Learning Session 2

Orakei Health Services Medication Reconciliation

Team members:

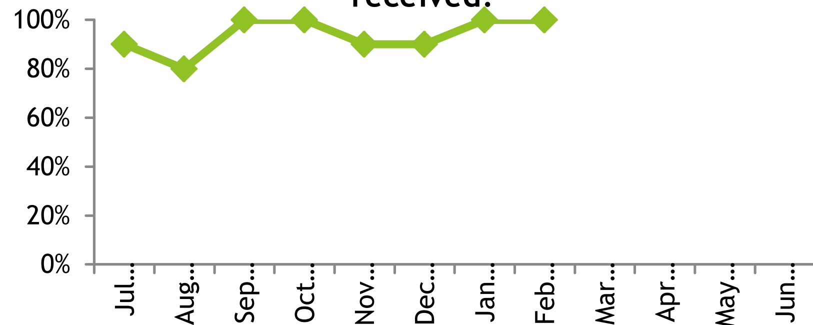
Alicia Caulton – Nurse Lead SiP

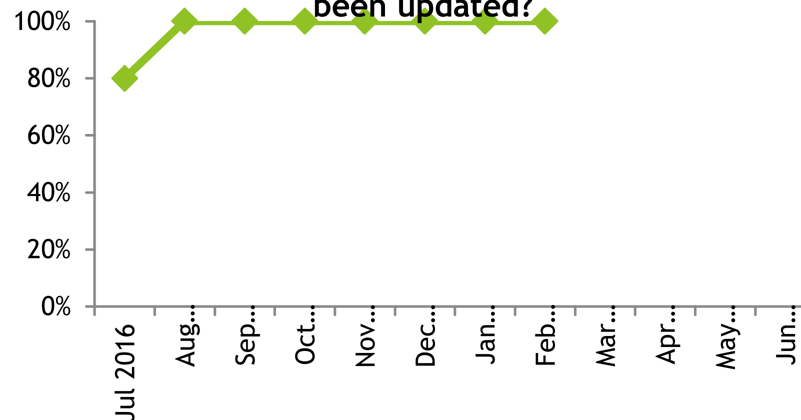
Gabrielle Moss – GP/Clinical Lead

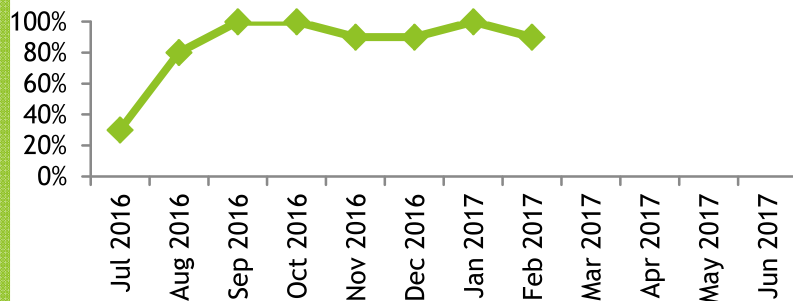
PHO and Facilitator:

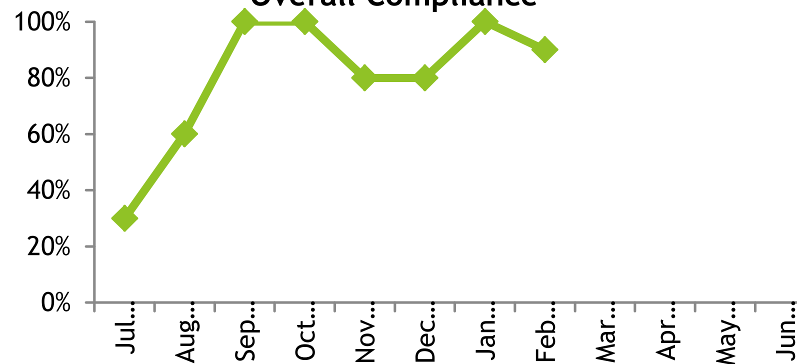
Auckland PHO

Measures Summary









Key Ideas Tested

Idea Tested	Outcome (success or failure) / Advice/message to other practices
Use "medication status" functions of prescriptions to document medications reconciliation – allowing changes to be made without appearing as prescriptions printed or dispensed	Success. Steady increase from start of process, 100% of medication reconciliations now updated in medication lists. Easy to identify stopped, altered or new medication.
Getting patients in for any significant changes.	Generally good, slight decline from last month. Leaving it to GP to decide most appropriate method of recall, depending on the individual patient and their clinical scenario.

Highlights and Lowlights

- Highlights
- Everyone willing to participate, great buy in from all Doctors and Nurses.
- Increase in patient safety, records updated quickly, not as likely to have prescription errors.
- Lowlights
- Sometimes unable to recall patients to come in within time frame when nurses busy/short staffed.
- Increase in workload for Doctors when receiving discharge summaries.

Trigger Tool

- Key findings from trigger review and actions taken
- Missing clinical notes from daily record. Discussed with team, suggestions of prompts on incomplete notes in appointment book and time allocated at end of day to review all notes are complete.
- Patient confusion over verbal instructions given by Dr. Set up outbox documents of commonly themed instructions. Encouraged team to write down complex instructions for patients.
- Polypharmacy – patient confusion over dosage regimes, indication for meds. Suggest query builder for those taking >4 long term meds and setting alerts to offer yellow cards. Consider medication reviews by pharmacy to simplify regimes and identify possible interactions
- Patient error in warfarin dose resulting in overcoagulation. Nurses to review regimes and ensure patients with communication issues have simplified instructions – ie only one dose tablets. Query builder of all warfarinsed patients that could potentially be changed to dabagatrin or enrolled in pharmacy lead INR monitoring.
- Dosage regime calculations for meds for children- encouraged team to always document weight in prescriptions.

Safety Climate Survey

All 9 staff members completed the online safety climate survey.

Have just received our report.

Strengths were teamwork and safety system and learning.

Workload was identified as least positive attribute.

We will discuss the report at our next meeting with everyone.