Pharmacist charting of unintentionally omitted pre-admission medications in St John's Hospital

Project lead: Aine Leen

Project Team

C Johansson, E Kehoe, G Creaton: Dept of Pharmacy

Dr A Abdalla: COVID 19 Lead Clinician

Dr H Holloway: Chair of D&T Committee

IMSN Conference

27th Nov 2020.

Presentation Overview

Change in medication reconciliation process:

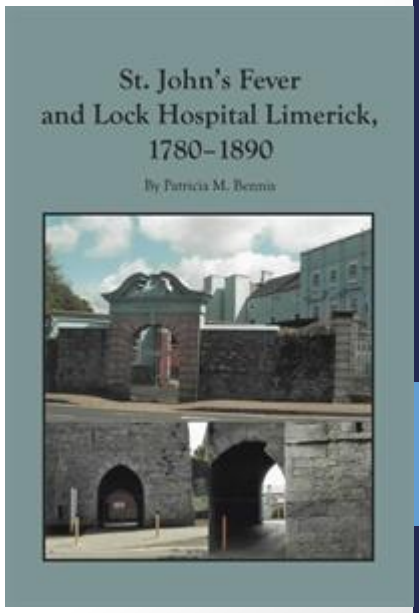
- Where it took place?
- Why?
- What changed?
- How was it changed?
- What effects did this have?
- What now?

Study Setting

St John's Hospital is an acute General Public Voluntary Hospital in Limerick city.

89 in-patient beds (all adult patients).

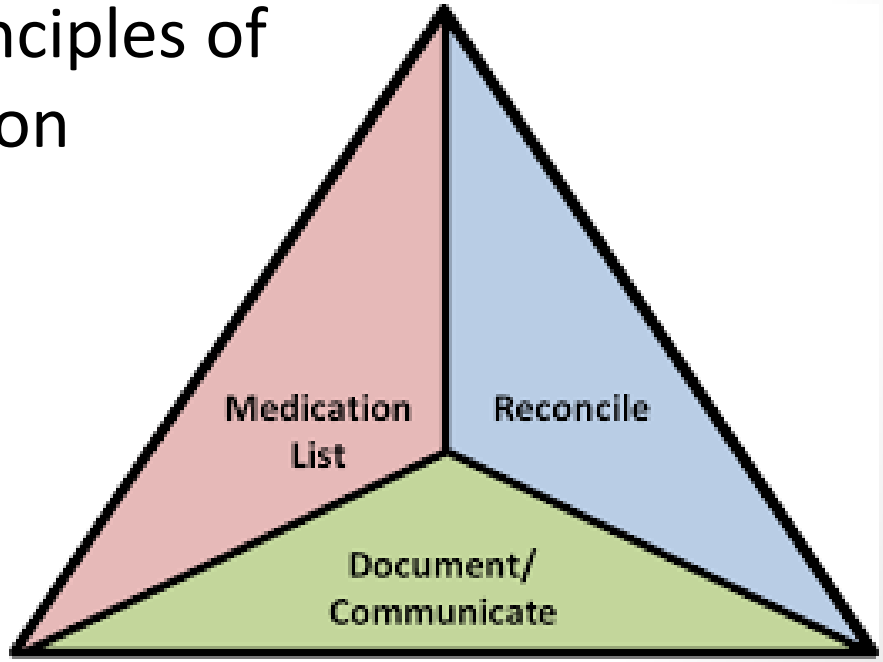
2.0 full time equivalent (FTE) in-patient ward-based clinical pharmacists.



Medication Reconciliation

Collect, Check, Communicate.

HIQA Guidance for Health and Social Care Providers: Principles of good practice in medication reconciliation - May 2014



Potential Issues with Traditional Medication Reconciliation Process

Slow – potential for delayed / missed doses

Communication – potential for errors

Proposed New Process

Collect, Check – As usual.

Communicate – Pharmacists to chart unintentionally omitted pre-admission medications in patient kardex'.

Medical staff were asked to review and endorse with their own signature if appropriate for the medication to be administered by nursing staff.

Potential Advantages

- Less missed doses ->
Improvement in patient safety

- Less risk of miscommunication ->
Improvement in patient safety!

Implementation

- Part of the hospital Covid contingency plan
- Agreed with lead consultant and drugs and therapeutics committee
- NCHDs and nursing staff informed
- On the spot education

Aims of Study

- To establish the frequency of pharmacists charting unintentionally omitted pre-admission medications
- To establish the level of agreement between pharmacists and medical staff with regard to appropriateness of charting unintentionally omitted pre-admission medications
- To obtain qualitative feedback from NCHDs

Study – Data Collection

- Any healthcare records pertaining to patients who:

1) were admitted during May or June 2020 and
2) contained documentation of medication reconciliation carried out by a pharmacist

were eligible for inclusion.

- The data was collected retrospectively from a total of 50 healthcare records.

Study - Interviews

Ten NCHD's were interviewed.

- "thoughts on this practice"?

- "effective in reducing the number of doses missed by patients"?

- "effect on patient safety"?

- "level of agreement between medical team and pharmacist"?


RESULTS

Results 1

Findings from data collection (N=50)

In 29 cases, no unintentionally omitted pre-admission medications noted.

Total of 49 unintentionally omitted pre-admission medications (21 patients).

Total number of unintentionally omitted medications noted by pharmacist during medication reconciliation process (N=49)	N	%
Charted	33	68
Charted and “held”	1	2
Queried in clinical notes	11	22
No documented action	4	8

Results 2

Average of 1.57 medications charted per patient amongst patients with discrepancies (n=21)

Average of 0.66 medications charted per patient amongst total population (n=50)

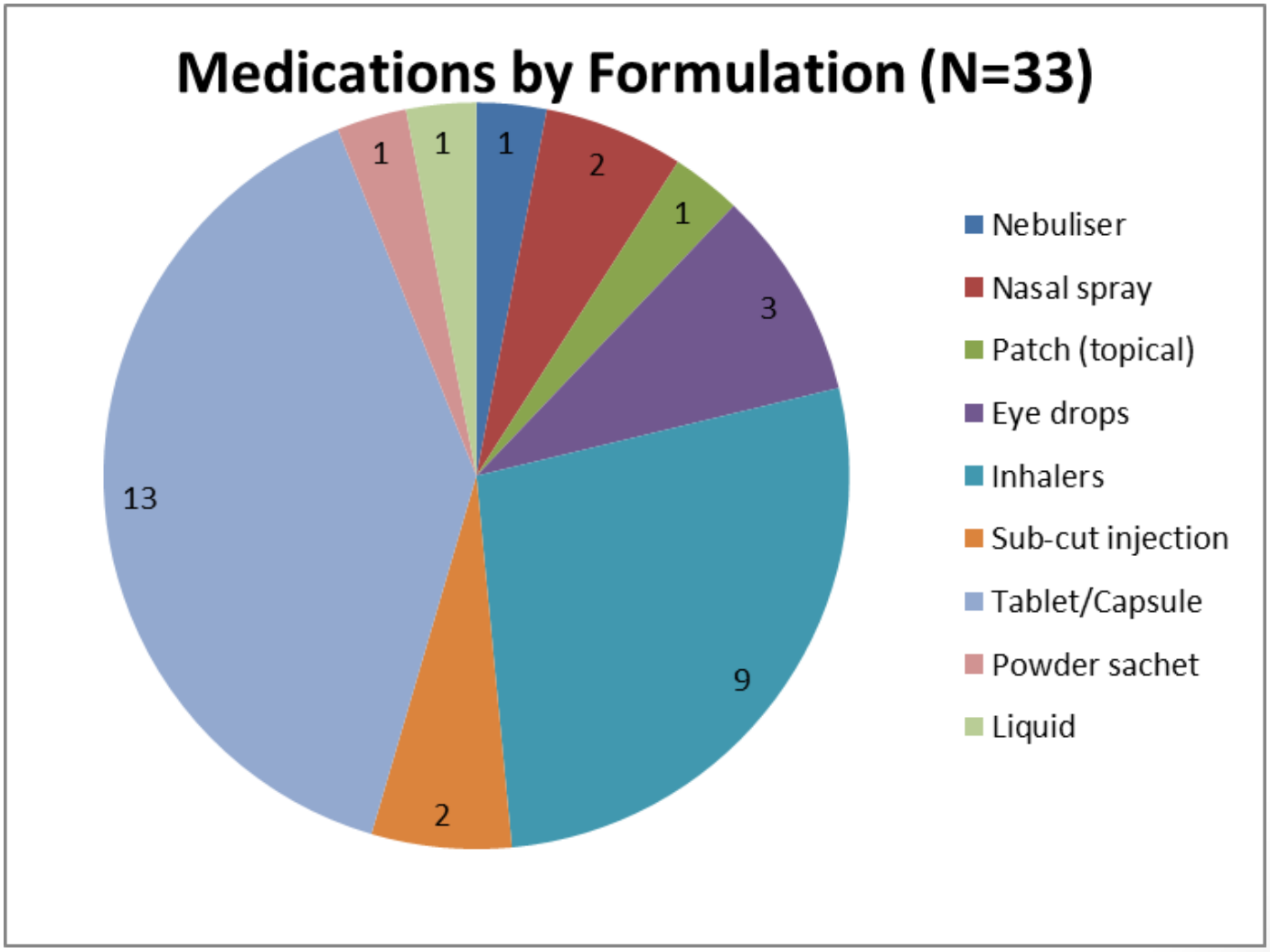
Results 3

Doctor signature present 75.76% of the time (25 out of 33 cases)

Medications charted by pharmacist (N=22)			
Signed by Doctor	Given by Nurse	Signed as Self-Admin by Nurse	Number of Occurrences
✓	✓	-	25
✓	-	-	0
-	✓	-	3
-	-	-	4
-	-	✓	1

One case were doctor stopped/held drug after pharmacist charted – Ventolin inhaler, rewritten.

Results 4


Medications by Formulation (N=33)
1
2
1
3
9
2
13
1
1
Nebuliser
Nasal spray
Patch (topical)
Eye drops
Inhalers
Sub-cut injection
Tablet/Capsule
Powder sachet
Liquid

NCHD Interview Results

Overall, the change in service provision has been positive	100% agreed
Should continue beyond the COVID crisis	100% agreed
Positive effect on patient safety	100% agreed

DISCUSSION

Discussion – Patient Perspective

- Role in medication reconciliation process unaffected
- Potentially less missed doses
- Potentially less errors due to miscommunication

Discussion – NCHD Perspective

- Simplifies their role in medication reconciliation
- Less ambiguous, unclear notes/ post-its
- Some initial hesitations, however now fully supportive and enthusiastic

Discussion – Pharmacist Perspective

- Improved job satisfaction
- Improved relationships with medical colleagues
- Some initial hesitations; certain situations still require clarity (e.g. controlled drugs)

Discussion – Where to go from here

It is hoped that this practice will remain in St John's Hospital.

Potential issues that may arise going forward include how to standardise this process amongst pharmacists, and what training is required by the clinical pharmacist.

Conclusion

- This change in clinical pharmacy practice was well received in St John's Hospital.
- This intervention was perceived to have a positive impact on patient safety.

References

- HIQA Guidance for Health and Social Care Providers: Principles of good practice in medication reconciliation - May 2014. Available from: https://www.hiqa.ie/sites/default/files/2017-01/Guidance-Medication-Reconciliation.pdf
- Grimes TC, Deasy E, Allen A, et al. Collaborative pharmaceutical care in an Irish hospital: uncontrolled before-after study. BMJ Quality & Safety 2014;23:574-583.
- Manning A, Kelly E, Kingston C, Knox R, Dillon L, Castilla E, Brosnan S, Tighe P, Ryder S, Keane C: The impact of clinical pharmacists charting unintentionally omitted medicines on missed doses in an acute medical unit

Questions?