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NSW Health Symposium Oct 2012

Improving Medication Safety on Discharge
Clinical Excellence Commission (CEC) Award for Improvement in Patient Safety

Introduction

Transition of care from hospital to the community is a vulnerable time for medication error.

A review of the process for providing medication to patients and communicating medication information to primary care teams on discharge from acute inpatient facilities at Bloomfield Hospital identified significant potential for medication misadventure. In particular, discrepancy between the discharge medications provided to the patient on a handwritten discharge prescription and the medication information communicated in the computer generated discharge summary.

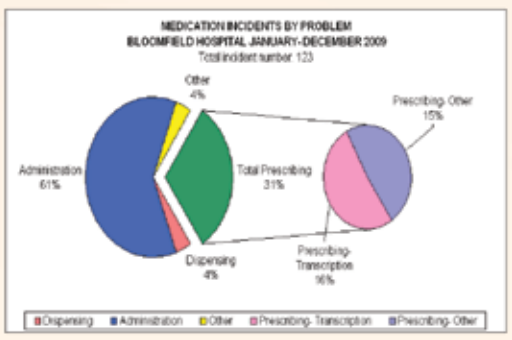
This project was commenced to ensure that medication information was accurately communicated to primary care teams on discharge.

Aim

To reduce the rate of discrepancy between medications prescribed and dispensed on discharge and medication information communicated to primary care teams in the discharge summary to 0% in 12 months.

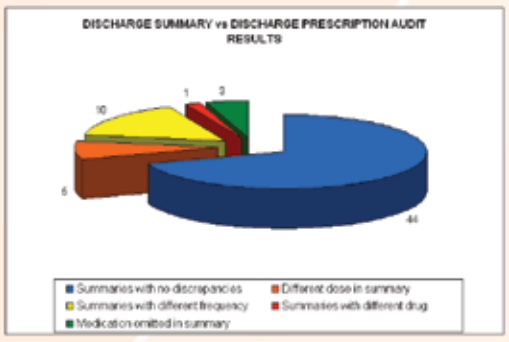
Nature and Extent of the Problem

Analysis of Bloomfield Hospital IIMS data indicated that transcription error is a common cause of medication incident.



Similar rates of transcription error were suspected in the discharge summary however this information is not captured in IIMS data. Therefore, an audit of discharge summaries was conducted.

The audit compared the medication information in 60 discharge summaries to the medications dispensed on the discharge prescription for the same 60 patients. The audit identified that 16 of the 60 discharge summaries contained at least 1 discrepancy in comparison to the discharge prescription.



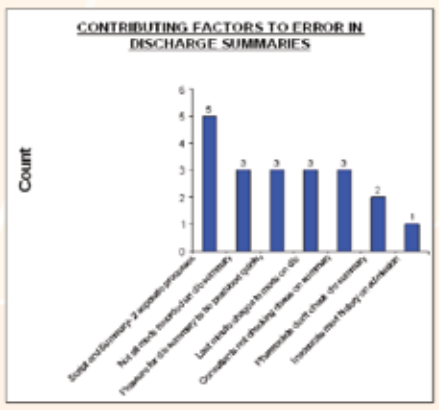
Analysis of the summaries indicated that the discrepancies were due to transcription error rather than a conscious decision to change medications on discharge.

Planning and Implementing Solutions

The project team was established. Team members included representation from Bloomfield Hospital executive, senior medical and nursing staff and pharmacy staff.

The project was overseen by the Bloomfield Hospital Drug and Therapeutics Committee.

The team identified that the most significant contributing factor was that the discharge prescription and discharge summary were 2 separate documents produced on 2 separate occasions.



The team decided to consolidate the 2 documents into 1, therefore eliminating potential discrepancy. As a result, both the prescription and the medication information in the discharge summary will be reconciled against the medication charts by a clinical pharmacist prior to dispensing and communicating with the primary care team. Any discrepancies are clarified and corrected.

Interventions were trialled using PDSA (Plan, Do, Study, Act) principles. Modifications were made to the existing computer generated discharge summary template to enable it to be used as a discharge prescription. Legal requirements for a computer generated prescription were considered and adhered to. Medical and administrative staff were trained on the changes and how to use the new prescription template.

The new computer generated prescription template was gradually phased in for all acute inpatient discharges.

Outcomes

After implementation, 60 discharge prescriptions were audited against medication information provided in the discharge summary. Results were as follows:

	Pre implementation (2010)	Post implementation (2012)
Number of discharge summaries containing a discrepancy	16 (27%)	0 (0%)

Feedback was sought from staff involved in the new process: medical staff, administrative staff and pharmacy staff. Feedback was positive and minor adjustments were made to the process according to their suggestions.

Conclusion

This project has resulted in the accurate provision of medication information to the primary care teams on discharge from hospital, reducing the risk of unwarranted changes to medications after discharge.

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