Audit: Are we undertaking appropriate medicines reconciliation at Severn Hospice?

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What is 'medicines reconciliation'?

- Ensure all medication the patient is currently taking is correctly documented on admission
- Collecting information on medication history to create a full list of current medications
- Checking the list against the in-patient medication chart ensuring appropriate action for any discrepancies
- Communicating through appropriate documentation any changes, omissions or discrepancies

Aim

- To ensure the accurate prescribing of in-patient drugs through appropriate medicines reconciliation
- To improve the interdisciplinary communication regarding patients' medications

Background

- Several cases where previously prescribed medications have been missed on admission, which could have lead to patient harm e.g. Anti-hypertensives, Zoladex
- Medicines reconciliation routinely occurs in acute trusts
- Errors are frequently found in prescribing (not all leading to harm)

What's currently happening at Severn Hospice?

- Doctors are prescribing medications based on:
  - Patients' own drugs
  - Hospital discharge summary/medicines from hospital
  - GP summary
- Sources of information not formally documented
- Not formally documenting steroid or antibiotic history
- No third party checking
- No pharmacy involvement
- No medicines reconciliation policy

Audit Standard

WHO aim that all adult admissions should have MR within 24hrs of admission

NICE/NPSA Safety Alert 2007

- All healthcare organisations that admit adult patients should have a medicines reconciliations policy
- Pharmacists should be involved in MR as soon as possible
- System for collecting and documenting information about current medications

Method

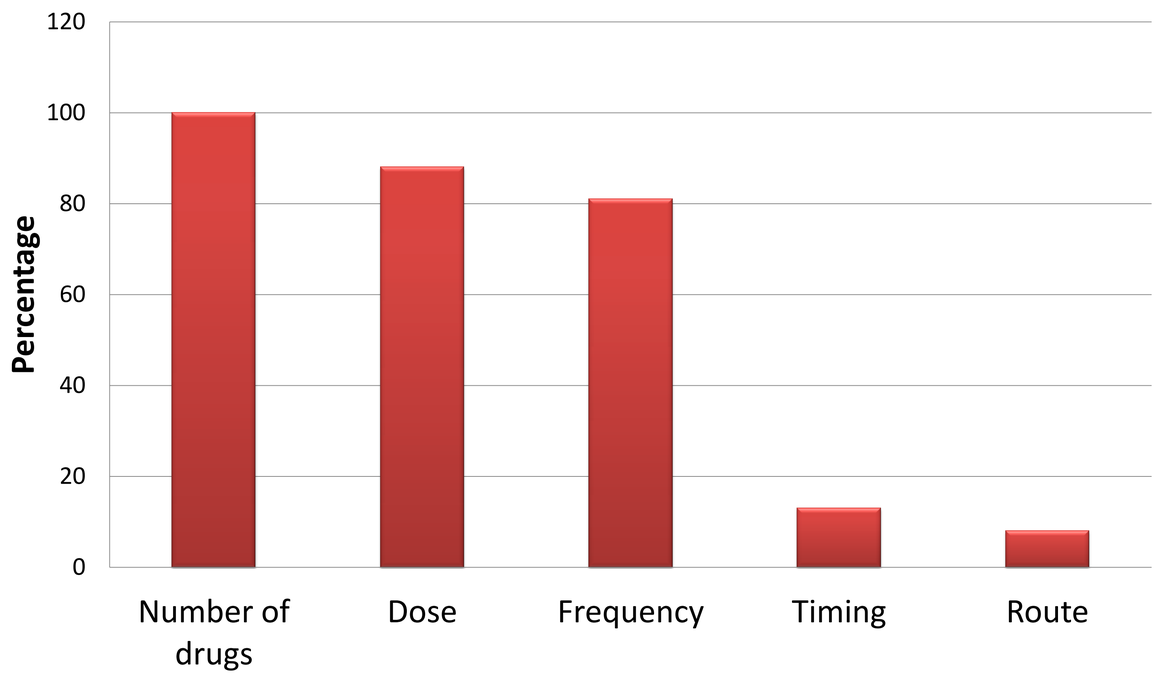
- All patients admitted 1st Jan 2012 to 30th June 2012 who were ultimately discharged from Telford and Shrewsbury in-patient units
- The admission documentation and discharge summary reviewed
- Data recorded using the NICE MR audit tool

Data recorded

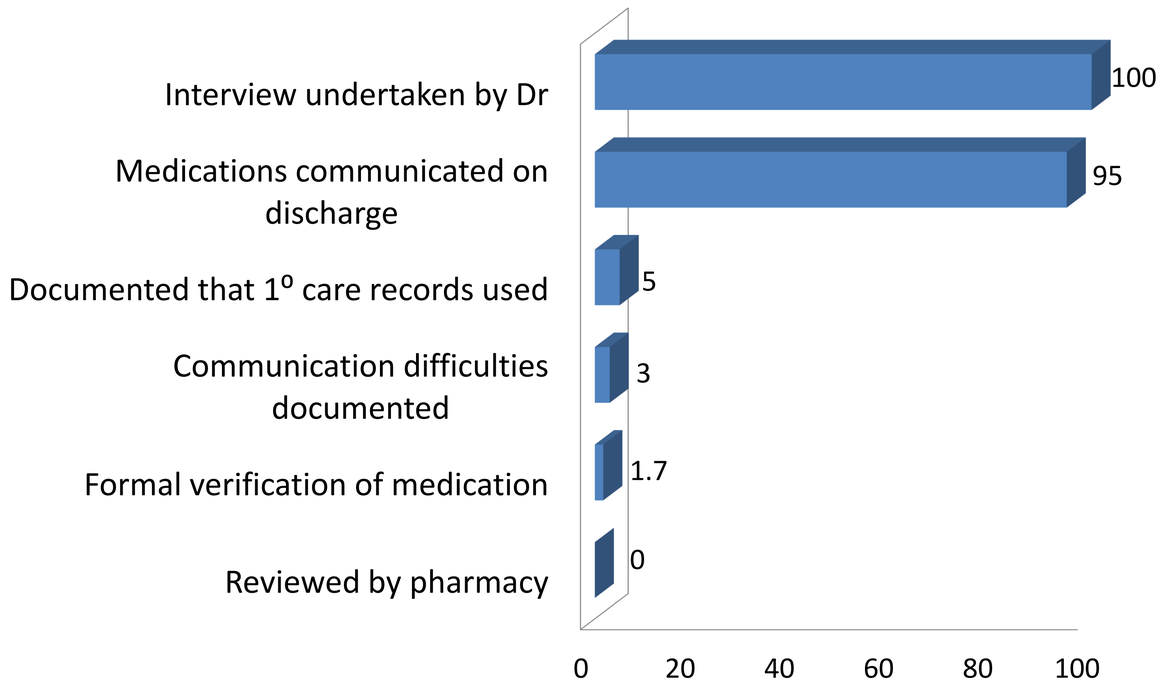
- Number of medicines
- Medicine name, dose, frequency, route, timing recorded?
- Who undertook the MR?
- Who verified the primary care records with the hospice prescription?
- How long after admission was a pharmacist involved?
- Were primary care records used?
- Medication on discharge letter?
- Steroid history?

Results

Documented drug information *[% based on average per pt]*



Percentage of required information documented



Patients on steroids

- 21/58 (36%) of patients were on steroids on admission
- Of that 21, 6 (29%) had steroid history documented
- Of the remaining patients who weren't on steroids 1/37 (3%) had steroid history documented

Discussion

- We are generally documenting drug name, dose and frequency well
- Poor documentation of timing and route (these are likely assumed to be implied)
- We have no formal verification or checking of medication history after admission
- Checking with primary care records/hospital discharge letter may be taking place but we aren't documenting that this is occurring
- Despite a large percentage of our patients using steroids we aren't documenting further information which would be helpful in our management

Recommendations

- A medicines reconciliation policy
- Amending admission documentation to prompt recording steroid history and source
- Future audit: improvements to discharge summary i.e. documenting allergies, full list of current medications and alterations
- Look in to current pharmacy cover to see if we could involve pharmacists in MR at Severn