Sikker Psykiatri

Landssjúkrahúsið

Safe Psychiatry - Faroe Islands

Prevention of medication errors and inappropriate medicine among mental health patients

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BACKGROUND

We know that people with severe mental disorders on average tend to die earlier than the general population. There is a 10-25 year life expectancy reduction in patients with severe mental disorders. The Danish Society for Patient Safety *(Dansk Selskab for Patientsikkerhed-DSFP)* is co-ordinating a four year national collaborative QI program (April '14 – Dec '17) which aims to achieve substantial and lasting improvements in the following factors contributing to premature death for people using inpatient psychiatric services:

1. Medicine management
2. Timely and efficient diagnosis and treatment of co-morbid physical disease
3. Reduction in the use of physical restraint
4. Suicide prevention.

The Psychiatric Centre at the National Hospital of the Faroe Islands is one of eight sites participating in the program.

FOCUS – MEDICINE MANAGEMENT

The focus for this poster is on Medicine Management, specifically ensuring medicine reconciliation is undertaken safely, reliably and to a high quality preventing medication errors and injudicious medical treatment.

NATIONAL CONTEXT

Several Danish studies have consistently shown that inconsistencies in information about patients' medication during transitions and errors in medication orders frequently occur. Annual reports from the Danish Patient Safety Database indicate that medication errors are one of the most commonly reported unintended events constituting 24% of hospital incidents. *sikkerpsykiatri.dk*

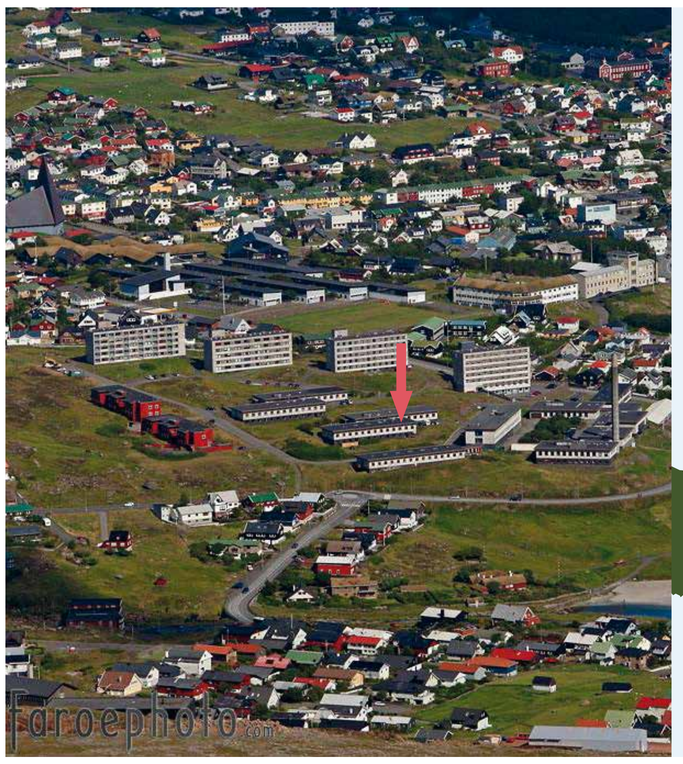
TÓRSHAVN PSYCHIATRIC HOSPITAL

When we implemented a new electronic patient record system, which includes a common medication module for all GPs, hospitals and pharmacy services across the islands, we assummed medication errors would be eliminated; we were wrong. As such, we had to develop other steps within the medicine reconciliation and medicine review processes, in order to reduce medication errors and inappropriate medical treatment.

Data from 2014 – 15 indicate medicine reconciliation is undertaken within 24hrs of admission for <85% of patients admitted to our ward.

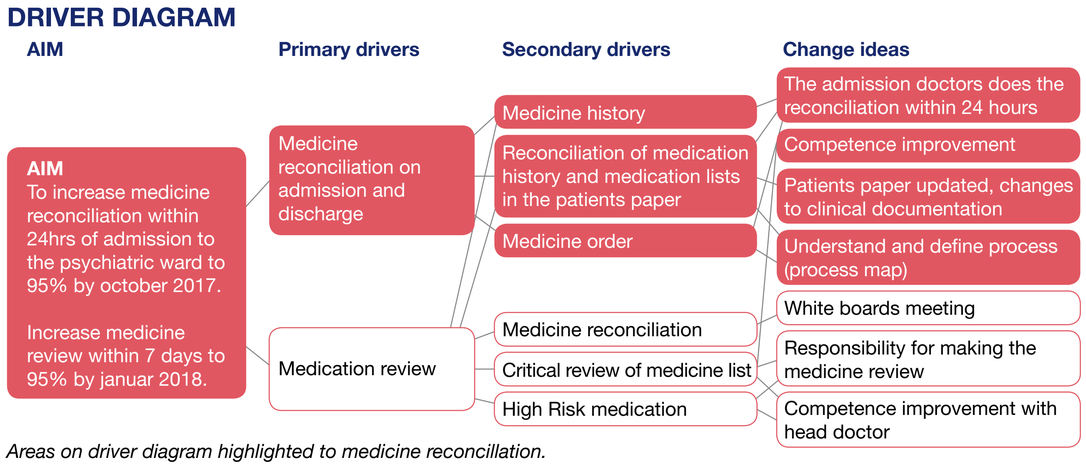
METHOD

A multi-professional team has been established including carers and management. The team also collaborates with users and carers from the patient organization "Sinnisbati". The project uses the Model for Improvement (MFI) and collaborates closely with DSFP to ensure methodological rigor.



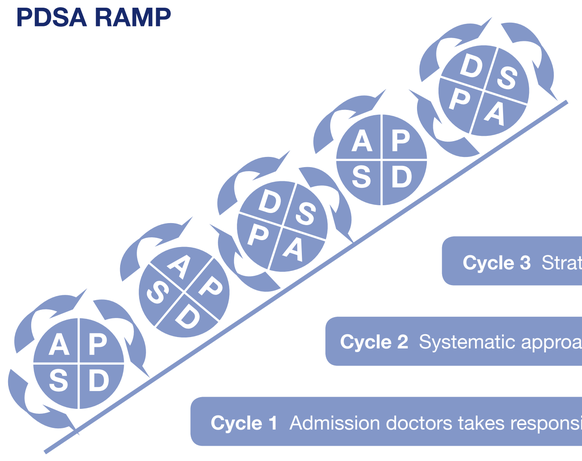
Tórshavn

DRIVER DIAGRAM



Areas on driver diagram highlighted to medicine reconcillation.

PDSA RAMP



Cycle 4 Undertake process map analysis of whole admission process to understand better the factors contributing to instability in the processes.

Cycle 3 Stratification of data based on admission and discharge.

Cycle 2 Systematic approach to record medicine reconciliation in patients paper file.

Cycle 1 Admission doctors takes responsibility for the whole reconciliation process.

DATA

Data is collected once a week. The QI project leader and other staff manually checks electronic patient records to identify if each element of the reconciliation process has been completed by the designated clinician. Due to low admission rates (average 5 per week), monthly data are presented in control charts.

MEASURES

Outcome: 95% of admitted patients have a completed medicine reconciliation within 24 hours.
Process: 95% of patients have their medicine history completed within 2 hours of admission. 95% of medications are prescibed within 24hrs of admission. 95 % of medicines reconciliation forms completed and uploaded on patient´s file with 48hrs of admission.
Balancing: Feedback from patients about medicine reconciliation (along with all aspects of care) is collected via a weekly patient café.

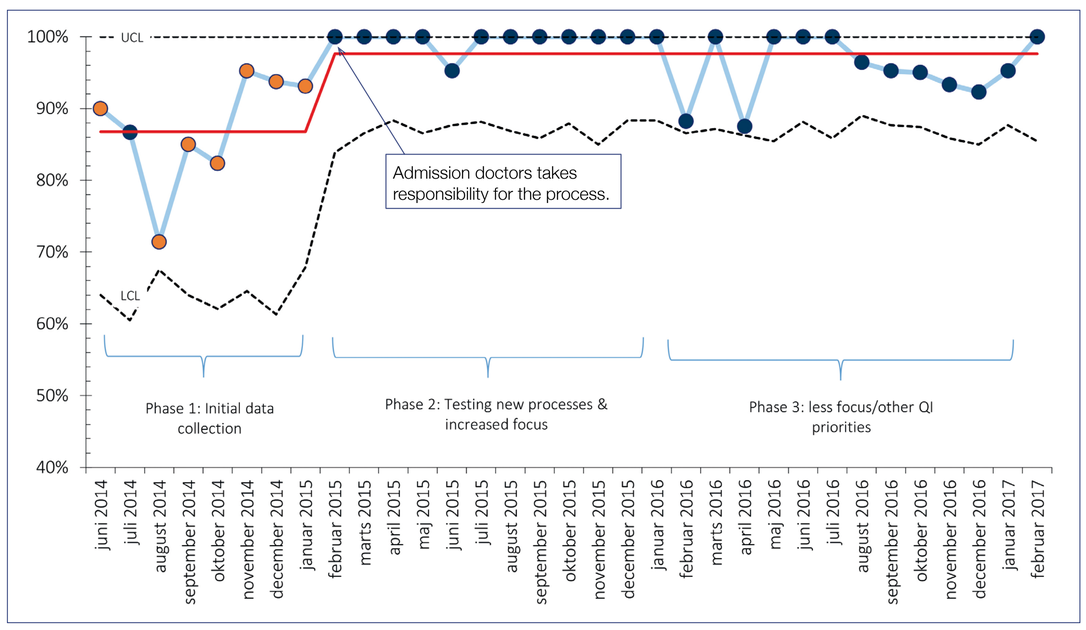
RESULTS

Admission data collected over the 33 month period (June 2014 to February 2017) indicate a stable process, typically between 11 and 29 patients admitted per month. Process data are presented as the outcome data reflect changes in the processes. Also, the process data are more useful for learning and providing insight into factors that have led to the changes in the outcome data. Data regarding factors relating to both process measures show a shift in early 2015 (after 8 months of data collection). Afterwhich, the data appear relatively stable.

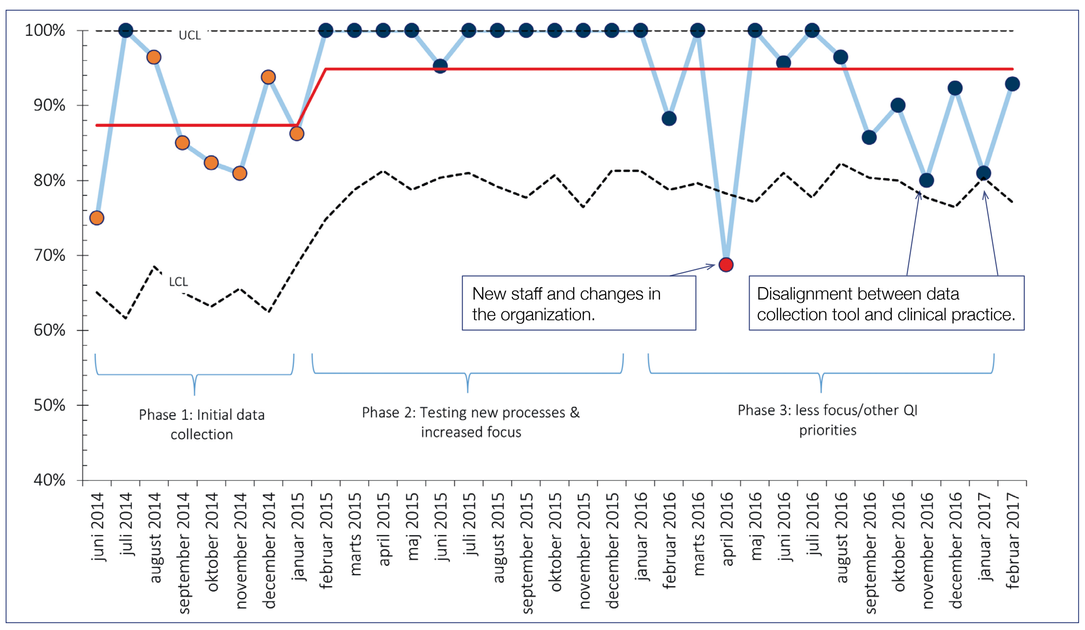
However, we propose that there have been three phases:

1. (June 14 to Jan 15) Start of data collection and increase in team understanding of the process
2. (Feb 15 to Jan 16) Resources and attention focused on ensuring reliable medication history and prescription orders completed
3. (Feb 16 to current) Staff team engaged in multiple improvement projects (improving physical health assessment, reduction of restraint and reduction of suicides) and a number of changes in ward staff.

% patients with medicine history completed <2hrs of admission



% patients with medication prescribed <24hrs of admission



CASES

What doctors say about medicine reconciliation:

"It is a important task and the beginning of medicine review, which can result in reduction of interactions and negative sideeffect of medicine, and so it can help the patient to a better quality of life and to better compliance around the medication." ***Doctor***

"Very often, the medication is a mess, when people get admitted to the hospital, which is what makes the medicine reconciliation so very important." ***Doctor***

What patients say about medicine on admittion:

"At first, I was suprised. But then I thougt, "Gee, I thought they kept these things in order." But I actually think it is fine and reassuring that they do this in order to keep things in order." ***Patient***

"It was actually kind of stressfull, because I had only brought my medication for my mental state and not my physical state. They didn´t order painkillers, even though I told them, that I usually had to take painkillers becuse of my back. I got stressed, because I didn´t remember the name and amount of all the medicine, that I take." ***Patient***

CHALLENGES

- Keeping staff focused and motivated whilst running multiple QI projects
- Keeping QI work on track with a changing staff team
- Making improvement work 'business as usual' and not a 'time-limited project'.

LESSONS LEARNED

- The importance of continuing data collection over a prolonged period of time to provide confidence that processes are fully imbedded
- New electronic systems, e.g. single electronic patient record do not necessarily provide the solution to all problems
- Check the processes of data collection reflect 'real world' clinical processes
- QI requires dedication from the team and leaders
- It is important that the organization continues to build the improvement capability
- Organizational prioritization of QI and leadership endorsement
- Share the data with colleagues to ensure a mutual understanding of the QI work.

NEXT STEP

- Ensure systematic patient feedback is collected and used to improve the quality and safety of our service
- Ensure measurement reflects clinical processes
- Review process map against clinical reality
- Increase the level of patient and carer involvement in the improvement work.

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