

Quality issue / initial problem

Following a relative’s complaint whereby a patient was administered incorrect medication on admission, we recognised the need to improve accuracy of medication documentation in order to prevent medication related adverse events and to optimise patient well being.

Specific aim

By December 2018, 95% of admissions to Rossbank Ward will have been clerked in using at least 2 sources of information in determining what medications the patient is currently on with one of these sources coming from the patient or his/her family.

Tests of change

- Implementation of new admission proforma with newly formatted medicines reconciliation section with explicit requirement to identify 2 or more sources with tick boxes.

Document at least TWO sources, ONE of which should be **patient, relative or carer**. If none of these are available, please document at least THREE alternative sources.

Patient

☐ Relative or carer

☐ GP Practice

☐ GP Repeats List

☐ ECS

☐

Patient’s own medication

☐ Community Pharmacy Tel:

☐ Discharge Letter Date:

☐ Referral Letter Date:

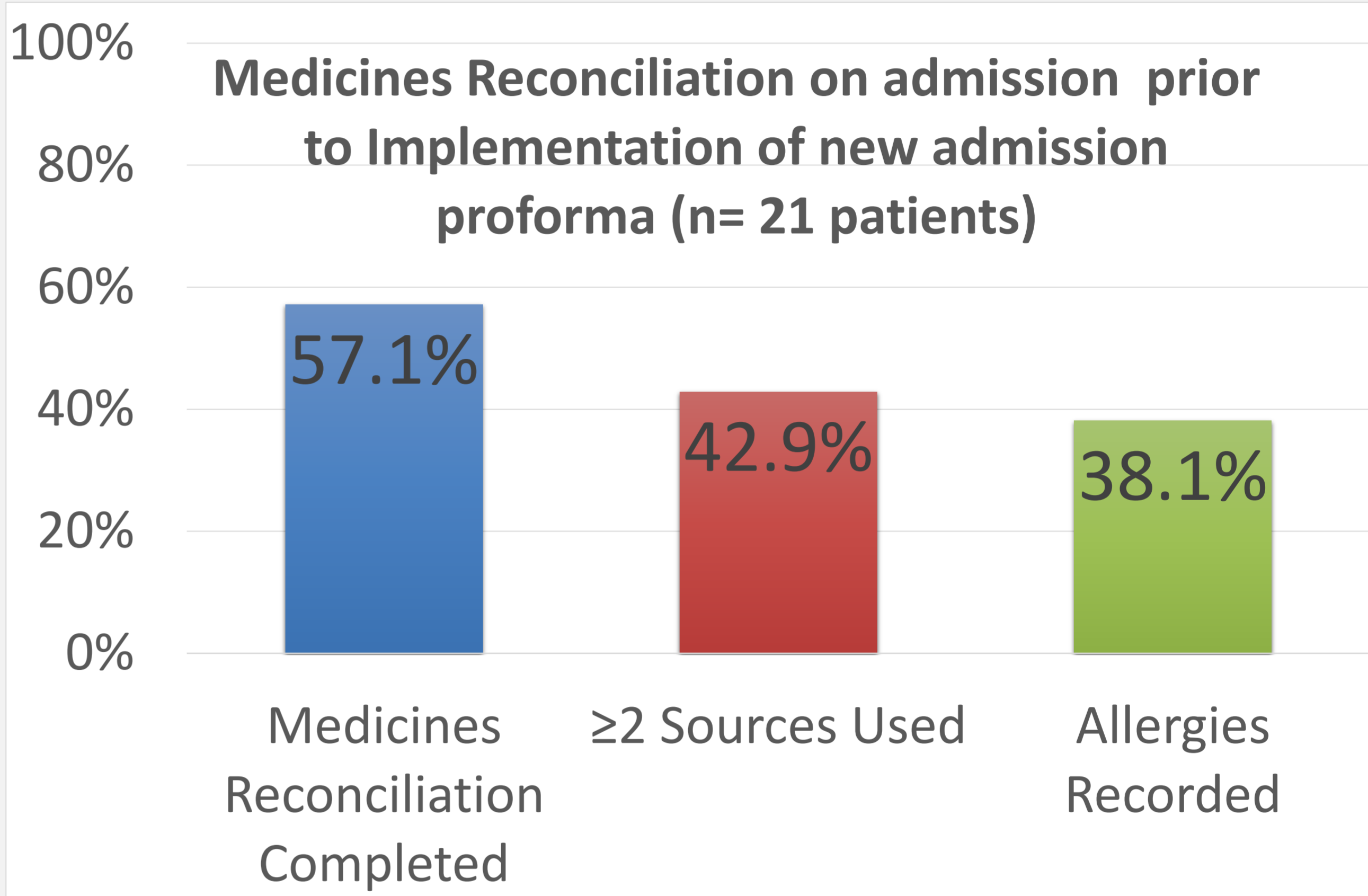
☐ OP Letter Date:

☐

Other (specify):

☐

Measurement of improvement



Outcome Data:
Weekly run chart for number of sources used for each person admitted to the ward.

Tools

- Process mapping
- Run chart

Effects of change

- A more robust and consist method of Medication Reconciliation on Rossbank Ward, MCH
- Early testing of admission documentation shows that of 3 patients , 100% had medicines reconciliation and 1 of the 3 had included information from the patient or carer.
- It is hoped that change can be sustained by continual use until there is sufficient evidence of an improved median.

Lessons learned and message for others

- Ensure that aims are specific and that there is not more than one variable
- Early and continued engagement with colleagues through sharing ideas, planning and results
- Not to be reticent about starting and adjusting when needed