Medicines reconciliation audit in primary care

Helen Marlow and the Medicines Management Team, Surrey Downs Clinical Commissioning Group (email: h.marlow@nhs.net)

Introduction

In primary care, medicines reconciliation should be carried out for all people who have been discharged from hospital or another care setting. This is an important element of medicines optimisation.

Our work aimed to audit the medicines reconciliation process in GP practice and make improvements to the safety and quality of the process.

Included in our good practice repeat prescribing standards:

The practice repeat prescribing policy describes how, following receipt of hospital out-patient and discharge letters:

- medication records are updated
- changes to medication are clearly documented
- changes are communicated to the patient/carer

The GP should review medication changes following any outpatient, or in-patient hospital stay within two weeks of discharge/out-patient visit, and update the patients medication record.

What did we do?

Our Prescribing incentive scheme required practices to evidence a robust process for medicines reconciliation for patients discharged from hospital.

To demonstrate a robust process, practices undertook a baseline audit, with recommendations for improvement of patients:

- Discharged following an acute medical admission
- Are >75 years of age who have been discharged from an inpatient stay from anywhere

We adapted the Health Improvement Scotland (HIS) medicines reconciliation care bundle into an audit. The HIS medicines reconciliation computer template was adapted (for EMIS web, SystmOne and Vision) and used by most practices to improve their medicines reconciliation process and assist data collection for the audit.

What did we find?

- 100% (n=33) of GP practices participated in the audit of 478 patients.
- 30% of discharge letters were received in the practice 5 days or more after the patient was discharged.

<table>
<thead>
<tr>
<th>Audit question</th>
<th>Yes</th>
<th>No</th>
<th>DNA / Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the discharge letter work flowed on day of receipt?</td>
<td>378 (79%)</td>
<td>73 (15%)</td>
<td>27 (6%)</td>
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<tr>
<td>Did medicines reconciliation occur within 2 weeks of the date of discharge?</td>
<td>398 (83%)</td>
<td>80 (17%)</td>
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<tr>
<td>Was the medicines reconciliation performed by a clinical member of staff?</td>
<td>435 (91%)</td>
<td>37 (8%)</td>
<td>6 (1%)</td>
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<tr>
<td>Has the read code for medicines reconciliation (8B318) been used?</td>
<td>352 (73%)</td>
<td>126 (27%)</td>
<td></td>
</tr>
<tr>
<td>Is it documented in the notes that any changes to the medication have been acted upon?</td>
<td>341 (71%)</td>
<td>68 (14.5%)</td>
<td>69 (14.5%)</td>
</tr>
<tr>
<td>Is it documented that any changes to the medications have been discussed with the patient/carer where appropriate and within 2 weeks of discharge?</td>
<td>199 (42%)</td>
<td>200 (42%)</td>
<td>79 (16%)</td>
</tr>
<tr>
<td>Has the read code for post hospital discharge medication discussed with patient (8B350) been used?</td>
<td>122 (25.5%)</td>
<td>356 (74.5%)</td>
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</tbody>
</table>

Comments and Next steps

- Using the computer template enabled changes in medication to appear in the consultation notes resulting in improved communication with other prescribers in the practice.
- Practices agreed actions to improve their medicines reconciliation process and made suggestions for refining the template. Both will be reviewed during the 2015/16 re-audit.