Medication Accuracy at Transitions in Care
Let’s start!

Erica Van der Schrieck-De Loos MSc, Project leader WHO H5s NL
CBO Dutch Institute for Healthcare Improvement

EU Union Network PaSQ
Med Rec conference, Zagreb, Croatia, 2 December 2013
National guideline in daily practice

Van der Schrieck-De Loos et al., 2010-2013
Quality of daily practice

CBO 2012
1. System level
2. Macro level
3. Meso level
4. Micro level

(Inter)national solution
Medication Accuracy at Care Transitions
1. System level

1. Dutch Inspectorate of Health

Safety measures, November 2012
1. System level

“Commitment on this topic is definitely worth it. Due to the necessary deployment of extra staff hospitals appear quite often to actually carry out medication reconciliation. However, investment on this staff pays for itself quickly.
“Commitment on this topic is **definitely worth it.** Due to the necessary deployment of extra staff hospitals appear quite often to actually carry out medication reconciliation. However, **investment on this staff pays for itself quickly.**

[IGZ 2012: De Veiligheid telt : p.27, 28]
“Medication wrongly given or not given while necessary, therefore, leads to the patient and thereby to the hospital to undesirable situations and thereby to greater costs.”
“Medication wrongly given or not given while necessary, therefore, leads to the patient and thereby to the hospital to undesirable situations and thereby to greater costs.”
1. System level

2. Patient Safety agreement MoH

22 May 2013


Prof. dr. Cordula Wagner, NIVEL, June 2013

http://nos.nl/l/516304
1. System level

Global WHO High 5s network

- Australian Commission on Safety and Quality in Healthcare
- NL - CBO Dutch Institute for Healthcare Improvement
- Trinidad & Tobago Ministry of Health
- USA Agency for Healthcare Research & Quality
- WHO Collaborating Centre for Patient Safety: The Joint Commission
- French Haute Autorité de Santé
- German Agency for Quality in Medicine/ German Coalition for Patient Safety
- Singapore Ministry of Health
1. System level

Clinician    Ward    Hospital    Globally
Healthcare is a decade or more behind many other high-risk industries in its attention to ensuring basic safety.
1. System level
2. Macro level
3. Meso level
4. Micro level

(Inter)national solution
Medication Accuracy at Care Transitions
2. Macro level
2. Macro level

Miscommunication about medications
Evaluation of target population
BPMH & inaccuracies $\leq 24$ hours
2. Macro level

1. Failures home medications
2. Incorrect doses/dosage forms
3. Missed/duplicated doses
2. Macro level

4. Home medication after discharge

5. Duplicate therapy at discharge (hospital substitutions)
2. Macro level

Incomplete or miscommunicated information at points of transition in the patient care process

Admission
Transfer
Discharge
Nothing is particularly hard if you divide it into small jobs

Henry Ford
3. Macro level

When you are in deep shit, say nothing, and try to look like you know what you're doing.
3. Macro level
(Inter)national solution
Medication Accuracy at Care Transitions

1. System level
2. Macro level
3. Meso level
4. Micro level
3. Meso level

Early adopters

Innovators

Rogers: 1995
3. Meso level
3. Meso level

Cross links

National platform

National evaluation
3. Meso level

1. Goal

2. Measures

3. Implementation of interventions
3. Meso level
Data in itself is not enough for improvement

Massoud ISQua, Hong Kong, China 2011
3. Meso level

Small changes = sustainable
3. Meso level

1-3 physicians are overconfident about the quality of care they provide
3. Meso level

Low hanging sweets
1. System level
2. Macro level
3. Meso level
4. Micro level
4. Micro level

1. Best Possible Medication History < 24 hours

WHO H5s SOP 2009
4. Micro level

An up-to-date and accurate patient medication list is essential to ensure safe prescribing in any setting.
4. Micro level

1. Obtaining a complete and accurate list of each patient’s current home medications: including name, dosage, frequency and route.
2. Identify & Resolve Inaccuracies < 24 hours

4. Micro level

Compare BPMH vs Admission Medication Orders
4. Micro level

2. Using that list when writing admission, transfer and/or discharge medication orders, and
3. Comparing the list against the patient’s admission, transfer, and discharge orders. Identifying and bringing any discrepancies to the attention of the prescriber and, if appropriate, making changes to the orders. Any resulting changes in orders are documented.
4. Micro level

3. Comparing the list against the patient’s admission, transfer, and discharge orders.

Identifying and bringing any discrepancies to the attention of the prescriber and, if appropriate, making changes to the orders.

Any resulting changes in orders are documented.
4. Micro level

One of the most common leadership mistakes is expecting technical solutions to solve adaptive problems...

Ron Heifetz “Leadership without easy answers”
Van der Schrieck-de Loos, EM et al. 2009. The role of the client in patient safety, a necessity, not a desirability. CBO: UtrechtZonMw research report. Copy via E: e.vanderschrieck@cbo.nl
Levelofhealth.com
4. Micro level
Hospitals ‘require’ the med rec SOP
Pharmacist-based med rec reduces medication discrepancies in acute hospital admissions of elderly patients

≥ 75% reduction < 1-5 months

40% - 90% ≤ 24 hours
SOP or not to SOP
Medication Accuracy at Transitions in Care
Let’s start!

Annemieke van Groenestijn, Advisor WHO H5s NL
Erica Van der Schrieck-De Loos MSc, Project leader WHO H5s NL
E: e.vanderschrieck@cbo.nl
W: who.int/patientsafety/implementingchange/high5s
CBO Dutch Institute for Healthcare Improvement
EU Union Network PaSQ
Med Rec conference, Zagreb, Croatia, 2 December 2013
Filmpje
3. SOP strategy

Proactive Med Rec model

**STEP 1**
BPMH

**STEP 2**
Admission Medication Orders (AMO)

**STEP 3**
Verify every medication in BPMH has been assessed by prescriber.
3. SOP strategy

Retroactive Med Rec model

**STEP 1**
Primary Medication History

**STEP 2**
Admission Medication Orders (AMO)

**STEP 3**
BPMH

**STEP 4**
Compare BPMH with AMOs and resolve any discrepancies