Reducing Medicines Harm Across Transitions
Medication Reconciliation
WebEx Series 2017

Thursday 16 February 2017
3pm–4pm
Presented by:
NHS Tayside

#SPSPMeds
@SPSPMedicines
SPSP Medicines
February 2017 WebEx
NHS Tayside
Reducing medicines harm across transitions
Welcome

AIM: Support the learning and sharing between boards regarding medication reconciliation as a whole system

What is our theory for improvement?
What tests of change have resulted in improvement?
A few WebEx etiquette points for our meeting today:

If you are not presenting your phone is automatically on mute

Be open to learning and sharing

Use the chat box to participate in the discussion and type in any questions you have

There will be time at the end of the WebEx for Q and A with the presenting board, and we will be monitoring the chat box
If you want to get involved in the conversation, please click on the Chat icon circled in red.

Select **All Participants** from the drop down menu, type your message then click send!

This WebEx is being recorded as a resource and will be available on the SPSP website.
Medicines aims to bring together improvement activity related to medicines from acute care, primary care, maternity & children’s service and mental health.

This is a unique opportunity to consider the safer use of medicines from a whole system approach, focusing on the patient as they move between care settings and home.
Transitions

High risk

Omissions
<table>
<thead>
<tr>
<th>Ambition and Aims</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
<th>Change Ideas</th>
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</thead>
</table>
| **Ambition:** All patients will have their medicines accurately reconciled on admission to and discharge from hospital, including primary care. This information will be communicated to patients and healthcare professionals. | Person-Centred Care | - Patients are responsible for their own medicines  
- Patients are actively involved in medication reconciliation processes | - Medication Passport (app and booklet)  
- Patients represented on medication reconciliation implementation groups  
- Links with medication self-management programmes  
- Prompts for patients to take a meds list to all appointments/admissions  
- Green bags (SAS? Primary Care / ?preop)  
- ‘Tell me how you are taking your medicines’  
- Ensuring involvement of informal carers in MR discussions, they are often the ones giving medication to the patient.  
- Reminders to return unused medication stored at home.  
- Teach back with whoever is giving out the medication to ensure safety and understanding.  
- Risk assessment process to identify patient/carer understanding and ability re medication management. |
| **Aims:** 95% of patients will have their medicines accurately reconciled within 24 hours of admission (+ accurate Kardex)  
95% of patients will have their medicines accurately reconciled on discharge (+ accurate IDL)  
95% of patients will have an accurate GP medication list within 2 working days of IDL being received. | Leadership and Culture | - MR is integrated with other key strategic policies  
- A single system approach supported by senior leadership  
- MR is a named priority by NHS leaders at all levels  
- CMO letter (18/2013) | - Policy to support MR across the continuum of care  
- Establish MR group with oversight of acute and primary care services that reports to senior management  
- Education of senior leaders regarding impact of MR  
- Awareness of local data regarding MR processes  
- Dashboard linking data from acute and primary care  
- MR leads are named for key health disciplines |
| **Community pharmacy aim (TBC)** | Teamwork, Communication and Collaboration | - Roles and responsibilities for MR are understood by the multidisciplinary teams | - Feedback loop established between pre-hospital, primary and secondary care regarding communication of medicines information  
- A joined up measurement & reporting strategy across acute and primary care interface  
- Standard method of documenting medicines information  
- Admission and discharge ‘pairs’  
- Use of ‘teach back’ with patients regarding medicines information  
- Pharmacists based in the ED for admitted patients to start medicines reconciliation immediately  
- Informing community pharmacists of admissions to hospital for patients on blister packs/delivery systems |
| **Safe, Effective and Reliable Care** | Safe, Effective and Reliable Care | - Staff understand the importance of MR  
- Standardised processes / documentation | - MR included as part of structured ward rounds/work flow  
- MR prompts on white boards  
- NES LearnPro MR module  
- Real cases used during staff training to demonstrate the importance of MR |
| **Systems and IT Infrastructure** | - Explore and optimise eHealth solutions to support MR such as electronic prescribing and administration in hospitals (HEMPA) and primary care electronic solutions.  
- Standardised documentation/communication tools | - Linking of ECS and IDL information  
- Use of eMR form during admission  
- Incorporation of ECS into inpatient medical records  
- Automation of communication between acute care and GPs/ community pharmacies (e.g. ECS and IDL)  
- Linking secondary care and general practitioner prescribing  
- Rationalisation of locations for documentation of key information (e.g. drug allergy – up to 6 places in health record) |
From previous 3 WebExes:

- November 17th (NHS Highland)
- December 15th (NHS Lothian)
- January 19th (NHS D&G)
Changing the Landscape in Tayside
Changing the landscape in Tayside

- Landscape needs to change as right now we are making it too difficult

- Need to make it more straightforward e.g insulin chart

- The Monitoring and Measurement of Safety Framework

- Moving from assurance to enquiry

Vincent et al. The Health Foundation, 2013.
More questions than answers – we don’t know the answers yet but...

- Opportunity to reflect and make medicine safety part of existing organisational structures
- Expert group convened – scoping aims and priorities and deciding why/where/who/how?
- Proposals and recommendations to ADTC to get agreement on a way forward
NHS TAYSIDE

AREA DRUG AND THERAPEUTICS COMMITTEE (ADTC)

Executive Management Team (EMT)

Clinical Quality Forum (CQF) for reporting into Improvement & Quality Committee (I&QC)

Directors Group

Area & Local Medical Committees
Area Pharmaceutical Committee
Area Clinical Forum
Medication Safety Community

ADTC

Medicines Advisory Group (MAG)
Medicines Policy Group (MPG)
Non-medical Prescribers Group (NMP)
Medicines Safety and Quality Subgroup (MSQ)
Antimicrobial Management Group (AMG)
Oncology and Haematology Medicines Management Group (OHMMMG)
Patient & Public Reference Group (PPRG)

MCN Formulary Groups
Wound Management Group
Patient Group Directions Group

May 2016
What will success look like in Tayside?

- Clarity about priorities for med safety across the organisation
- Consistency of enquiry – regardless of where you are
- Shift from being a programme/collaborative/project to being part of the normal activity
Meet Morag
74 years of age
Type2 diabetes
Treated with insulin – Insulatard twice daily
HbA1c 45 mmol/mol
eGFR 15 ml/min
Social: independent, family nearby
• Unwell for 48 hours
• Reviewed at home by NHS 24
• Transferred by ambulance to Acute Medical Admissions Ninewells
• No medication – ECS checked – Insulatard ‘as directed’ and gliclazide 80 mg twice daily
• Patient reported insulin doses prescribed along with gliclazide
• Diagnosed with urosepsis
• Diabetes Specialist Nurse review in ward
• Prescription error identified with aid of SCI diabetes electronic record
• i.e. Insulatard twice daily not four times daily
• Gliclazide had been stopped at diabetes clinic review two weeks prior to admission
• Nurses administering insulin in hospital
• Relative reported that Morag had been increasingly confused of late
Admitted to Hospital by Ambulance
Aim:

By December 2015, 95% of patients brought in by Ambulance from their own home admitted to Ward 4 of Perth Royal Infirmary arrive with their own medications.

Goals:

• Decrease the number of missed medication doses in ward 4 of PRI
• Improve Medicines reconciliation for patients admitted to ward 4 of PRI
• Decrease the number of prescribing errors
• Reduction in waste and additional supply of medicines
PROCESS:
% OF PATIENTS BROUGHT IN BY AMBULANCE (BIBA) WITH MEDICINES
% OF PATIENT’S MEDICINES BROUGHT IN BY AMBULANCE

OUTCOME:
% OF ACCURATE MEDICINES RECONCILIATION PRIOR TO PHARMACY INTERVENTION FOR THOSE PATIENTS BIBA
% OF PATIENTS BIBA WITH NO MISSED DOSES PRIOR TO PHARMACY REVIEW
COST OF ONE STOP DISPENSE SUPPLY AND MEDICINES SUPPLIED ON DISCHARGE FOR WARD 4

BALANCING:
% OF DRUG HISTORIES COMPLETED BY PHARMACY TECHNICIANS DUE TO THE INCREASE OF PODS BROUGHT INTO HOSPITAL
NUMBER OF MEDICINES ORDERED FOR INPATIENT STAY
P Chart - % of patients own medicines BIBA

P Chart - % of patient's own medicines brought in by Ambulance

P Chart - % of pts BIBA with one or more missed doses
Medication Reconciliation: Story so far....

For us it began in 2005!

Successes

- Reliable systems in acute admissions units
- Process spread to over 85% of in-patients areas but reliability not yet achieved
- Development of single measurement tool based on measures in CMO letter
- Engagement with all SPSP programmes (except Community Pharmacy)
- Involvement of junior doctors and medical students in data collection/improvement
- Collaboration with ADTC
- Mapping of med rec across the system
Challenges

- Engagement with medical staff and lack of understanding of importance
- Need to refresh & re-brand med rec
- Communications at the interfaces
- Variation of process and documentation (mapping by eHealth clinical lead)
- Pharmacy dependant process
Medications Reconciliation on Admission
So, in Morag’s case how could current improvement work have ensured a robust, reliable med rec process and improved her patient journey?

- Bringing in Morag’s medication acts as a useful prompt for discussing medication with her and her carers.
- It may have helped elicit a better med rec given Morag’s recent confusion.
- The paramedics may have been able to bring in any hand-held insulin dosing record that was present in Morag’s house. This may have provided accurate insulatard dosing and information on the discontinuation of Gliclazide.
• Although not an issue in Morag’s case but recognised as an issue for many patients admitted to hospital is missed doses.

• Given the sheer number and variety of medicines available it is not possible for our admitting wards to keep sufficient stock to prevent missed doses.

• If more patients bring their medication to hospital this will reduce missed doses on admission.

• This is an area of the ambulance service project where our data shows improvement.
Implementation of Insulin Prescribing & Administration Record

### Implementation of Insulin Prescribing & Administration Record

**Prescribing subcutaneous insulin**

DO NOT USE abbreviations ‘U’ or ‘IU’ when prescribing insulin. If the usual insulin regimen is unknown, do not omit insulin, but use a suitable substitute until insulin details are established. Use the diagram opposite to guide a suitable alternative preparation e.g.:

- Prescribe once daily or twice daily isophane in the elderly
- Use short-acting/intermediate mixture twice daily in others
- Calculate dose as 0.3 units/kg/24hrs for those at risk of hypoglycaemia, 0.5 units/kg/24hrs if insulin resistant

Review monitoring results daily and adjust insulin if required to optimise blood glucose control to avoid hypoglycaemia and hyperglycaemia.

Only prescribe intravenous insulin in acutely unwell or fasting patients, or those who are unable to tolerate oral intake.

### Routine Subcutaneous Insulin Prescription

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Name of Insulin Preparation</th>
<th>Dose</th>
<th>Time of Administration</th>
<th>Prescribed by</th>
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<td>e.g. before breakfast</td>
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<td>e.g. at 22.00 hours</td>
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**Notes:**

- Discontinued by sign, date and draw a line through prescription.
Percentage of Discharge Prescriptions with Gaps in Communication Regarding Changes in Drug History (prior to pharmacist verification)

Discontinued Drug Recorded
Dose Change Recorded
Drug Change Recorded

Full implementation
Test of change introduced

% Discharge prescriptions with accurate drug list & clear communication to the GP regarding any changes in drug history (prior to pharmacist verification)
Benefits for EVERYONE

- **Patient** – Accurate discharge prescriptions & less delays hence reducing risk of harm and waste
- **Doctors** – Improve accuracy of discharge prescriptions and better communication with the GPs regarding medication changes
- **Pharmacists** – Less time checking and amending discharge prescriptions and better communication with the community pharmacy teams
Successes

- Goal Achieved & Sustained at > 90%
- Waste, Harm & Variation
- Replicated in Orthopaedics
- Spread across Surgery & Orthopaedics
- Engagement & commitment from Primary Care

Challenges

- Benefits out with Surgical wards?
- Impact on Med Rec in Primary Care?
What does our landscape look like now?
This letter replaces all previous discharge letters that have been received relating to this patient's episode of care.

Ninewells Hospital, Dundee
Discharging Ward: 21 (Cardiology)

Dr. NEIL ANDERSON
LAURENCEKIRK MEDICAL GROUP
LAURENCEKIRK HEALTHCARE CENTRE
BLACKEMUIR AVE
LAURENCEKIRK
AB30 1GX

Date: 13/01/2017
Letter Version: 0.1
Enquiries to:
Telephone:
Email:

Patient Name, CHI, DOB: __/__/__ Address

Electronic Discharge

Complete heart block

Date of Admission: 06/01/2017
Mode of Admission: Emergency
Source of Admission: A & E
Admission Reason: Dizziness, collapse
Admission Ward: 21
Admission Specialty: Cardiology
Discharge Type: Discharge from NHS Inpatient/Day case care
Discharge Date: 13/01/2017
Discharge Destination: Private Residence - Lives alone

Operations, Procedures, Investigations and Complications

Pacemaker Insertion- VVIR 10/01/2017 Principal

Allergy Information

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Date Recorded</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>H/O: drug allergy</td>
<td>03/07/2014</td>
<td>Furosemide 20mg tablets</td>
</tr>
<tr>
<td>H/O: drug allergy</td>
<td>15/10/2012</td>
<td>Fludoxacillin 250mg capsules</td>
</tr>
<tr>
<td>Adverse reaction to naproxen</td>
<td>11/05/2010</td>
<td>Naproxen 250mg tablets</td>
</tr>
<tr>
<td>H/O: drug allergy</td>
<td>11/05/2010</td>
<td>Augmentin 375mg tablets (GlaxoSmithKline UK Ltd)</td>
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Thank you and questions.....
Medicines Reconciliation Summit

Thursday 2 March 2017

COSLA Conference Centre
Haymarket, Edinburgh
Improving and Maintaining Medicines Reconciliation on Admission at North Bristol NHS Trust

Jane Smith
Principal Pharmacist
Governance and Medication Safety Officer
North Bristol NHS Trust Bristol

Medicines Reconciliation Summit
Thursday 2 March 2017
COSLA Conference Centre
Haymarket, Edinburgh

Registration closes:
23rd February 2017
Registration closes on the 23rd of February

Please contact your board SPSP Programme Manager

http://www.scottishpatientsafetyprogramme.scot.nhs.uk/events
WebEx Series

WebEx Schedule for 2017

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<th>Date</th>
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<th>NHS Board Presenting</th>
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<tbody>
<tr>
<td>16(^{th}) March 2017</td>
<td>3pm – 4pm</td>
<td>Summit teach back</td>
</tr>
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<td>??</td>
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</tbody>
</table>

We would like your help to shape how and what we share in 2017/18
hcis-medicines.spsp@nhs.net
www.scottishpatientsafetyprogramme.co.uk/programmes/medicines
@SPSP Medicines

THANK YOU