Please reconcile, not wait a while!

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In 2016 NICE published standards that stated people who are in-patients in an acute setting should have a reconciled list of their medicines within 24 hours of admission.

This guidance includes all healthcare professionals such as doctors, nurses, pharmacist and pharmacist technicians.

Evidence shows that medicines related patient safety incidents are more likely when medicines reconciliation happens more that 24 hours after a person is admitted to an acute setting.

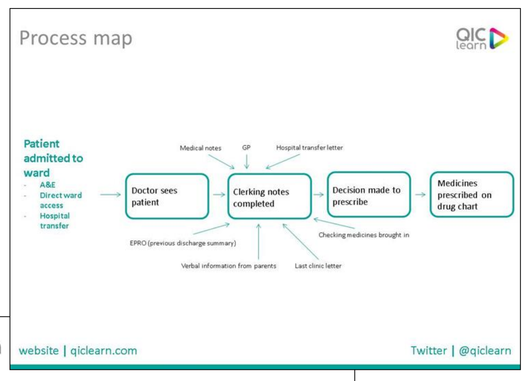
What are we trying to accomplish?

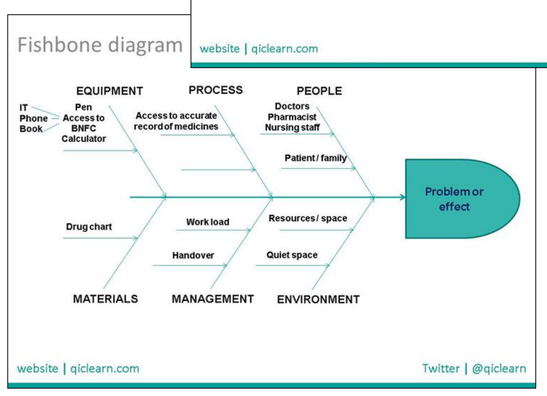
To improve medicines reconciliation on the paediatric wards

To ensure that 100% of patients have their regular medications prescribed by midday the day after admission, by mid July

SPECIFIC
MEASURABLE
ACHIEVABLE
RESULTS FOCUSED
TIME BOUND

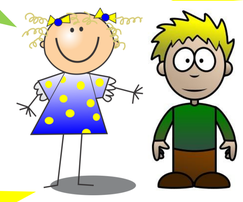
Understanding the problem





"It's obvious isn't it? To ensure my daughter gets her correct medications and doesn't miss any of her doses"

"The process of ensuring that all patients medication list is up to date when they are admitted to hospital, including ensuring they are having the medication they are meant to be on"



We asked people on the ward what medicines reconciliation meant to them...

"Going through each individual patients medications, clearly knowing the doses, frequency etc. and creating a clear list and then comparing it to what is prescribed by us"

"The pharmacist comes and checks our prescriptions with the patients and makes it better!"

"So that you don't duplicate medications my son already takes, to ensure that there are no interactions and for the safety of my child"

Medicines reconciliation is:
The process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated.

Methodology

The paediatric pharmacy team reviewed all in-patient drug charts, Monday - Friday

The number of regular medications and the number of medicines reconciled on the drug chart was recorded each day

The effectiveness of various interventions were reviewed using PDSA cycles

Change ideas

- Teaching sessions to raise awareness
- Message in doctors WhatsApp group
- Posters on the wall in clinical areas
- Questionnaires for parents to ask them about their child's medication
- Label added to medical notes about regular medications to prompt doctors

Plan
- Paediatric Teaching Session

Do
- Layout session

Study
- Measure Improvement
- Evaluate feedback

Act
- Not sustainable over time

Plan
- Poster

Do
- Design

Study
- Measure Improvement
- Evaluate feedback

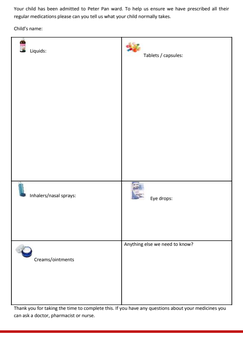
Act
- Raised awareness but limited impact

Plan
- Questionnaire for parents and children

Do
- Commitment from nurses to handout and doctors to use to prescribe

Study
- Measure Improvement
- Evaluate feedback

Act
- Good improvement
- Parent satisfaction



Plan
- Governance meeting

Do
- Attend and disseminate information

Study
- Measure Improvement
- Evaluate feedback

Act
- Slow change

Plan
- A & E Teaching Session

Do
- Layout session

Study
- Measure Improvement
- Evaluate feedback

Act
- Slow change

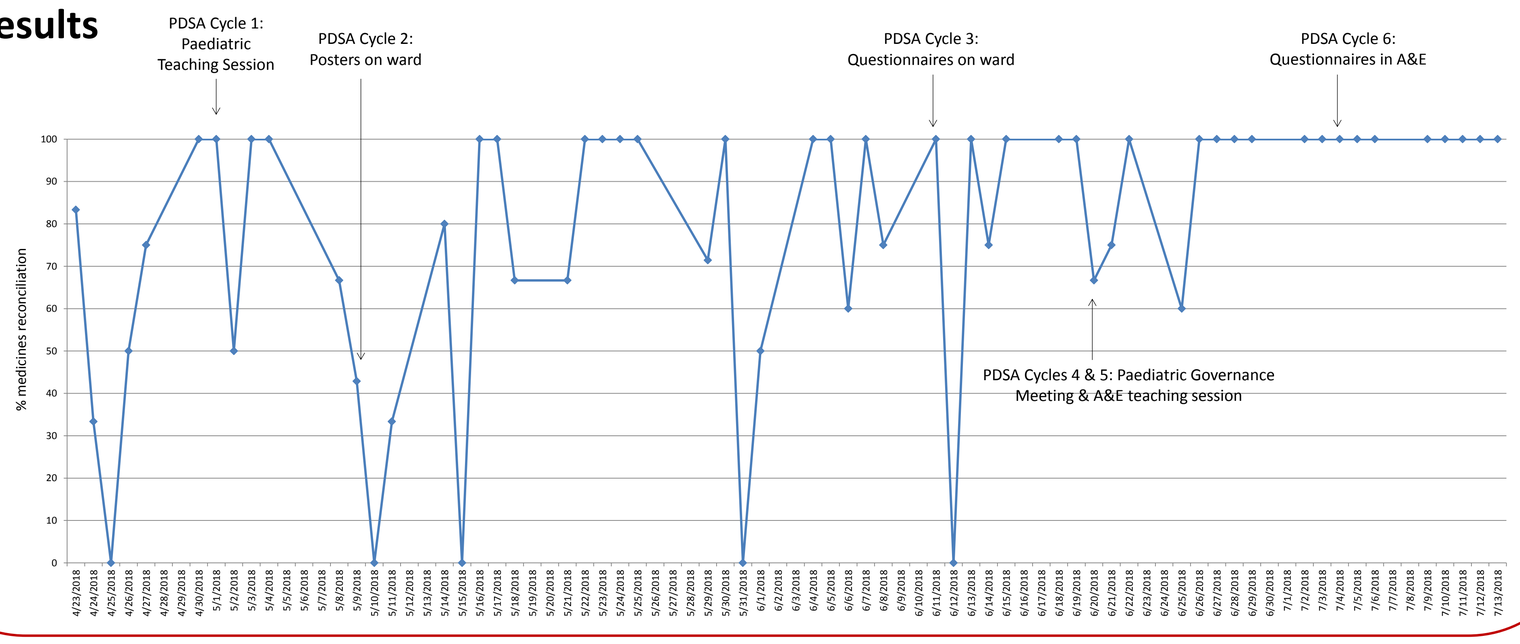
Plan
- Pilot questionnaire in A&E

Do
- Commitment from nurses to handout and doctors to use to prescribe

Study
- Measure Improvement
- Evaluate feedback

Act
- Excellent, sustained improvement

Results



What was the impact?

- The mean reconciliation rate was 79% and the worst rate was 0% (occurred 5 times)
- On average, 38 patients were reviewed each week
- 100% reconciliation was achieved on 34 occasions (from 58 days)
- 100% reconciliation achieved for the last 3 weeks of data collection

Learning & reflections

Since the 26th June 2018 we have been able to achieve 100% medicines reconciliation for three consistent weeks

The main success of this project has been including everyone – from children and parents, to their nurses and doctors. Additionally, both A&E and the paediatric ward have been involved, ensuring consistency across the whole paediatric team.

Our next challenge is to ensure we can sustain this change!

Next steps

What next?
- Share the key learnings with the paediatric department including parents and their children

Ideas
- Identify change champions who can help continue the success of this project
- Brainstorm ideas to ensure sustainability of success

Audit
- Re-audit in 6 and 12 months to see if the improvement has been sustained

References:
1. NICE Quality Standard QS120. Medicines optimisation. Published date March 2016
2. Aronson Jeff. Medicine reconciliation. BMJ 2017, 356: i5336

Acknowledgements

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