safety IN PRACTICE

Community Pharmacy Medicines Reconciliation 2019-20

Every patient, every time

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Waitematā District Health Board
Best Care for Everyone

Adapted with permission

Contents

Section 1: Introduction

1.1 Background

A key aim of the Safety in Practice programme is to work with Primary Health Care teams to reduce preventable patient harm from the care they receive. Adverse drug events (ADEs) are major causes of patient morbidity and mortality, and a source of significant costs for both organisations and patients.[1]

Medicines reconciliation is defined as the process to collect, compare, and communicate the most accurate list of medicines that a patient is taking, together with details of any allergies and adverse drug reactions (ADRs). This has the goal of providing the correct medicines for a given time period at all transition points.[2]

International studies show:

- Between 10 and 67% of medication histories have at least one error[3]
- Up to one-third of medication errors have the potential to cause patient harm[4]
- More than 50% of medication errors occur at transfers of care[5]
- Patients with one or more medicines missing from their discharge information are 2.3 times more likely to be readmitted to hospital than those with correct information on discharge[6]
- 85% of discrepancies in medication treatment originate from poor medication history taking.[7]

'Implementing Medicines New Zealand 2015-2020'[8], emphasises that healthcare providers will need to work together to ensure medicine reconciliation happens consistently at each transition and involves the patient.

Medicine reconciliation standards HQSC

The recommended processes in this clinical module are based on the Medicine Reconciliation Standards developed by the Health, Quality & Safety Commission.[2] This is summarised below:

- **Collect:** The healthcare practitioner collects the most accurate list of medicines, allergies, and adverse drug reactions (ADRs) using a minimum of two source types.
- **Compare:** The healthcare practitioner compares the collected medicines, allergies and ADR list against the prescribed information, identifying and documenting any discrepancies.
- **Communicate:** At each transfer point, all changes that have occurred to the patient's medicines, allergies and ADR lists will be documented, dated, and communicated by the healthcare practitioners involved to ensure the care of the patient is continued.

A medicine discrepancy is categorised as 'unintentional' or 'intentional'. Action is required to resolve the discrepancy and must be documented for accountability with a time, date and signature.[2]

Measuring Reliability of Your Care

Pharmacist Scope of Practice

According to The Pharmacy Council of New Zealand, "The practice of pharmacy is necessarily broad and is wider than pharmacists working directly with patients, given that such roles influence clinical practice and public safety. In a clinical role, the pharmacist acts as a medicines manager, providing patient-centred medication therapy management, health improvement and disease prevention services, usually in a collaborative environment. Pharmacists ensure safe and quality use of medicines and optimise health outcomes by contributing to patient assessment and to the selection, prescribing, monitoring and evaluation of medicine therapy".[9]

Optimal medicines management and patient education are core responsibilities of pharmacy practice. In conjunction with a Pharmacy Expert Group, measures have been developed that we believe represent best practice for medicines reconciliation. These have been further refined following feedback from 6 pharmacies who participated in the medicines reconciliation pilot in 2017/18.

It is best practice to document all interventions and recommendations made to evidence work that has been carried out. This is one way pharmacists can show all the work that they do, which is in line with Pharmacy Council of New Zealand Competence Standard O1.4.7. Therefore, the process measures relate to documented evidence that the best practice activities have been performed.

"Competence Standard O1.4.7

Supports and provides continuity of care with accurate and timely documentation of clinical and professional interventions and recommendations, using agreed handover protocols."

1.2 Aim

All patients with non-GP* generated prescriptions will have their medicines reconciled and follow-up actions completed at time of dispensing by June 2020.

*Non-GP generated prescriptions include prescriptions that have the potential to change regular medicines such as hospital discharge and outpatient prescriptions. This excludes A&E and dental prescriptions, one-off or new specialist prescriptions.

1.3 Equity

We all have a role to play in reducing inequity in health in New Zealand. Particular groups are consistently disadvantaged in regard to health, and these inequities affect us all.[10]

Health inequities are avoidable, unnecessary and unjust differences in the health of groups of people.[10] This may be between socioeconomic groups, ethnic groups, different geographical regions, levels of ability or disability, and between males and females. Research indicates the poorer you are, the worse your health will be.[11] Inequalities experienced in early life influence people in later life, and inequalities take a cumulative toll on an individual's health over their lifetime.[10]

To promote equity in health, we need to understand the inequity, design interventions to reduce them, review and refine the intervention and evaluate their impact. It is important to minimise the impact of disability and illness on socioeconomic position and access to the determinants of health.[11]

In particular as health providers, we need to emphasise the power of joint decision making and trust with patients, it is important to prioritise time to listen to their health issues in their words, ideally with protected time in consultation room, involving their whānau if preferred by them. It is important they have an understanding of the treatment options, the risks involved and where to go for help.

The most effective conversations are based on a mutual trust and understanding, giving patient's confidence they are in control and empowered to make informed decisions. There are significantly increased risks of avoidable medicine related harm in Māori and Pasifika, it is important we understand this and take special care to ensure optimal health outcomes for all.

1.4 Measures & rationale

This module comprises process and outcome measures. The **process measures** are evidence the activity has taken place. This information needs to be recorded in the patient file (Toniq or RxOne).
The **outcome measures** assess whether there is good continuity of care. Even if the 'non-GP generated' script has been reconciled; the next GP script may still have out-of-date medicines or doses. This step is to be completed when the next GP script has been received.

To assess your process, we require data from a random sample of 10 patients each month who have received a 'non-GP generated' script. Please do not include NHI or identifiable data, the information needs to be anonymous.

Note: If there is a change in medicines from a non-GP generated script, place an alert on the patient record so that when the next GP script is presented you can check changes have been incorporated.

For this module to be successful, it is best to start by getting to know your GPs and informing them that you are part of the Safety in Practice programme. Let them know the measures you are working on with this module, and ask them how they would prefer to be contacted if you have any queries.

Table 1: Measures and Rationale

Is there documented evidence that the patient has received the following care when they presented a 'non-GP generated' prescription?

	Process measure	Rationale
1.a Collect	**Is there evidence the prescription was reconciled with a minimum of 2 valid sources?** Yes ☐ No ☐	Medicines reconciliation standards[2] require that: *The healthcare practitioner collects the most accurate list of medicines, allergies and ADRs based on a standardised data set using a minimum of 2 information source types.* Medicines reconciliation uses at least 2 sources; using only one may not be accurate. If there are changes, remove previously dispensed but uncollected repeats so incorrect medication is not taken. Encourage patients to return unwanted or changed medicines to you for safe disposal. ***NOTE:*** ***Primary sources include:*** *patient or carer, patient held medicine list (i.e. yellow card), patient's own medicines as (note date of supply and expiry dates).****Secondary sources include:*** *previous dispensing history, Testsafe, information from GP or other healthcare professional, aged residential care facility.*
1b	**Is there evidence that the adverse drug reaction status was checked?** Yes ☐ No ☐	**ADRs** (adverse drug reactions) are responses that are noxious and unintended and occur at 'normal' doses.[2] When documenting, include: • Medicine name and formulation • Type of reaction, severity and date of onset. Document NKA 'no known allergies' or 'no known ADRs' if none, or 'unknown' if status unknown. • Source of information eg patient, Centre of Adverse Reactions Monitoring (CARM), MedicAlert®.
1c	**Is there evidence that the allergy status was checked?** Yes ☐ No ☐	**Allergies** are immune-mediated and can cause reactions ranging from mild to anaphylaxis.

2. Compare	**If there were any unexplained discrepancies, is there evidence they were clarified with the prescriber?** Yes ☐ No ☐ NA ☐	Medicines reconciliation standards[2] require that: The healthcare practitioner *compares* the collected medicines information, allergies and ADR list against the prescribed information, identifying and documenting any discrepancies. If there is a discrepancy, clarify if this is intentional or unintentional. NA = no unexplained discrepancies
3a. Communicate	**Is there evidence the patient was educated about any changes, or that there have been no changes?** Yes ☐ No ☐	Medicines reconciliation standards[2] require that: At every transfer point, all changes that have occurred to the patient's medicines, allergies and ADR list will be *communicated*, dated, and documented to ensure continuity of patient care. Timely communication and accurate documentation at all transfer points is essential for reducing medication errors. Full communication includes details of the sources of information, discrepancies identified, and reasons for changes.
3b	**Is there evidence the patient was given the opportunity to ask questions?** Yes ☐ No ☐	A study of 100 patients' understanding of medications at discharge found about 15% were unaware that a new medication had been prescribed, and only half understood specific information about their medications, including dosages, dosing schedule, and purpose. Patients generally remember and understand less than half of what clinicians explain to them. Ask open-ended questions to understand what they know and where the knowledge gaps are.
3c	**Is there evidence the patient was offered an up-to-date list of their current medicines?** Yes ☐ No ☐	Create an accurate list of medicines so it is accessible or available for other users. Ask the patient or carer if they would like a print-out when they first present the script so you have time to prepare it. This could also be in the form of a Yellow card. For pharmacies within the Waitematā region, these can be ordered using the form on: www.waitematadhb.govt.nz/health-professionals/medicines/resources/ Yellow cards can be set up in Toniq – see Appendix 2 An up-to-date medicines list is important for patients, carers and other health professionals to know which medicines they are taking and when. Other relevant patient information may also be offered from www.saferx.co.nz or www.healthnavigator.org.nz and Self Care Cards.

Outcome measures – if next GP script is presented		
4a	**Is there evidence that the next GP script has been checked with the up-to-date medicines list in the pharmacy?** Yes ☐ No ☐ NA ☐	Patients who have been discharged from hospital or have been to an outpatient clinic are generally given a prescription with a 1 month supply of medicines. Upon returning to their GP, they will receive a new prescription that may not have been reconciled with the changes made in hospital or at the outpatient appointment. It is important that this new GP script is carefully checked with the patient history and previous dispensings to make sure it is up-to-date. Check the new script against the most up-to-date list you have on Toniq or RxOne NA = there was no GP script
4b	**If there are any discrepancies, have you clarified and documented these?** Yes ☐ No ☐ NA ☐	To check if the changes are intentional, contact the GP to let them know that the discharge or outpatient script was different. The GP may not have realised the medicines were changed in hospital (unintentional), or they may have decided to make further changes, or return to the previous medicine or dose (intentional). If the patient is fully aware the GP has intentionally changed the medicines and knows they are different to the discharge prescription, this can be considered a clarified discrepancy. Yes = have received the next GP script and discrepancies have been clarified to determine if intentional or not No = have received the next GP script, there were discrepancies but have not clarified with GP or patient NA = there were no discrepancies or there was no GP script presented. Please note in the comments section of the spreadsheet the reason for selecting NA.

Section 2: Instructions

When you receive a non-GP script, go through the Process Measures for "Every patient, every time".

Document the information in the patient file e.g. in Toniq as an intervention or in RxOne as an event audit, so it can be found easily. To upload a checklist onto Toniq, there is a guide in the resources section of your clinical module on the website here. If you are using RxOne, the checklists have been incorporated for you.

2.1 Monthly data collection and submission

In order to assess your processes for medicines reconciliation, you will need to collect data from 10 *random* patients dispensed these medicines every month. As a team, you will then reflect on your results monthly, look for opportunities for improvement and undertake PDSA cycles (Plan, Do, Study, Act)

Note: We DO NOT require NHI or patient identifiable data, so please ensure it is anonymous.

2.1.1 Identify patients

On the day of the data collection each month, run a report on Toniq or RxOne for all non-GP scripts dispensed during the month.

Tip: Some pharmacies found it useful to create a new medicine called 'hospital or non-GP' and process it when they processed a non-GP script. This allowed that to easily search for 'non-GP generated' prescriptions and run a report at the end of the month, when searching for their 10 patients.
This was also useful so everyone was aware that medicines may have changed, so they knew to carefully check the next GP script.

2.1.2 Randomize

From the report generated in step 2.1.1 it is important to select a **random sample of 10 patients**. If you have more than 10 patients in your report, you can randomise patients using an online random number generator.
Note the SiP programme does not endorse any advertising that comes with these online tools.

2.1.3 Audit

a) Evidence for Process Measures

For the 10 **selected** patients, review their patient file for documented evidence that the Process Measures occurred. Record responses into the audit spread sheet.

Documented evidence is required for compliance to Process Measures - please tick 'No' on the spreadsheet if the information has not been documented in the patient file.

b) Evidence for Outcome Measures

Outcome measures require follow up one month later if a GP script has been presented.

For the 10 patients, review their patient file for **documented** evidence that the Outcome Measures occurred. Record responses in audit spreadsheet.

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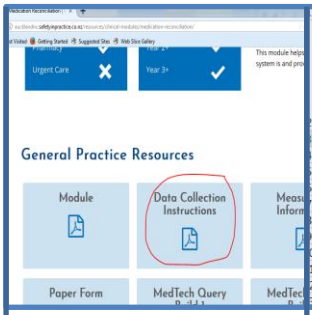
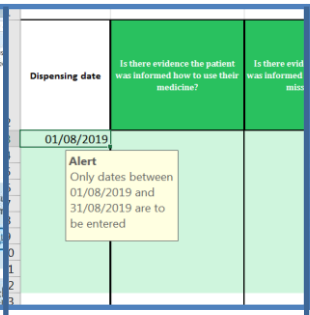
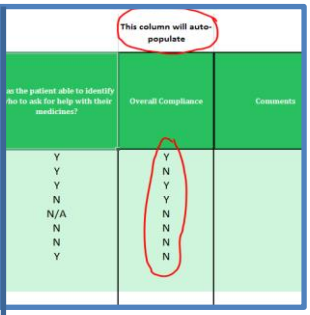
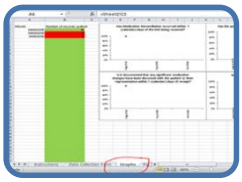
If one of the 10 sample patients has not returned with a GP script, please select NA and note this in the comments section of the data collection spreadsheet.

2.1.4 Complete the spreadsheet

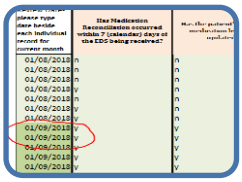
Tip: Your first set of data (baseline data) is relating to the month of August so this is due on October 10th.

Please note: we expect low scores for the baseline August 2019 data, prior to the Safety in Practice programme beginning

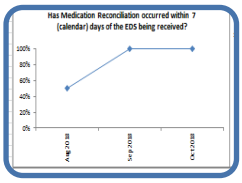
			
Download the spread sheet for your module in the Resources section of www.safetyinpractice.co.nz	Record the date of dispensing in a DD/MM/YY format in the left column. (Alert boxes in yellow will guide you). For your first data set collected in September this is 1/8/18	Mark Y, N or N/A by clicking on the dropdown menu, against for each measure and each patient according to your findings in the previous section.	The final measure "Overall compliance" will auto-populate.



Graphs will be automatically generated in the next tab in the spread sheet.



Next month, add your data to the same spread sheet.



This means you can track your progress over time.

2.1.5 Submit

Submit your data on the 10th of each month to audit@safetyinpractice.co.nz

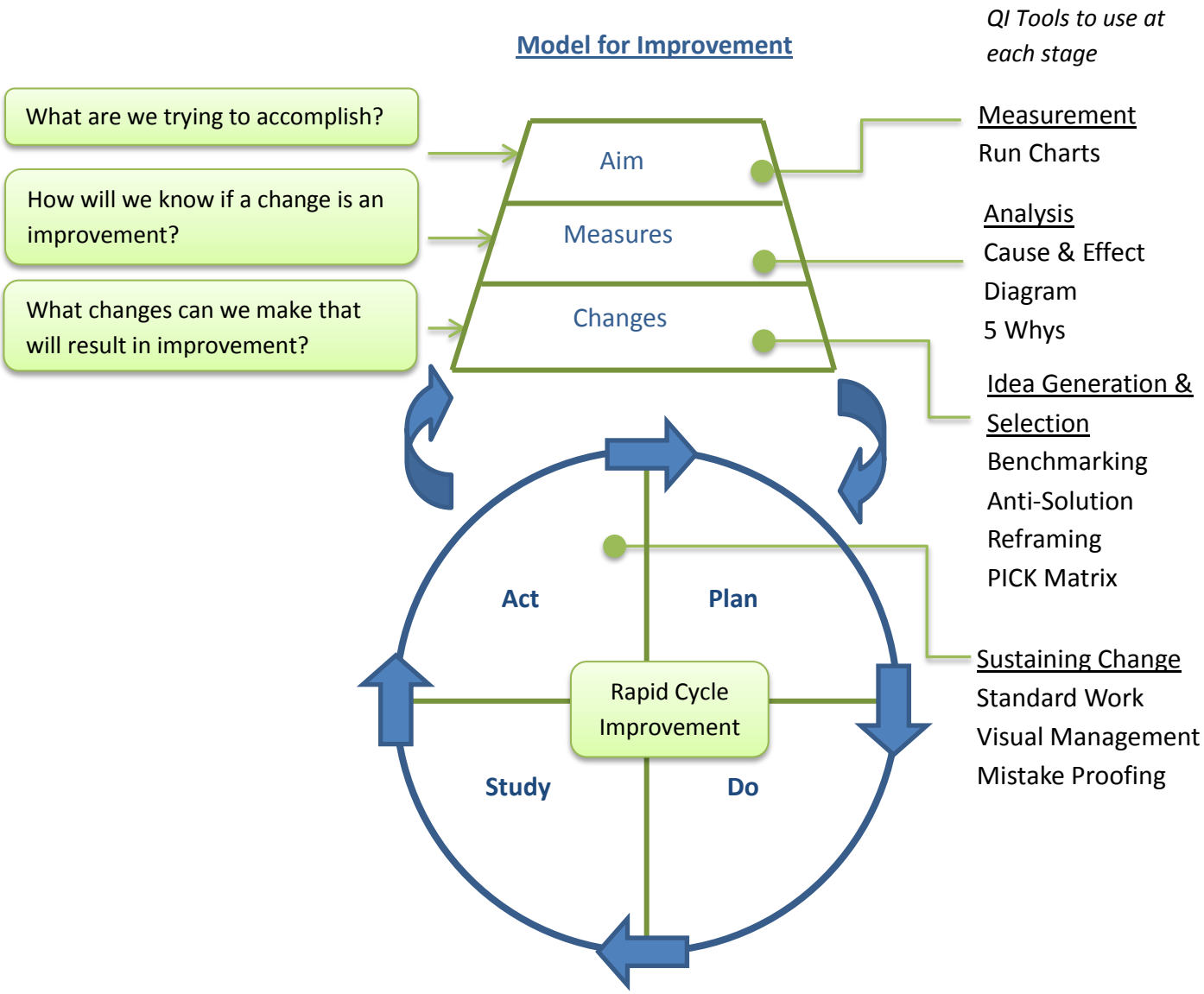
Tip: Please ensure all data sent to Safety in Practice in anonymized

2.2 Getting your team ready for Safety in Practice

Points to consider

- Read through this document so you are familiar with the content
- Identify responsible leads to drive the programme in your pharmacy
- Organise a staff meeting to talk about Safety in Practice and what is involved
- Develop a process or an SOP document for locums and new staff. Think about how you and your team can ensure the locums are up to speed on what you do and why you do it. That way, you should hopefully find your results continue to show improvement when covered by locums.
- Decide on how to create up-to-date medicines lists and make sure all staff know how to do this
- Decide how you will document any interventions and discussions with prescribers and agree to this as a team
- Decide how to document patient discussions in the patient file and agree to this as a team
- Discuss how randomise the 10 patients per month for data collection
- Decide who will be responsible for completing the data collection sheet and submitting data
  Note: It is a good idea to share this task as this ensures the skills are developed across team members.
- Engage with your GPs regarding the CP SiP programme and discuss medicines reconciliation and the process you will be using. If they have any questions, you can refer them to the Safety in Practice website.
- Display posters in the pharmacy so patients are aware that you are a 'Safety in Practice' pharmacy. Posters will be available at the learning sessions, or you can request one from info@safetyinpractice.co.nz

2.3 Creating Change – Using the Model for Improvement



Before you start:

- Bring together your team – this is the group that will work with you to plan and carry out the test of change
- Select the process you wish to change

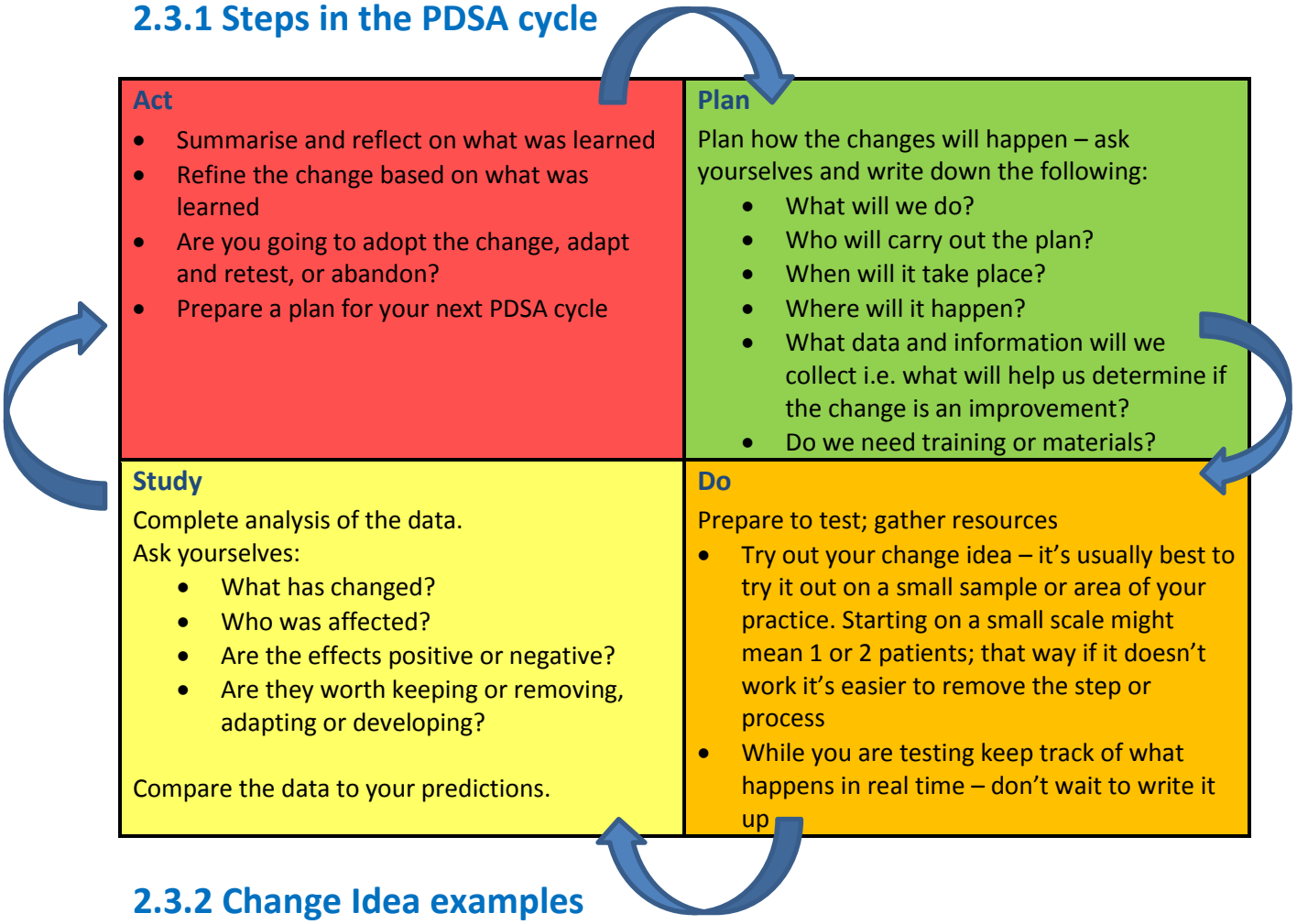
As a team answer the 3 questions above:

1. Aim: *What are we trying to accomplish? (write an objective for this PDSA cycle)*
2. Measure: *How will we know if a change is an improvement?*
3. Changes: *What changes can we make that will result in improvement?*

The following QI techniques will help you engage your team at every step:

- Meeting Facilitation Tips
- Silent Brainstorming
- Post-it Note Brainstorming
- Dot Voting

2.3.1 Steps in the PDSA cycle



2.3.2 Change Idea examples

General	• Discuss results of baseline data collection together and include SiP as a regular agenda item at team meetings • Arrange education session for the pharmacy team about the medicines reconciliation process and the HQSC standards • Meet with your local GPs to inform them you are part of Safety in Practice, working on the Medicines Reconciliation module.
Clinical processes	• As a team, identify barriers that will prevent you from adhering to recommended medicines reconciliation process and look for ways of addressing them • Check repeats that are yet to be collected for patients presenting with a 'non-GP generated' prescription to make sure they are correct
Documentation	• Agree on how you will all document that medicines reconciliation has taken place • Decide on how you will all flag 'non-GP generated' prescriptions so you can be alerted when the next GP script is presented
Discussion with patient	• Use a consistent process to flag 'non-GP generated' scripts, so that a discussion with the patient occurs upon medicine collection • Involve the patient so they are aware of any changes to their regular medicines • Encourage the patient to return unwanted medicines if there have been changes • Provide information about medicines or conditions. See www.healthnavigator.org.nz for resources • Optimise use of Yellow Cards or Self Care Cards if applicable • Utilise SafeRx® patient information on www.saferx.co.nz if applicable

2.4 Previous teams' experiences

Benefits	Challenges
•Confidence within the team that medicines reconciliation is taking place for every patient, every time •Good conversations with patients to explain any changes to their regular medicines •Improved concordance and understanding of new medicines •We now have a process to organise yellow cards when preparing medico packs. •We are using TestSafe more , and checking the clinical notes. There is a lot of valuable information in there. •Improved relationship with GP to freely discuss discharge prescriptions.	•Time commitment required – no easy way out •Took time to effect change •It takes time to organise the up-to-date list of medicines •Contacting prescribers and thinking about how to best approach the conversation.

Tip: Some groups also organised a printed chart of medicines in the patient file, so it can be easily adapted and printed. Teams found it useful to ask the patient when receiving the script if they would like a list of medicines, so this can be prepared while the medicines are being dispensed. Some patients were also happy to come back later for their printed list, so it could be prepared when the pharmacy was not so busy.

Section 3: Resources

3.1 Contacts

- Questions, feedback or general enquiries: info@safetyinpractice.co.nz
- Submitting data: audit@safetyinpractice.co.nz
- Website: www.safetyinpractice.co.nz

3.2 Glossary

Allergies	Immune-mediated and can cause reactions ranging from mild to anaphylaxis.
ADRs (adverse drug reactions)	Responses that are noxious and unintended and occur at 'normal' doses.
Discrepancy	Any medicine that is omitted, altered, added or substituted without documented explanation in the patient's clinical record or other form of accepted communication. Any medicine difference which is undocumented, even if clinically indicated is called a discrepancy.[2]
'non-GP generated' prescriptions	Include hospital discharge, outpatient and specialist prescriptions. One-off or new specialist prescriptions are not included in this clinical module.
Medicines reconciliation	The process to collect, compare, and communicate the most accurate list of medicines that a patient is taking, together with details of any allergies and/or adverse drug reactions (ADRs) with the goal of providing correct medicines for a given time period at all transition points.[2]

3.3 Resources

- Health Quality & Safety Commission 2010. Medicine Reconciliation Standards, Version 3. Wellington: Health Quality & Safety Commission. www.hqsc.govt.nz/assets/Medication-Safety/Med-Rec-PR/Medication_Rec_Standard_v3.pdf (Accessed 17-08-18)
- Ministry of Health 2015. Implementing Medicines New Zealand 2015-2020. Wellington: Ministry of Health 2015. ISBN-978-0-478-44826-9. www.psnz.org.nz/Folder?Action=View%20File&Folder_id=86&File=ImplementingMedicinesNZ2015to2020June2015.pdf (Accessed 17-08-18)
- Health Quality & Safety Commission. Three steps to better health literacy – a guide for health professionals. www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/health-literacy-booklet-3-steps-Dec-2014.pdf (Accessed 17-08-18)

3.4 References

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10. Ministry of Health, Reducing Inequalities in Health. 2002, Ministry of Health: Wellington. www.health.govt.nz/publication/reducing-inequalities-health (Accessed 06-05-19)
11. Signal L, Martin J, Cram F, Robson B. The Health Equity Assessment Tool (HEAT): A user's guide. 2008. Wellington, Ministry of Health. ISBN 978-0-478-31747-3 www.health.govt.nz/system/files/documents/publications/health-equity-assessment-tool-guide.pdf (Accessed 06-05-19)

Appendix 1: Medicines reconciliation checklist

Patient NHI/Name	Date

Clinical Checks

Collect

1a Is there evidence the prescription reconciled with a minimum of 2 valid sources?

Yes ☐ No ☐

1b Is there evidence that the adverse drug reaction status was checked?

Yes ☐ No ☐

1c Is there evidence that the allergy status was checked?

Yes ☐ No ☐

Compare

2 If there were any unexplained discrepancies, is there evidence they have been clarified with the prescriber?

Yes ☐ No ☐ NA ☐

Patient Education

Communicate

3a Is there evidence the patient was educated about any changes or that there have been no changes?

Yes ☐ No ☐

3b Is there evidence the patient was given the opportunity to ask questions?

Yes ☐ No ☐

3c Is there evidence the patient was offered an up-to-date list of their current medicines?

Yes ☐ No ☐

Outcome measures – if next GP script

4a Is there evidence that the next GP script has been checked with the up-to-date medicines list in the pharmacy?

Yes ☐ No ☐ NA ☐

4b If there are any discrepancies, have you clarified and documented these?

Yes ☐ No ☐ NA ☐

Appendix 2: Setting up a Yellow Card in Toniq

The Yellow Card is stored as a template and can be printed from within Toniq.

Select a patient, press **F3** LTC/Services; **U** Use Diary Template

Arrow down and select 'Yellow Card' and press **F9** Print.

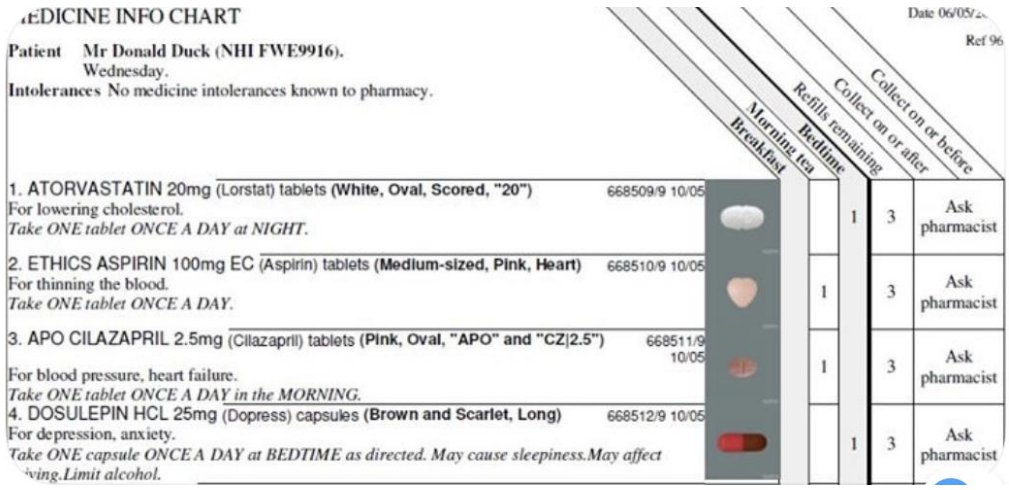
Note: You must have configured a landscape printer

7. Administration
1. Setup
3. Printer setup
3. Device setup

Then the Medication Chart can be printed on the reverse side.
Select a patient, press **F10** Other, Medication Chart and complete the dose times.
Or from within a Dose Pack, simply select the **Chart** option under **F9** Print.

This is assuming each medicine has been assigned the appropriate chart section;
If not, use **F6** Edit Item as appropriate.

Note: Charts is an optional Toniq module which not all pharmacies have access to.



EDICINE INFO CHART

Patient Mr Donald Duck (NHI FWE9916).
Wednesday.
Intolerances No medicine intolerances known to pharmacy.

Date 06/05/2...
Ref 96

	Morning tea	Breakfast	Bedtime	Refills remaining	Collect on or after	Collect on or before
1. ATORVASTATIN 20mg (Lorstat) tablets (White, Oval, Scored, "20") 668509/9 10/05 For lowering cholesterol. *Take ONE tablet ONCE A DAY at NIGHT.*			1	3		Ask pharmacist
2. ETHICS ASPIRIN 100mg EC (Aspirin) tablets (Medium-sized, Pink, Heart) 668510/9 10/05 For thinning the blood. *Take ONE tablet ONCE A DAY.*			1	3		Ask pharmacist
3. APO CILAZAPRIL 2.5mg (Cilazapril) tablets (Pink, Oval, "APO" and "CZ|2.5") 668511/9 10/05 For blood pressure, heart failure. *Take ONE tablet ONCE A DAY in the MORNING.*			1	3		Ask pharmacist
4. DOSULEPIN HCL 25mg (Dopress) capsules (Brown and Scarlet, Long) 668512/9 10/05 For depression, anxiety. *Take ONE capsule ONCE A DAY at BEDTIME as directed. May cause sleepiness.May affect ...ving.Limit alcohol.*			1	3		Ask pharmacist

Appendix 3: Yellow Card Order Form – Waitematā DHB

YELLOW MEDICATION CARD ORDER FORM

(For use by GP Practices & Community Pharmacies only)

Quantity	Product	Product Code
☐	A4 yellow cards – 100 card pack	5.9.014
☐	Wallet-size yellow cards – 50 card pack	5.9.015

Write number of packs

_____

_____

Your address (please print clearly)

Name of Practice/Pharmacy: _____

Delivery Address: _____

_____

Telephone no: _____

Contact person: _____

_____

Please fax or post this form to:

Inwards Goods
North Shore Hospital
Private Bag 93-503, Takapuna
Fax: 09 4418980

_____