Medication Reconciliation Upon Transfer Improvement Project

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Chief Quality Officer

A performance Improvement Project
Medication Reconciliation

5 Patient Safety Components

- Device-associated Module
- Procedure-associated Module
- Medication-associated Module
- MDRO & CDI Module
- Vaccination Module

- Errors
- Omissions
- Reconciliation
- Interaction
Medication Reconciliation – A Patient Safety Component

• Medication use module is a complex & challenging
• IHI, ISMP, JCI, AHRQ believed that medication reconciliation is the right thing to do to benefit patients and help in delivering safer patient care.
• Communicating medication list effectively during transition of care:
  – Admission
  – Transfer
  – Discharge
• It is a critical step to assure patient safety
Definitions

**Medication Reconciliation:** A process for obtaining & documenting a **complete** and **accurate** list of a patient’s **current medicines** upon admission & comparing this list to the prescriber’s **admission, transfer** and/or **discharge** orders to identify and resolve discrepancies.

**Admission Reconciliation Process:** requires a straightforward comparison of patient's pre-admission medications with admission orders;

**Transfer Reconciliation:** A complex process requires 3 sources of information:

1. Patient's list of home medications
2. Medications deactivated during admission
3. Medications ordered during admission & newly added medications on transfer.
12 Dimensions of Quality Care /Performance

- Appropriateness
- Availability
- Competency
- Continuity
- Timeliness
- Efficiency
- Equitability
- Safety
- Effectiveness
- Efficacy
- Respect & Care
- Prevention & early detection
- Safety
Background

- A trend of low compliance was noted in the % of medications reconciled upon transfer for admitted patients.
- Medication reconciliation was identified as one of high risk priorities requiring improvement and selected ‘medication reconciliation upon transfer’ as one of the strategic KPIs.
Find an Opportunity for Improvement
Organize a team
Clarify the current process
Understand the current problem
Select a desired outcome
Identify & Organize Multidisciplinary Team

**Facilitator**
- Hosn Saifeddine, Quality Manager
- Tariq Izzeldin, Pharmacy Supervisor (Medication Safety Officer)

**Project Leaders**
- Dr. Nellie Boma, CQO
- Dr. Amna Al Darmaki, DCMO
- Khuloud Bin Rafeea, Pharmacy Director

**Team Members**
- Zakaria Harb, Pharmacy Supervisor (PhamNet Application Specialist)
- Bader El Sa’ Di, Senior Pharmacist (PhamNet Application Specialist)
- Basma Beiram, Clinical Pharmacist
- Dr. Khawaja Wahji, Medical Informatics
- Dr. Dana Fayoumi, Senior Pharmacist
Committed people “passionate pursuit” + Build quality organization “structure” + Develop processes “engage people” = Better outcomes
Objectives

- To comply with Corporate Office(SEHA) target of medication reconciliation upon transfer at 30% in 2017 and 75% in 2018.

- To eliminate preventable medication errors and adverse events resulting omissions, duplications, & interactions.
PDCA Cycle
A FOCUS Plan, Do, Check and Act (PDCA) methodology was adopted and various basic and advanced quality methods/tool were utilized:

- Diverse cross functional team with wise decisions collaborated towards a higher impact.
- Benchmarking against Global/Regional and National hospitals.
- Brainstorming and Multi-voting to prioritize strategies for improvement.
- Cause and Effect analysis to identify root causes of the problem.
- Workflow diagram assigning responsibilities and timeframes.
Identifying Root Causes

Low compliance with Discharge medication reconciliation

Patient
- Lack of awareness of patient
- Lack of patient education and compliance
- Reliance on provider
- Health Literacy

System
- Complicated process
- Lack of consistency in documentation
- No reminder prompts to do med rec.
- Process review trigger
- Utilization of reports generated by system
- System issue raised by physicians

Personnel
- Lack of training & Awareness
- Unavailability of a super user
- Lack of interest by some physicians.
- Increased number of new physician
- Physician resistant to the system change
- Motivation

Leadership
- Issue not raised to the leadership before to gain their support

Communication
- No active meetings to discuss process and compliance
- Complexity of communication
- Data to monitor compliance was at long interval (every quarter)

Culture
- Issues of accountability
- Lack of team work
**DO – 5 Steps**

**1. HIS System Improvement:**
- Cleanup of all outpatient medication profiles.

**2. Education & Training:**
- Development of educational materials for end-users.
- Intensive academic detailing with Physicians.
- Formal/Informal educational sessions provided to Physicians and Physician extenders.

**3. Ownership of the Process:**
- Leadership commitment, involvement and resource allocation to achieve medication reconciliation as patient safety issue.
- Assign ultimate responsibility of reconciliation to the respective Chairs of the Department.

**4. Overseeing Implementation:**
- Daily audits for adherence to medication reconciliation upon transfer.
- Regular feedback on the performance to individual physicians.
- Daily progress report to CMO and Chair of Departments.

**5. Clinicians Education: (Physician Extenders)**
- Compulsive ongoing awareness provided to Nurses, Midwives regarding medication reconciliation.
Challenges – CIPP Group

**WHY DO**
- Clinicians verbalize lack of understanding of the chronic care management model

**DON'T DO**
- Clinicians who were skeptics described this model as risky
- Strong expression from clinicians about the feasibility, timing and the need and its priority

**CAN'T DO**
- Lack of willingness for collaborative work
- Lost of ownership of important elements of the status quo

**WON'T DO**
- Distrust and lack of respect despite believe in benefit of this charge
- Expressing deep concern about having to give up or let go of some valued aspect of status quo
CHECK (Post-Improvement Results)
Benchmarking – Regional

Medication Reconciliation upon Transfer - Tawam vs. Other SEHA BEs

Q1, 17: Tawam 10.1%, SKMC 3.1%, MQ 10.0%, AA 6.6%, AR 0.0%
Q2, 17: Tawam 21.2%, SKMC 6.6%, MQ 12.0%, AA 2%, AR 2%
Q3, 17: Tawam 46.7%, SKMC 21.2%, MQ 42.0%, AA 21.2%, AR 21.2%
Q4, 17: Tawam 81.7%, SKMC 65.7%, MQ 81.7%, AA 81.7%, AR 81.7%
Q1, 18: Tawam 84.0%, SKMC 80.5%, MQ 84.0%, AA 84.0%, AR 84.0%
Q2, 18: Tawam 83.7%, SKMC 83.7%, MQ 83.7%, AA 83.7%, AR 83.7%

Target: 75.0%
Benefits of Reconciliation

**TANGIBLE BENEFITS**
- Increased Timeliness of Care
- Increased Patient Safety
- Increased Effectiveness of Care
- Patient Centered Care
- Increased Access to Care
- Assure prevention & Control Strategies
- Increased patient satisfaction
- Continuity of Care
- Increased Availability

**INTANGIBLE BENEFITS**
- Improve Team Dynamics
- Develop skills & knowledge of healthcare staff
- Meet the Patient & Family Expectations
- Strong inter-relationship between primary care doctors and specialists
- Enhance customer loyalty and engagement
Share Results

- KPI Reports / PI Projects
- Hospital wide grand rounds / Lectures / Posters
- Departmental meetings
- Peer review forums
- Team STEPPS
- Story board displays
- Stake Holders results were shared through
ACT

• Expand the project to outpatient services.
• Target Medication Reconciliation associated with inpatient admission and transfer between different levels of care.
• Continue measuring and monitoring compliance with Medication Reconciliation.
• Review trends and evaluate strategies.
• Continue to discuss results with all staff.
• Continue with staff education.
• Implement Individual, Team and Department Recognition Programs.
If you want to go **FAST** go **ALONE**
if you want to go **FAR** go as a **TEAM**

Surround yourself with those on the same **MISSION** as you are
Thank You