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Medicines reconciliation on inpatient drug charts

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Introduction

On admission many medications which patients take at home are intentionally or accidentally omitted from their drug charts.

Previous reports indicate discrepancies of 30-70% between at home medications and admission medications[1].

Aims

In this audit we investigate:

1. How often medications were omitted
2. If reasons were documented for a drugs omission
3. If there was documentation of dates or clinical changes upon which to restart the medications

Hospital guidelines- the standards

Pharmacy led medication history should take place within 24 hours of admission

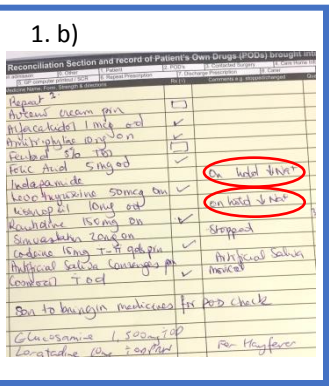
Unintentional discrepancies should be discussed with prescribers and documented in medical records

1. a)

Medicines Reconciliation Section and record of Patient's Own Drugs (PODs) brought into hospital

Figure 1: a) Buckinghamshire Healthcare Trust medicines reconciliation page on paper drug chart. b) Example of pharmacist medication history including reasons for medicine omissions (red circles).

1. b)



Methodology

- Prescription charts reviewed in patients admitted >48 hours

Sample:

- Patients admitted to medical and surgical wards

- Exclusion criteria:
  - Admitted for less than 48 hours
  - No regular medications prior to admission
- 129 patient paper prescription charts were reviewed
- 15 charts were excluded
  - 9 patients- admitted for fewer than 48 hours
  - 6 patients- no prior regular medications

Results

- 114 charts included in analysis
- 33% of patients drug charts were missing some pre-admission medications (37 out of 114)
  - **Unintentional discrepancies:**
    - 26 had no reason documented for the drugs omission
    - 6 had reasons given for only some of the omissions
    - 5 patients had no pharmacy review despite admission for >48 hours
  - **Intentional discrepancies**:
    - 6 had reasons given for all of the omissions

No omitted drugs had suggested restart dates.

2. a)

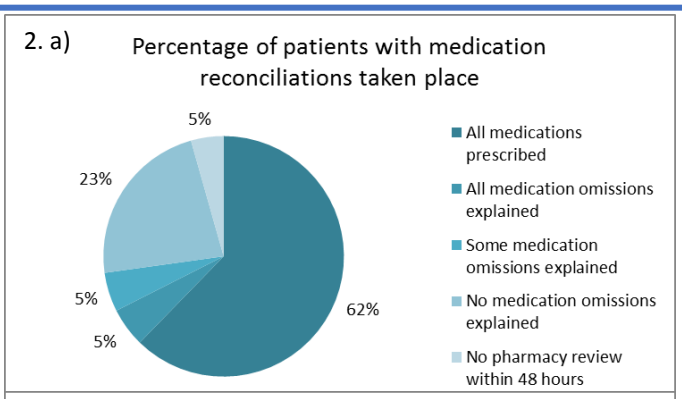


Figure 2a. Pie chart showing percentage of patients with medication omissions and whether reasons were documented.

2. b)

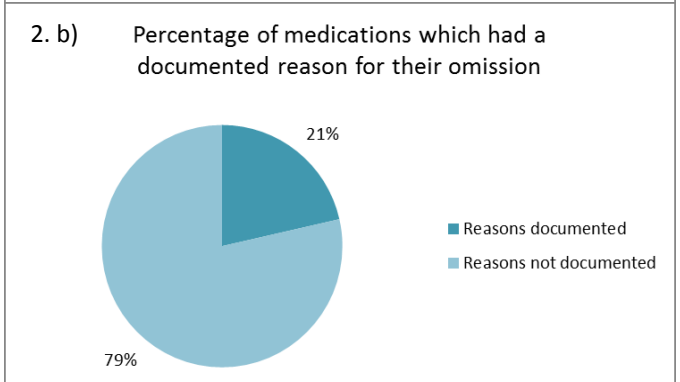


Figure 2b. Pie chart showing percentage of medication omissions which had documented reasons.

Summary

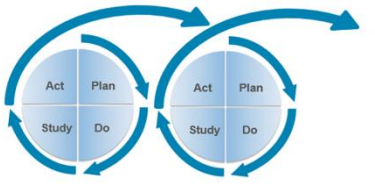
1. 33% of patients had unintentional drug omissions
2. The majority had no documented reasons

Limitations

1. Drugs omitted for clinically important reasons but not documented are recorded as unintentional
2. One off data collection point
3. Patient details not collected so no follow up over days to see how long full reconciliation took

Recommendations- Plan Do Study Act (PDSA) Cycle

- **Induction**
  - Familiarisation with the paper drug chart and medicines history page
  - Summary care record training- increase accuracy of admission medications during clerking
- **Electronic prescribing**
  - Doctors will be automatically alerted once pharmacy reconciliation history has been taken
- **Documentation**
  - Documentation on the drug chart- why medications being withheld and suggest dates or clinical outcomes at which to restart
- **PMS list of recently admitted patients**
  - Aid pharmacists over weekends/ bank holidays to prioritise recently admitted patients



- **Re-audit- PDSA cycle 2**
  - Two re-audit time points
    - After induction changes late 2019
    - After e-prescribing implementation in 2020

References:

1. A systematic review of the effectiveness and cost-effectiveness of interventions aimed at preventing medication error (medicines reconciliation) at hospital admission. The University of Sheffield, School of Health and Related Research (ScHARR)

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