SCOTTISH PATIENT SAFETY PROGRAMME

MEDICINES

Roles and responsibilities – Getting it right first time

Sarah Goldsworthy, Summit Facilitator

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Session Descriptor

Depending on the care setting a number of people may be involved in reconciling patients' medications.

What is the best approach? Who is ultimately responsible? What makes it difficult for people to take responsibility?

What systemic changes need to happen to engender responsibility at and between points in the system?

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Session Overview

Time	Topic	Speaker
13.35	Welcome	Sarah Goldsworthy
13.40	Surgical pre-assessment clinic	Mary Harris – charge nurse (Tayside)
13.45	Acute medical assessment unit	Simon Dummer - medical consultant (Lothian)
13.50	Primary care	Mark Easton – community pharmacist (Grampian)
13.55	Discussion	Sarah Goldsworthy
14.35	Wrap up – Key things to feed back	Sarah Goldsworthy
14.40	Close	

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Mary Harris

Charge Nurse, NHS Tayside

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Simon Dummer

Consultant, Acute Care (Medical) NHS Lothian

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Meds Rec: Roles and Responsibilities

- The acute medical unit and general medical wards in ERI
  - AMU – 54 beds, around 70 admissions per day
  - Gen Med – 72 beds, around 10-20 admissions per day
- Challenges to Med Rec faced by our unit
  - Very busy, increasing numbers/complexity without significant increase in doctor/pharmacy numbers
  - Most admissions occur throughout the night – no NOK/GP surgery
  - Rapid staff turnover, less continuity

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Meds Rec: Roles and Responsibilities

- What works, what doesn't
  - Consultant involvement but……
  - Emphasize handover of med rec as a job but…….
  - MMP –
  - Post take proforma
  - Angels/devils posters Alcoholic incentives
  - PAMA discharge
  - Dummer's Guide

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Meds Rec: Roles and Responsibilities

- Roles and responsibilities - an honest reflection
  - A lot for one person to deal with
  - How to fit into already busy job plan
  - Help is there from SPSP but when/how access?
  - With best will in world, Med Rec is not a hot topic and has to compete with other priorities
  - Data collection isn’t easy

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MEDICINES

Mark Easton

Community Pharmacist, Clinical Lead – SPSP PPC

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Scottish Patient Safety Programme Pharmacy in Primary Care

Mark Easton, Community Pharmacist and Clinical Lead SPSP PPC

Medicines Reconciliation Summit 2nd March 2017

Meds Rec Process at discharge

Patient discharge

eIDL produced

To GP

Meds Rec process actioned

To CP

GP10 issued or **CP contacts GP**

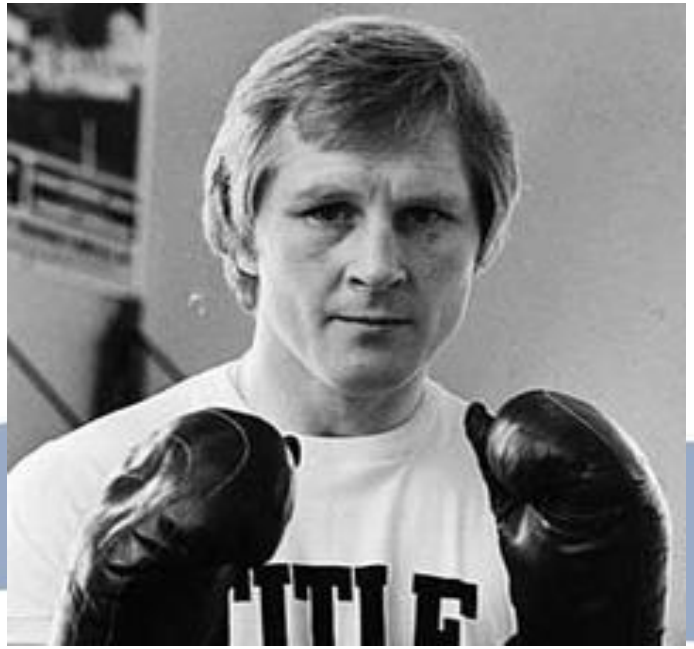
Notification in PCR

Meds Rec bundle actioned and PMR flagged

7 Days

Treatment agreed and medicines supplied

NHS Grampian



The Patient story

Admitted following a fall at home and a productive cough 11/05/2016

Community acquired pneumonia diagnosed

- Paracetamol 1g QDS
- Diclofenac 50mg TDS
- MST 20mg BD
- Gabapentin 300mg TDS

MCA supplied weekly by pharmacy

Wullie discharged

Monday 5pm
16/05/2016

eIDL sent to GP and CP

Pharmacist identified need to remove diclofenac from MCA

Dispenser recognised that Paracetamol had not previously been in MCA and was issued 10/05/2016

- Diclofenac discontinued
- Paracetamol in MCA
- MST not supplied as "own MST in CD Cupboard on Ward"

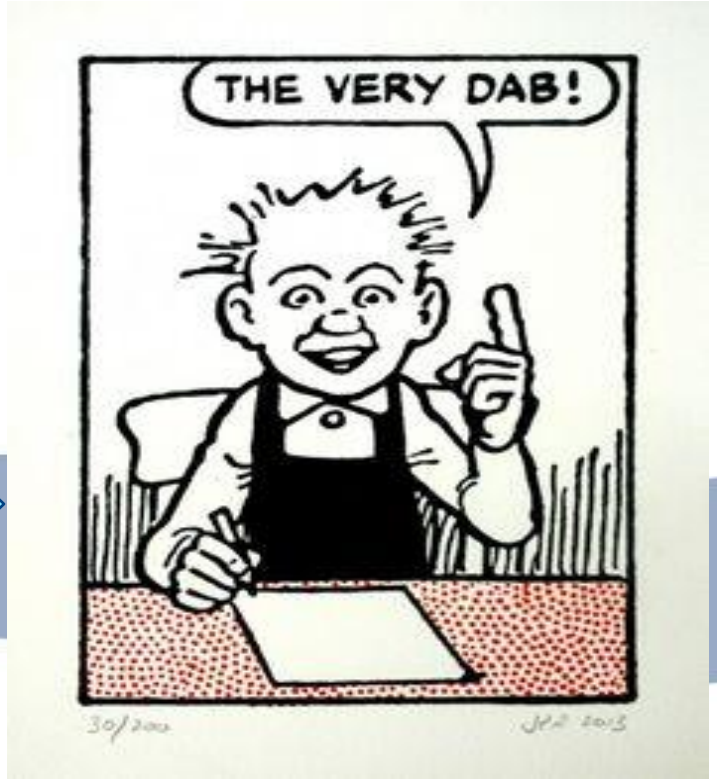
CP team complete meds rec process

Wednesday 18/05/2016
Relative informs CP that Wullie has no MST.

Outcome?

GP10 produced and hospital changes agreed.

✓MST supplied
✓Diclofenac removed
✓Paracetamol added to MCA and previous supply returned to pharmacy



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Discussion

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Discussion Question 1:

How must your system of medicines reconciliation change to increase its reliability?

Discussion Question 2:

What is your unique role in making this happen and who do you need to engage with to ensure that it does?

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What are the key things to feed back?

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