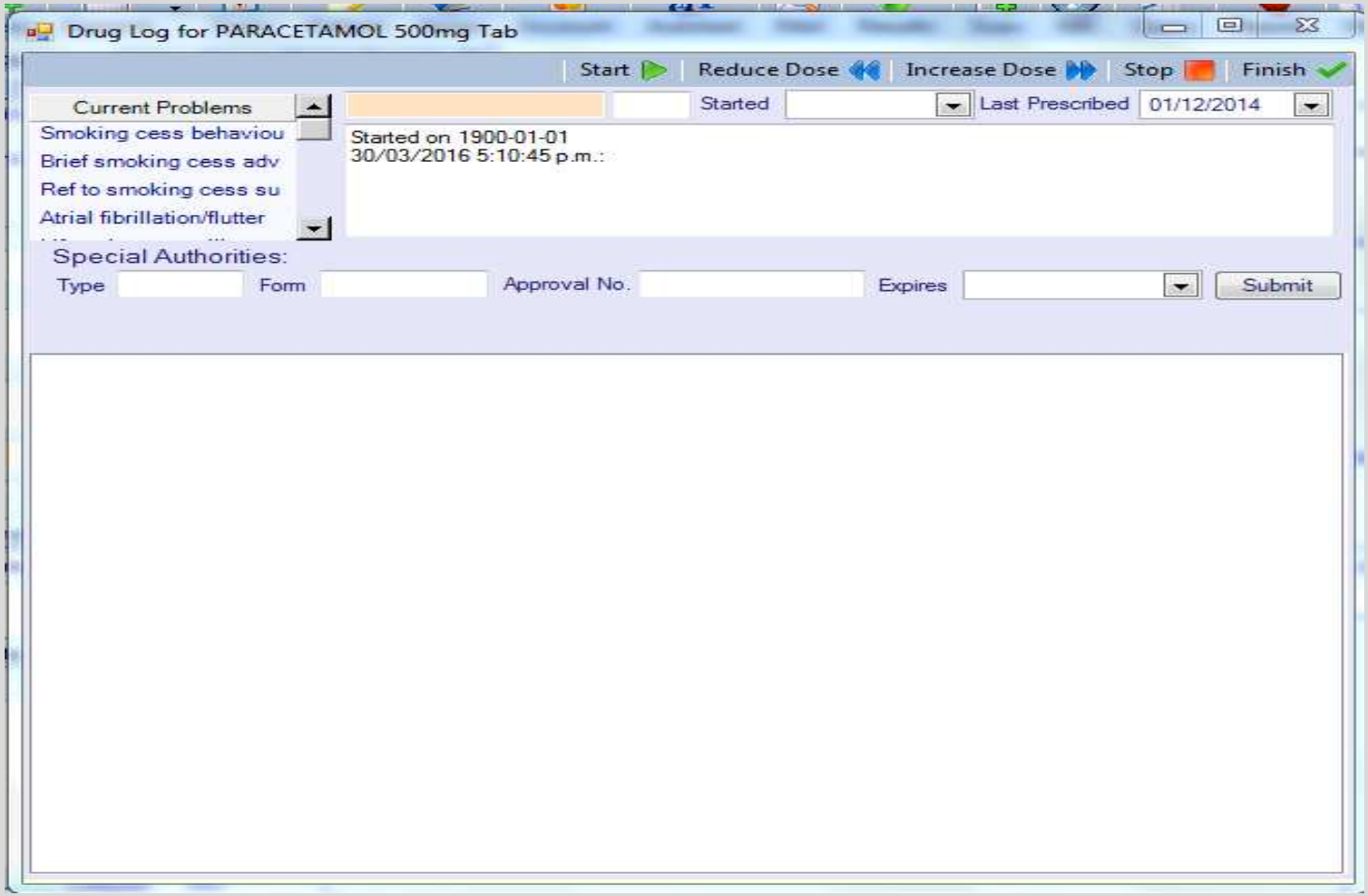
So What Changed

- Over this time we have changed our Practice Management System. “My Practice”
- We have also had a large contingent of Locum doctors
- The combination of a change to how we managed results and new doctors has had a marked effect.

What does the new system offer ?

- Engagement of portals and email correspondence to patients to ensure that we can reach them easily in a timely manner for both the patients and the business.

Reconciliation in the new system



Our Next Steps

- We need to continue to undertake EDS reconciliation
- We will be adapting our patient letters to the 70% patients whom do not need to have further service provided to an email system as well as a letter system. This is the next PDSA cycle we need to enact.
- Take the new letters and email them to patients whom have engaged with the portal system.

Highlights and Lowlights

- Highlights:
  - Director leadership and engagement into this quality improvement
  - Everyone has the patient as the central focus
  - That we have been able to resolve instances of harm and potential harm by engaging early with errors in discharge planning from the DHB
- Lowlights:
  - Complexity of discharge reconciliation for patient's whom are house bound
  - Expectation of the practice funding this work which should be managed by secondary services prior to discharge. Patients should be informed of medications or care plan changes prior to discharge and associated cost expectations of returning to their GP
  - The increased rate of errors in Secondary Care that General Practice is expected to capture and resolve to ensure patient safety in our healthcare system is an unfunded expectation of service delivery.

Achievements to date

Orewa Medical Centre has an Agreed Aim:

To reduce the risk of medication errors by reconciling discharge summaries from WDHB General Medicine and WDHB Home and Older Adult services for all patients whom have been discharged from their care.

- Our most successful PDSA: was to define patients into classifications and the streamline how we are communicating to those patients using a whole team approach
- We will continue to measure reconciliation
- We will continue to measure communication to patients within 7 days post discharge.

Achievements (cont.)

Do people on your team know what their responsibilities are and what is expected of them?

Yes, we have this clearly defined in our policy and procedures however, with a increased rate of short term locum doctors the responsibility falls back to our Medical Director and Senior GP. This creates an unrealistic workload and increases the chance of an error not being identified.

What has changed and what difference have the changes made?

We now focused on a new PMS system to help us be efficient and effective in reaching our patients within the 7 days discharge from hospital. However, getting to know the system has resulted in each clinician needing to be more vidulent about managing the patients discharge summaries. If we receive the discharge summary late then we lose the window of opportunity to enact on the patient behalf.

Add any thing else you'd like to share here:

- Experiences with trigger tool
- How the work has impacted your team. The mapping showed the amount of area the nurses were finding impacts from medications or medical plans not being reconciled. This could lead to a lot of duplicated work by the nursing team which would have been resolved with reconciliation.

Achievements (cont.)

- Add any thing else you'd like to share here:

Undergoing the learning experience from this project has allowed the practice to understand a new set of tools in quality improvement. These will be very useful in assisting the practice to target quality initiatives that they feel needs remedy. In particular looking at quality improvement such as how to ensure consistency in wound management would be a useful to the practice, rather than taking on such large issues as we found in Medical Reconciliation.

- Experiences with trigger tool:

This was a useful tool but again needs it's parameters defining so that the practice looks at itself and improves its own processes rather than trying to solve poor discharge advise or errors in discharge advise from the DHB.

- How the work has impacted your team:

The mapping showed the amount of area the nurses were finding impacts from medications or medical plans not being reconciled. This could lead to a lot of duplicated work by the nursing team which would have been resolved with reconciliation. The engagement of the team in the process showed that everyone has something to contribute to the solution.

Conclusion

- Safety in Practice:

The value of this experience to our practice has been moving quality improvement from being a Cornerstone task, to being a series of tools that anyone in our team can undertake to raise an issue and seek improvement.

The next steps for the practice is to:

- Continue to learn the new PMS system to ensure that we return to the high level of functioning that we had when using Med Tech 32.
- Define priorities for quality improvement so that as a practice we can set in place the next area to be reviewed.
- Continue to elevate to Secondary Care its responsibility in ensuring safe discharge from it's care back to the community
- Balance all of the levels of demand and expectation on General Practice with the practices enrolled population need for First Level Care access. As well as clinicians need for a work life balance.