Clinical Safety & Effectiveness Cohort 18 Team #9

Medication Reconciliation Upon Discharge from an Inpatient Psychiatry Unit

CENTER FOR PATIENT SAFETY & HEALTH POLICY

UT HEALTH SCIENCE CENTER™

SAN ANTONIO

The Team

- Clinical Pharmacy Service
  - Nicole Cupples, PharmD, BCPP, BCPS (CS&E Participant)
  - Cindy Gutierrez, PharmD, MS, BCPP (CS&E Participant)
- Pharmacy Service
  - Tera D. Moore, PharmD, BCPS, BCACP – Associate Chief, Clinical Pharmacy Programs (Sponsor)
- Psychiatry Service
  - Uma Kasinath, MD – Chief, Psychiatry Service (Sponsor)
  - Nicole Braida, MD – ACOS, Mental Health (Sponsor)
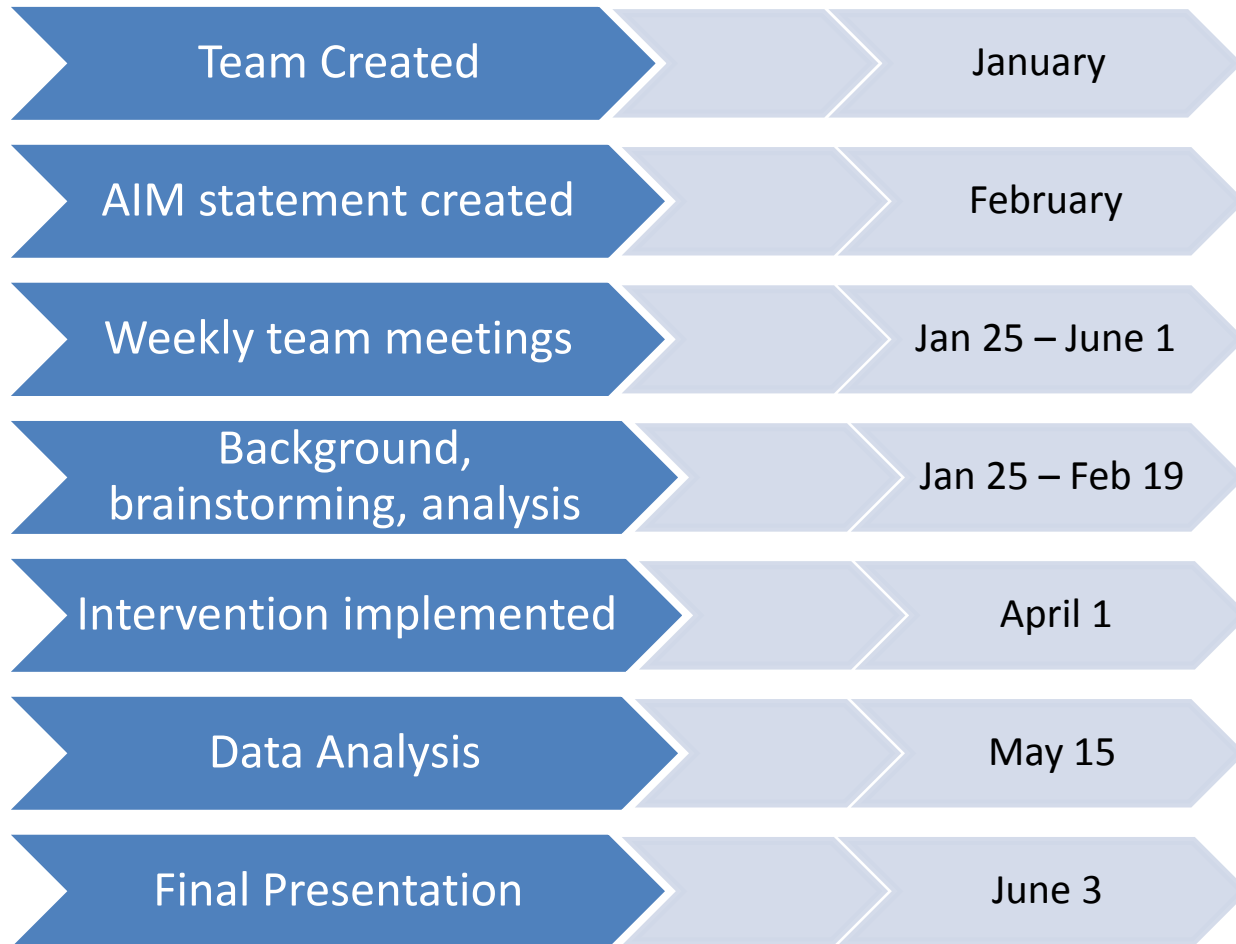- Facilitator: Edna Cruz, MS, RN, CPHQ

AIM Statement

To increase accuracy of medication reconciliation completed at discharge from inpatient psychiatry (GLA PSY at STVHCS) as documented in the Medication Reconciliation and Discharge Note from 37.5% to 75% by May 15, 2016

Project Milestones - 2016

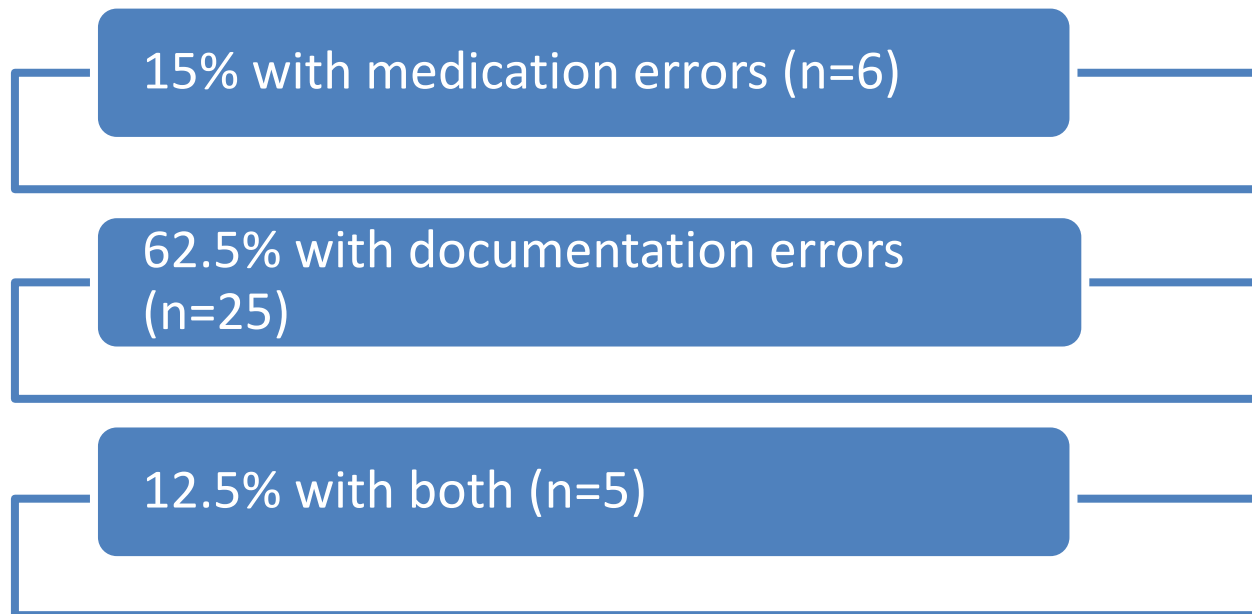|	
Team Created	January
AIM statement created	February
Weekly team meetings	Jan 25 – June 1
Background, brainstorming, analysis	Jan 25 – Feb 19
Intervention implemented	April 1
Data Analysis	May 15
Final Presentation	June 3

Background

https://yourpostalblog.wordpress.com/2013/04/26/taking-old-medications-out-of-circulation/

- Medication reconciliation is the #3 National Patient Safety Goal as discharge discrepancies lead to ADEs – a common event after hospital DC[1]

- A recent study evaluating an 80 bed private psychiatric hospital, found 45% of medication reconciliations to be without error.[2]

- The VHA has developed Essential Medication Information Standards to define the essential elements necessary on discharge and to comply with Joint Commission standards[3]
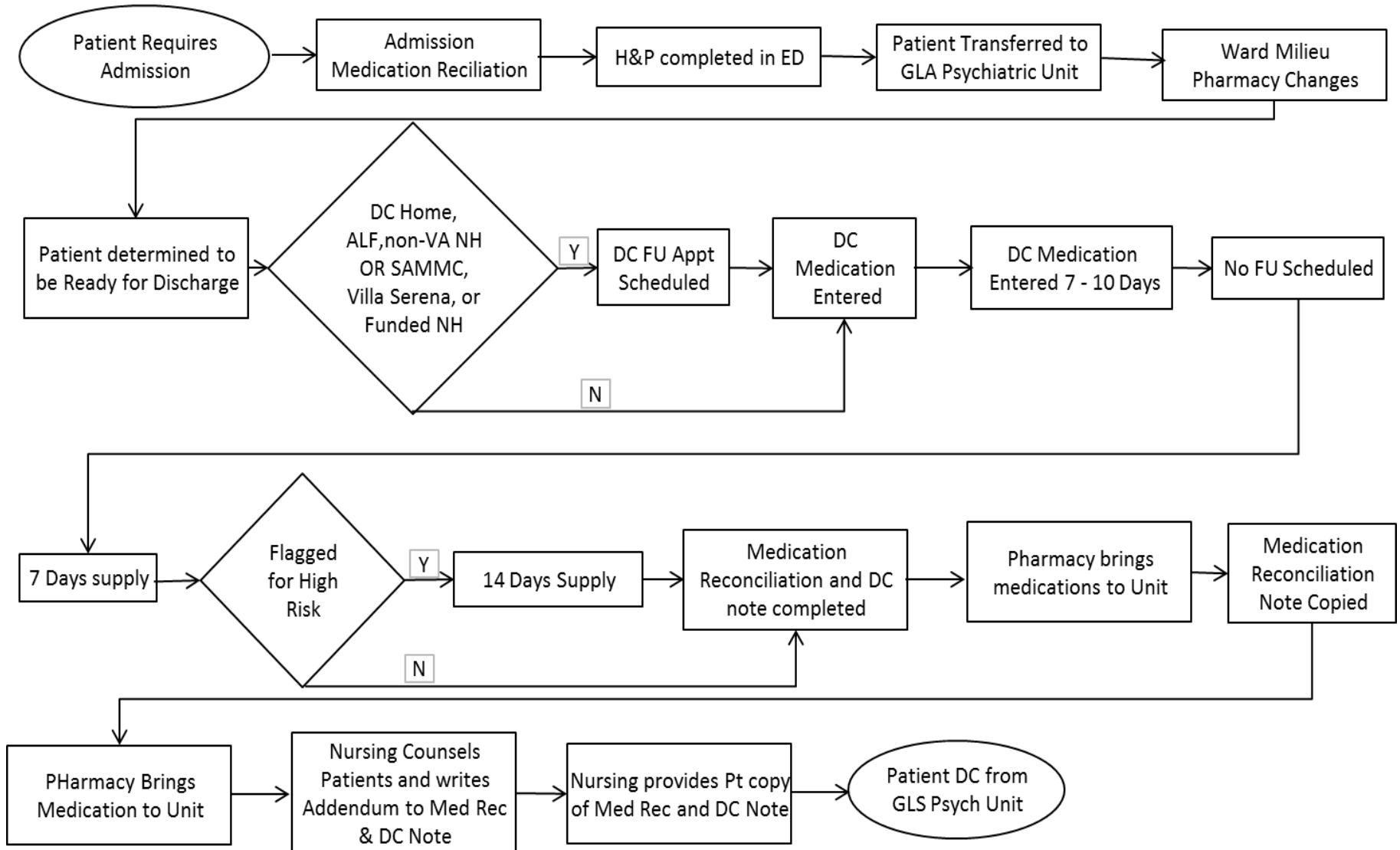
1.Medication Reconciliation from AHRQ Patient Safety Network 2015 **2.** Boswell et al. Ment Health Clin 2015 **3**. VHA Directive 1164, 2015

Preliminary Data Review

40 charts reviewed of patients discharged from GLA PSY in January 2016

15% with medication errors (n=6)

62.5% with documentation errors (n=25)

12.5% with both (n=5)

Flow Chart
VA Medication Reconciliation

```
( Patient Requires    )  →  [ Admission              ]  →  [ H&P completed in ED ]  →  [ Patient Transferred to ]  →  [ Ward Milieu        ]
(  Admission          )     [ Medication Reciliation ]                                 [ GLA Psychiatric Unit   ]     [ Pharmacy Changes   ]
```

```
[ Patient determined to  ]  →  ◇ DC Home,          ◇  — Y →  [ DC FU Appt  ]  →  [ DC         ]  →  [ DC Medication        ]  →  [ No FU Scheduled ]
[ be Ready for Discharge ]     ◇ ALF,non-VA NH     ◇         [ Scheduled   ]     [ Medication ]     [ Entered 7 - 10 Days  ]
                               ◇ OR SAMMC,         ◇                             [ Entered    ]
                               ◇ Villa Serena, or  ◇
                               ◇ Funded NH         ◇  — N →
```

```
[ 7 Days supply ]  →  ◇ Flagged  ◇  — Y →  [ 14 Days Supply ]  →  [ Medication            ]  →  [ Pharmacy brings      ]  →  [ Medication         ]
                      ◇ for High ◇                                [ Reconciliation and DC ]     [ medications to Unit  ]     [ Reconciliation     ]
                      ◇ Risk     ◇  — N →                         [ note completed        ]                                 [ Note Copied        ]
```

```
[ PHarmacy Brings      ]  →  [ Nursing Counsels        ]  →  [ Nursing provides Pt copy ]  →  ( Patient DC from    )
[ Medication to Unit   ]     [ Patients and writes     ]     [ of Med Rec and DC Note   ]     ( GLS Psych Unit     )
                             [ Addendum to Med Rec      ]
                             [ & DC Note                ]
```

Fishbone (Cause-and-Effect) Diagram

Materials

- TIME (TAKES TOO LONG)

Process/Methods

- NO MED REC COMPLETED
- MED NOT PROVIDED
- NEW MED NOT ON MED REC
- NON VA MEDS IGNORED
- NO SOP FOR MED REC

Problem Statement

During (time), Pareto accounted for 50% of problem which was 3X higher than desired and caused customer dissatisfaction.

People

- INCORRECT SIG
- MED NOT DISCONTINUED
- UNCLEAR PLAN
- MED REC NOT COMPLETED
- QUANTITIES
- REFILLS

Machine

- DOCUMENTATION UNCLEAR (TEMPLATE)
- WRONG INDICATION (AUTOPOP)
- NO STOP DATE FOR ANTIBIOTIC
- COPYING AND PASTING
- NO OUTPATIENT ORDERS FOR LAI
- FREE TEXT
- NO INDICATION FOR MEDS
- NON-VA MEDS NOT DATED

Pre-Intervention Data

List of patients admitted to inpatient psychiatry obtained from service line folder
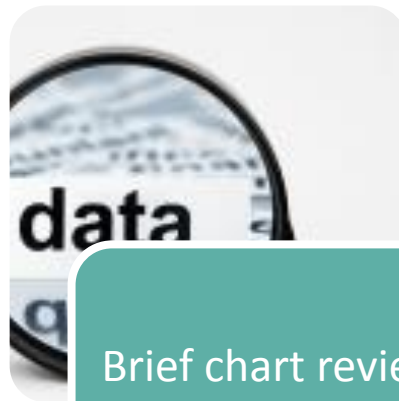
Brief chart review conducted to determine discharge dates

Discharges broken by week and 6 charts randomly selected for intensive review

Process Control Chart

Medicaton Reconciliation
Percent Correct at Time of DC
Sample per Week - p Chart
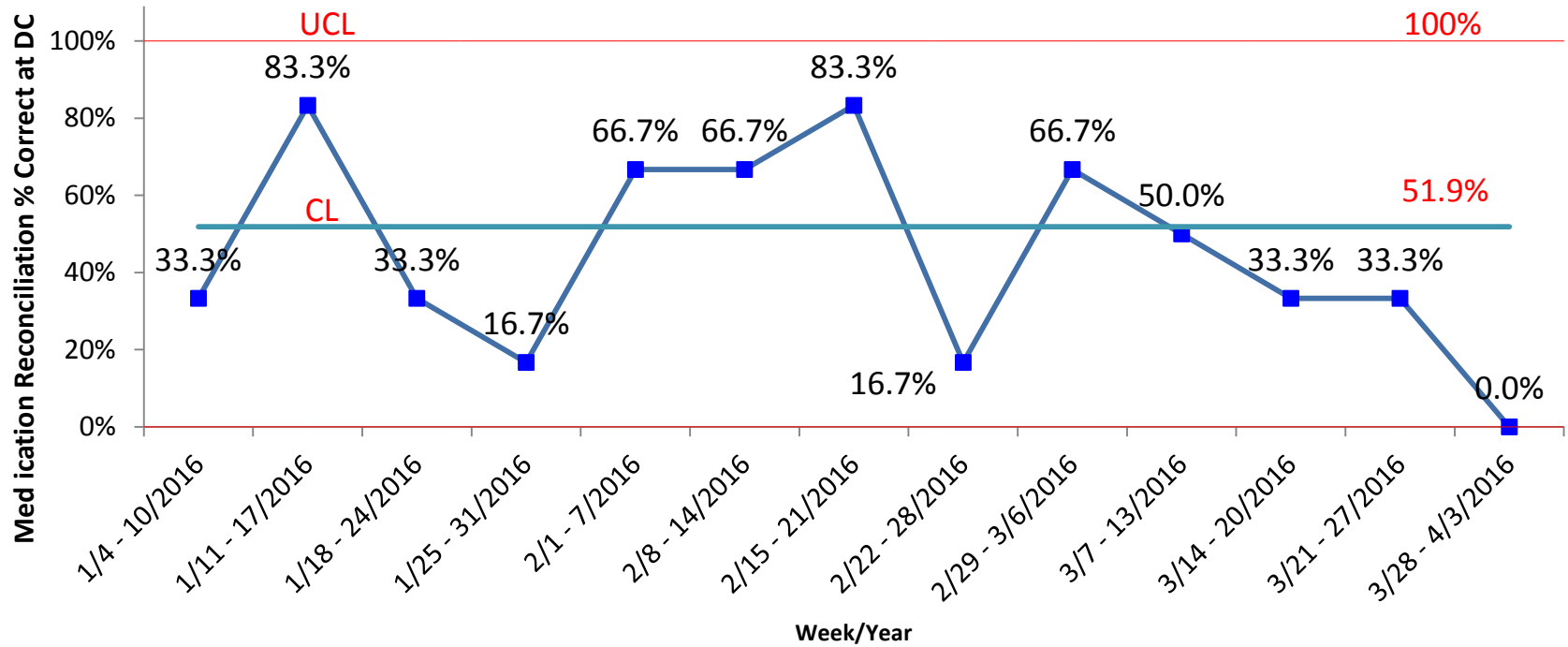
Action Plan

Aim Statement: To increase accuracy of medication reconciliation completed at discharge from inpatient psychiatry (GLA PSY at STVHCS) as documented in the Medication Reconciliation and Discharge Note from 37.5% to 75% by May 15, 2016

Action Strength	Action Driver	Action	Why	Start Date
Strong	Unstandardized process between providers	Develop and establish an SOP for providers	Standardize	April 4, 2016
Intermediate	Unstandardized process between providers	Development of simple checklist to be placed at all computer work stations	Simplify	April 4, 2016

Haugen AS et al. Ann Surg 2014;00:1-8

Intervention

After Input

Beta Test of Checklist

After Input

Revised

Draft of Check List and SOP Written and Sent to All Services

Nursing, Pharmacy, Inpatient Providers, Psychiatry
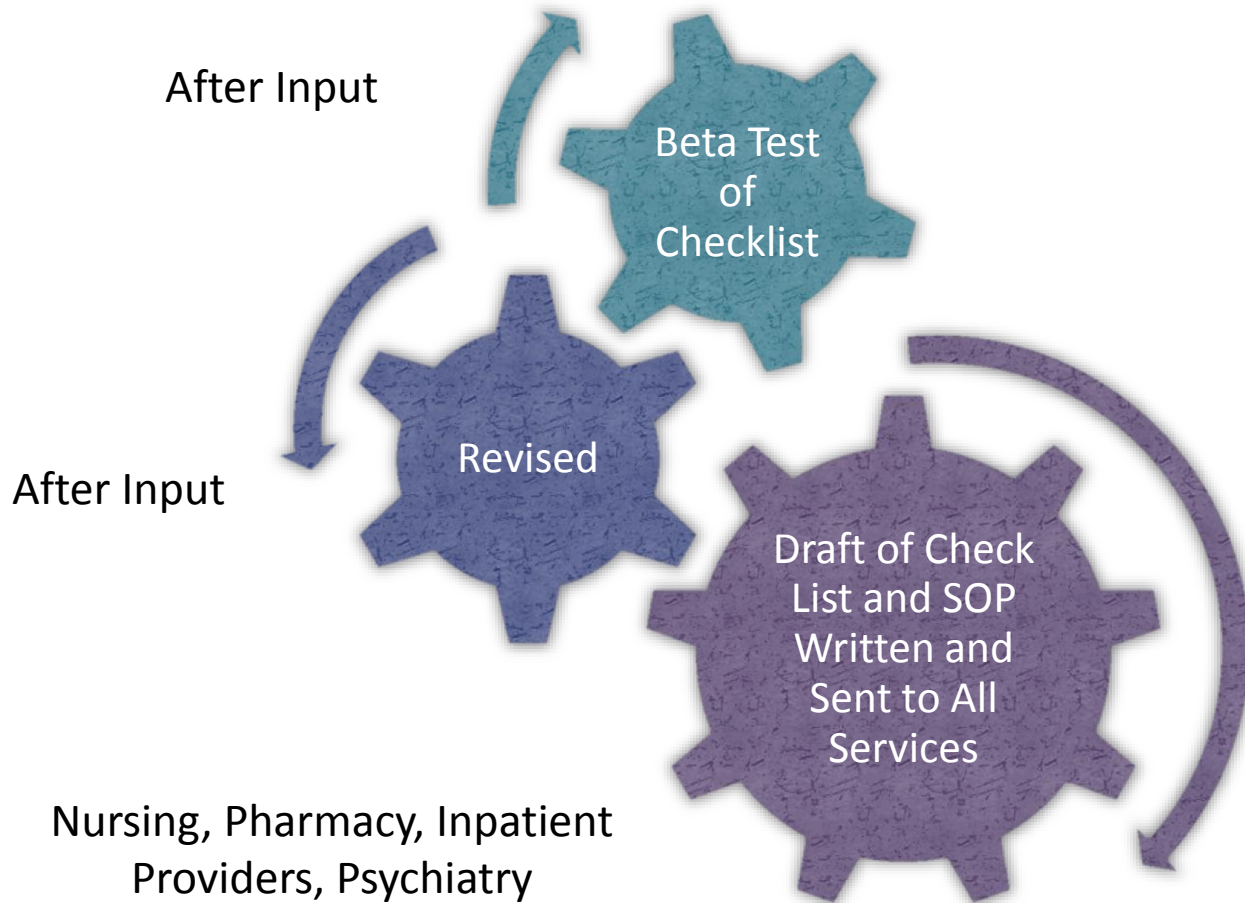
Discharge Checklist

✓	1. ❑	**D/C outpatient medications no longer indicated**
✓	2. ❑	Only **one** medication list per note (*delete any others that may have been copied into the note*)
✓	3. ❑	All medications have **correct** indications (*non-VA and OTC included*)
	4. ❑	No **duplicate** medications are present
✓	5. ❑	All **new** medications are listed (*including primary care medications*)
✓	6. ❑	All **changed** medications are listed
	7. ❑	All **discontinued** medications are listed
✓	8. ❑	Med Rec D/C Summary Note is error-free
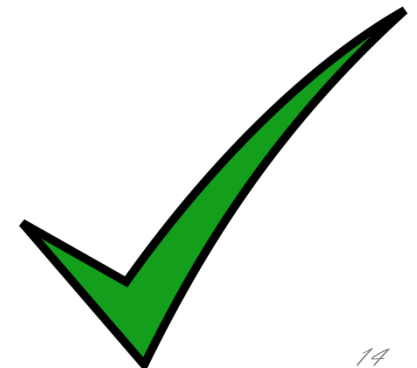
DO: Implementing the Change

April 4, 2016

Checklist Posted

Providers Notified

Questions

Questions

Questions

Use Encouraged
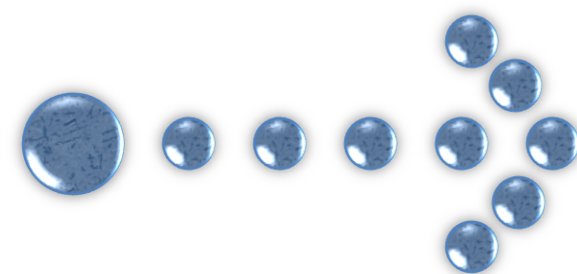
Calendar of Events

April 15, 2016	April 20, 2016	May 15, 2016	May 16 and Beyond
Obtain Feedback On Checklist Use	Attend Inpatient Provider Meeting	Last Day of Data Collection	Gather Final Data
Modify Checklist if Needed	Provide Copies of the SOP	Celebrate!	Complete CS &E Course
Query Use	Highlight Key Points for Discussion		Begin to Work on Other Elements of Discharge Process
Replace Missing Lists	Modify SOP if Needed		
	Initiate Process for Implementation		

Results

**Medication Reconciliation
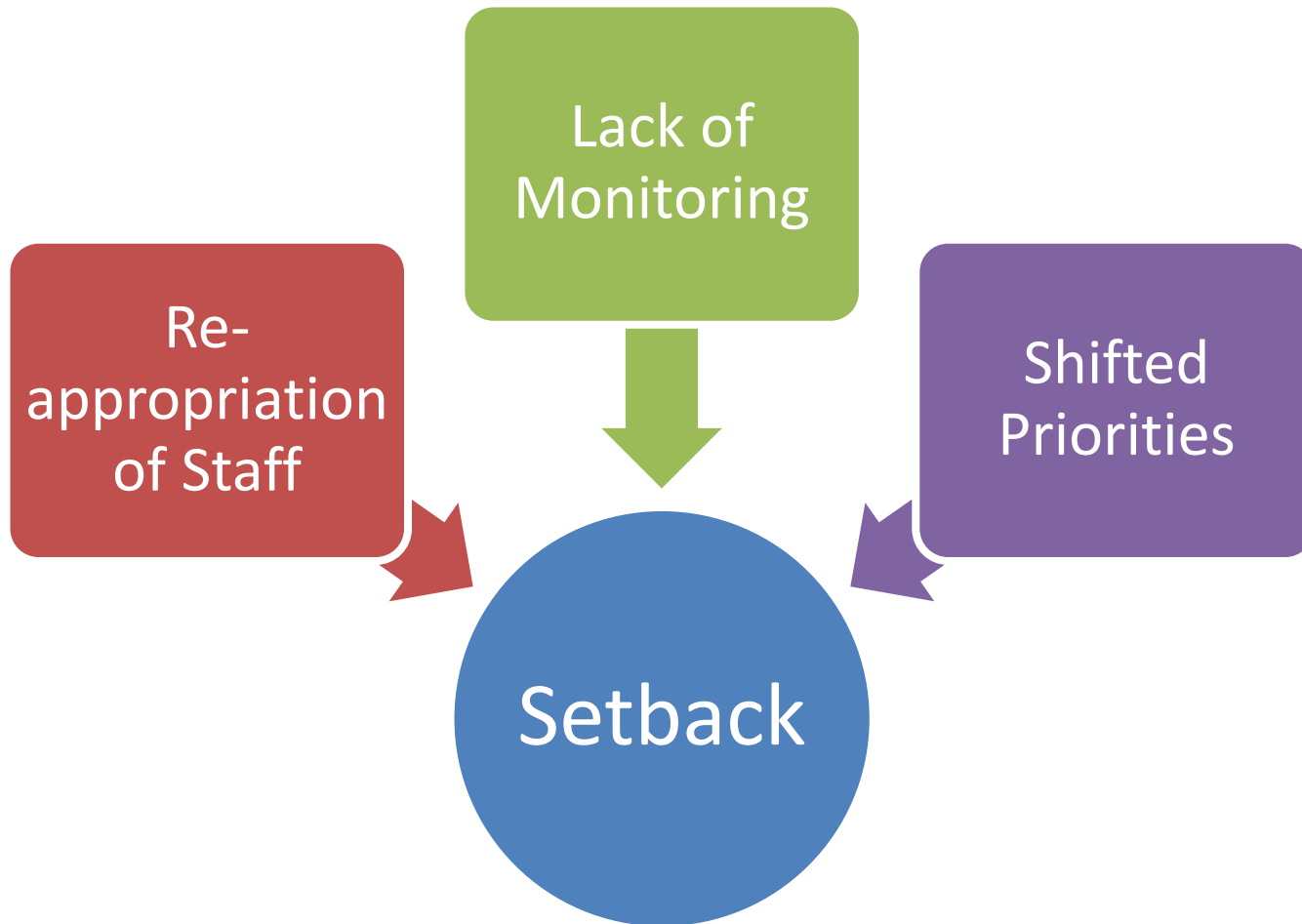Percent Correct at Time of Discharge
Sample per Week - p Chart**

UCL — 100.0%

91.1%

CL

44.9%

33.3%
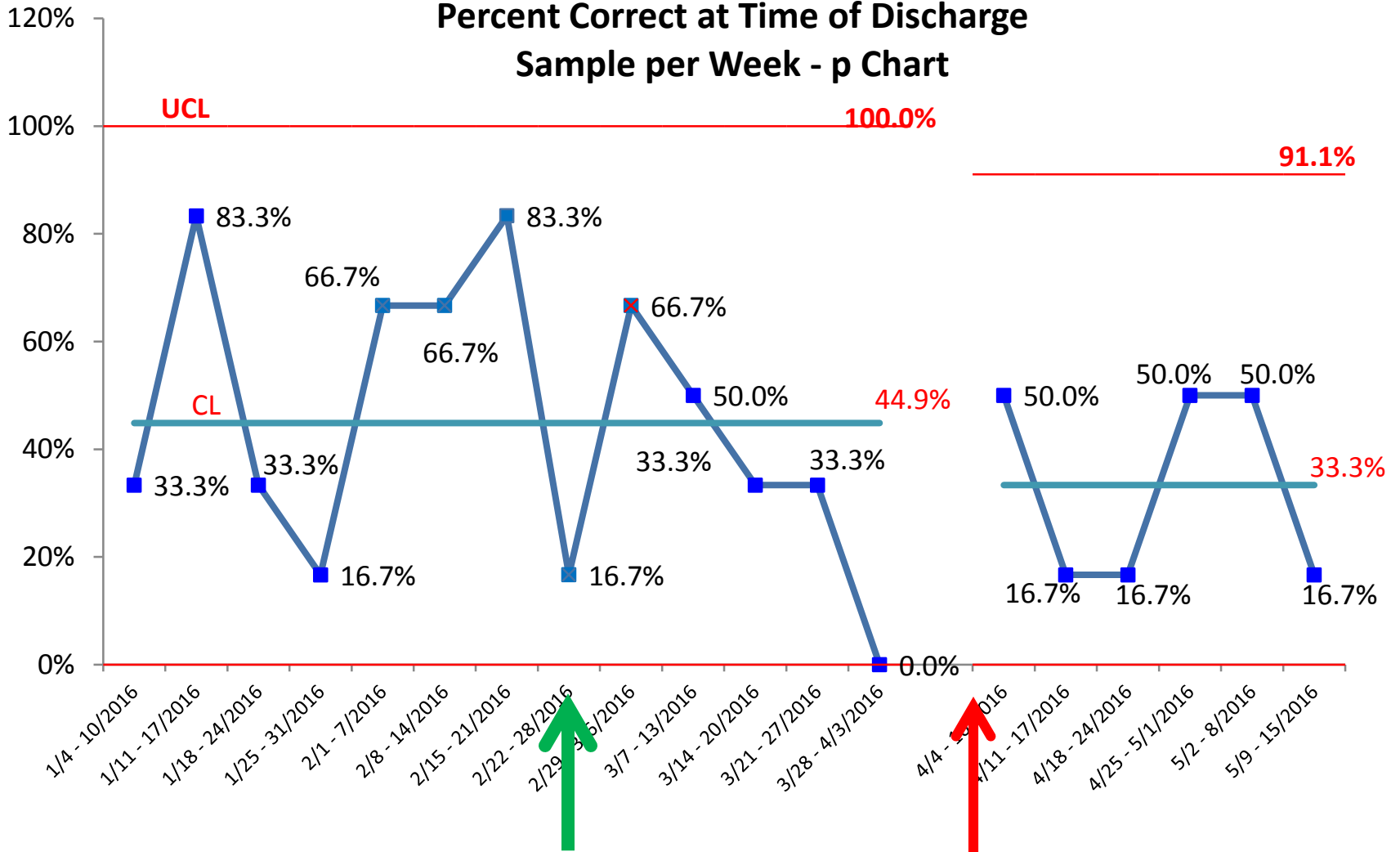
Re-appropriation of Staff

Checklist deployed

17

Results
Central Tendencies

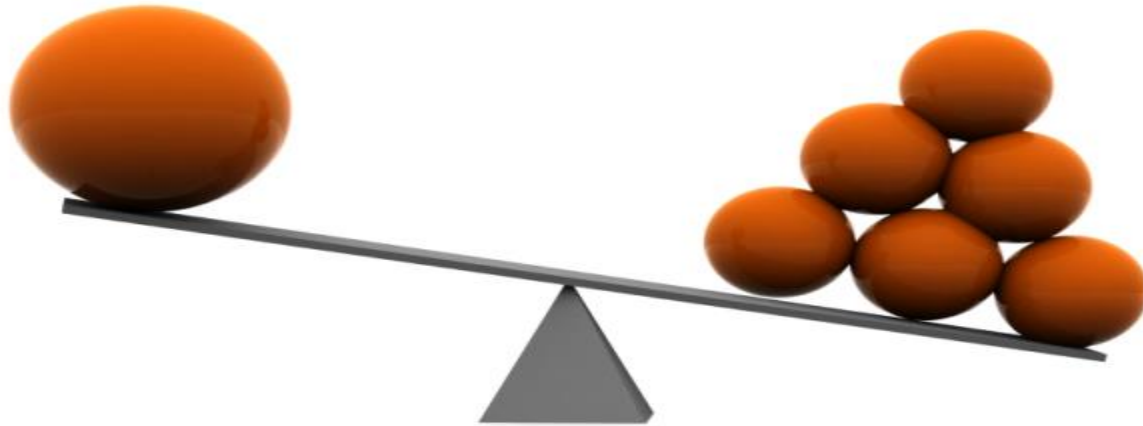|	**Pre-intervention**	**Post-intervention**
Mean	44.87 ± 27.64%	33.33 ± 18.26%
Median	33.33%	33.33%
Mode	33.33%	50.00%

Troubleshooting

ACT: Sustaining the Results

ACT: Sustaining the Results
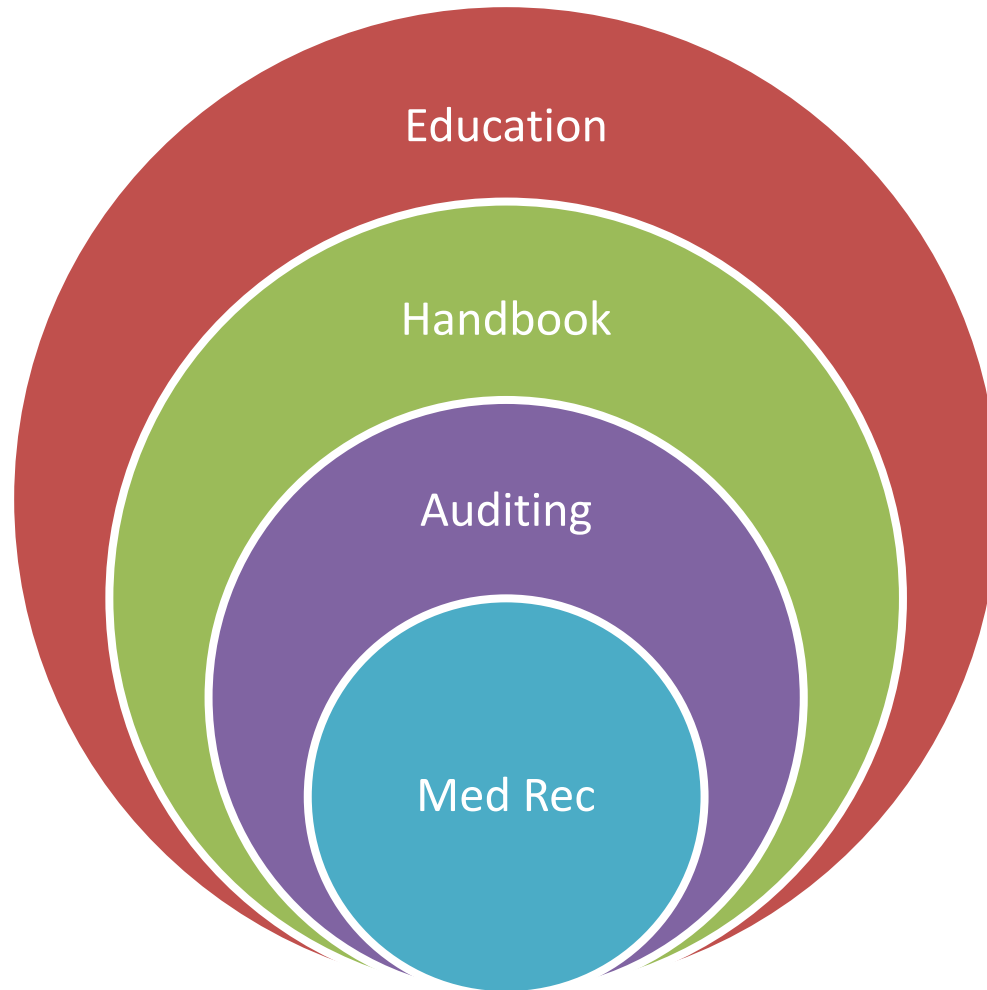
Return on Investment

COSTS
-CPS time

SAVINGS
Through Process Improvement
-medication waste
-provider time
-nursing time
-pharmacist time

Not So Soft Savings

- # Veteran Satisfaction
  - VHA exceeds private hospitals on care transition[1]
  - On par for discharge information and medication communication[1]

- # Provider Satisfaction
  - "When you get in the work environment, it's more and more clear that the team causes the largest change in outcomes for patients"- John Jelovsek, Cleveland Clinic[1]
  - Changing the culture

- # Regulatory Compliance[2]

1. McKinsey & Company, Inc for CMS. Prepared for Dept of VA Sept 1, 2015
2. Rozich JD, Howard RJ, Justeson JM, et al. Patient safety standardization as a mechanism to improve safety in health care. Jt Comm J Qual Saf. 2004;30(1):5–14.

Thank You

VETERANS