Medication Reconciliation- a New PHCC Service

PHCC Operations Department

Introduction

Implementing Medication Reconciliation (MR) is one of the Required Organizational Practices (ROPs) PHCC must have in place in order to achieve Accreditation. MR is an evidence based practice approach to ensure a complete, accurate and up to date medication list is obtained for each patient and that this updated list is communicated to all subsequent care providers.

Aim

- To ensure all patients attending PHCC Non-Communicable Disease (NCD) clinics have their medication reconciled, by a multidisciplinary team, before any new medication are prescribed
- Once MR process is complete, to communicate the updated medication list to the patient and next care provider or whenever the patient is transferred to another care setting

Methodology

- Introduction of New PHCC MR Policy, including new Medication List form
- Development of new MR training program
- Implementation (i) all relevant staff trained on MR process (ii) Launch of MR service in December 2013

  Step 1 – NCD Nurses perform MR process and obtain the full medication history

  Step 2 – NCD Physician verifies the MR information. When required, physicians may refer patients (using referral criteria) to the Pharmacist to undertake an Intensive MR service

  Step 3 – Pharmacist undertakes the Intensive MR process

  Step 4 – Communicate updated information to the next provider of service and the patient

Steps 1, 2, & 3 involve the documentation and reporting of medication errors / near misses on DATIX

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(Affix Patient Identification Label)

Patient Name:
PHC Number:
HC Number:
DOB/Age:

Medication List

☐ **Known Allergies/ Intolerances:** ☐ **No Known Allergies:**

1. The Medication List form must be updated at **each** patient visit if any medication are added, stopped or changed.
2. This must be a comprehensive list of all chronic medication taken by the patient including OTC, herbals, vitamins etc.
3. The Medication List will routinely be completed by physicians to create a master list of the patient's medication history.
4. Trained and competent nursing staff will complete and sign this form as part of the Medication Reconciliation process.

Medication Name (Generic)	Dose	Route	Frequency	Indications (Diagnosis)	Nurse Signature	START Date / Dr. Sign	STOP Date / Dr. Sign

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Expected Outcomes

- **Reduced medication errors / near misses via increased incident reporting and sharing lessons learned**
- **Reduced hospital admissions due to fewer medication errors Improved patient awareness / involvement regarding their medication leading to better medication adherence**
- **Reduced medication wastage**
- **Improved communication links with secondary care enabling seamless provision of high quality patient care**
- **Achievement of MR ROP Accreditation criteria**

Lessons learned/Critical success factors

- Obtaining buy from all staff regarding the benefits realization aspects of MR
- Start with one clinical area, gain experience, then embark on a wider roll-out Identifying reliable / accurate medication information sources
- Need to create strategic partnerships with HMC to facilitate transfer of information
- Accessibility of patient file
- Need for confidential counseling areas for staff to perform MR

Conclusion

Implementing the new PHCC MR service at our Health Centers will significantly improve patient safety, reduce harm caused by inappropriate medication use and enhance the overall quality of health-care delivery to our patients.

Sustainability/Replication potential

Following the successful launch and implementation of MR at our NCD clinics, and as part of the ROP Accreditation process, PHCC will be developing a strategic plan to roll-out the MR service to all our clinics by December 2015.

References

1. Technical patient safety solutions for medicines reconciliation on admission of adults to hospital, NICE / NPSA December 2007
2. Medicines Reconciliation Implementation Guide. National Prescribing Centre (NPC) 2008
3. Gleason, K., et al. (2012). Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation. AHRQ Publication No. 11(12)-0059

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