Improving Continuity of Medication Management at the Residential Aged Care Facility (RACF) and Hospital Interface

Organisation Name: Metro South Hospital & Health Service
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A district-wide gap analysis raised patient safety risks with the current process of discharging patients to RACFs from hospital. A MSH Medication Discharge Procedure for RACF Patients has been written to address these concerns. Prior to the procedure current practice was for the hospital pharmacist to send the patient with an IMAR, a 5 day signing sheet, on discharge. The procedure sees the implementation of a standardised IMAR process, the Emergency Discharge Medication Administration Record (EDMAR) form, a 5 day signing sheet that the emergency doctors can complete when the pharmacist is unavailable, and the Medication Administration Clinical Handover form to better improve continuity of medication management. The procedure has been released and a sustainable education roll out using an e-learning module has occurred across MSH and at the RACFs.

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Health Service: Metro South Hospital and Health Services
Metro South Health (MSH) Interim Medication Administration Record (IMAR) Gap Analysis

Difficulties

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Percentage of RACF residents receiving an IMAR, by facility (01/03/2014 to 31/12/2014)</th>
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<tbody>
<tr>
<td>RACF patients being discharged without an IMAR</td>
<td>Site 1: 80% Site 2: 50% Site 3: 30% Site 4: 70%</td>
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<tr>
<td>Lack of medication administration handover</td>
<td>Site 1: N/A Site 2: N/A Site 3: N/A Site 4: N/A</td>
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<td>Inconsistencies with IMAR processes across MSH</td>
<td>Site 1: N/A Site 2: N/A Site 3: N/A Site 4: N/A</td>
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<td>Poor communication by the treating team of last minute medication changes to the discharge plan</td>
<td>Site 1: N/A Site 2: N/A Site 3: N/A Site 4: N/A</td>
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<tr>
<td>No documentation of medication and IMAR supply</td>
<td>Site 1: N/A Site 2: N/A Site 3: N/A Site 4: N/A</td>
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<td>Significant knowledge gaps • 28% of survey respondents were unaware of the IMAR</td>
<td>Site 1: N/A Site 2: N/A Site 3: N/A Site 4: N/A</td>
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Recommendation: MSH Medication Discharge Procedure for RACF Patients

Aims to:

- Improve RACF patient safety
- Facilitate continuity of medication management
- Formalise and standardise processes across MSH
- Address concerns raised in the MSH IMAR Gap Analysis
- Meet *National Safety and Quality Health Service Standards*
  - Standard 2: Partnering with consumers
  - Standard 4: Medication safety
  - Standard 6: Clinical handover
BACKGROUND: Interim Medication Administration Record (IMAR)

- A complete, up-to-date, reconciled list of discharge medications for RACF residents

- Generated by hospital pharmacist’s using eLMS

- Formatted for RACF staff to use as a record of administration

- Valid for up to 5 days post-discharge

- Replaces RACF long-term medication chart (until GP review in 5 days)
NEW - Emergency Discharge Medication Administration Record (EDMAR)

• Generated by the Medical Officers in Emergency when a pharmacist is unavailable

• Formatted for RACF staff to use as a record of administration

• Valid for up to 5 days post-discharge

• To be used in addition to the RACF long-term medication chart (until GP review)
NEW - Medication Administration Clinical Handover Form

• Generated by the **patient’s primary care nurse** at the last point of contact prior to discharge to a RACF

• **Clinical Handover** is to include documentation on:
  – Whether the patient’s regular medications have been administered prior to discharge
  – Any ‘STAT’ or ‘PRN’ medication given within a minimum of 6 hours prior to discharge
  – Contact details
MSH Medication Discharge Procedure for RACF Patients – INPATIENT DISCHARGE PROCESS

CONFIRM PATIENT IS ELIGIBLE FOR THE IMAR PROCESS (refer to RACF contact list)

ON DETERMINATION OF DATE OF DISCHARGE - refer to Part A (step 1):
- Complete a discharge prescription / NIMC

Refer to pharmacist

Refer to Part B (steps 1 to 6):
- Reconciliation of discharge prescription / NIMC
- Initial communication with RACF and community pharmacy to establish requirements
- Arrange appropriate medication supply
- Produce DMR and IMAR
- When IMAR authorised notify the relevant medical team
- Consider RMMR referral
- IMAR, DMR, discharge medications, IMAR FAQ and photocopy of prescription (where applicable) placed in discharge bag and handed to clinical nurse responsible for patient

Refer to Part A (step 6):
- Import medication list into Enterprise Discharge Summary and review - if any changes made notify pharmacist to modify IMAR

Refer to Part C (step 2):
- Document when medications last administered as part of nursing discharge summary (if not available complete the medication administration clinical handover form)
- Ensure patient has all relevant items in discharge bag for hand-over to QAS
MSH Medication Discharge Procedure for RACF Patients – EMERGENCY DEPARTMENT DISCHARGE PROCESS

CONFIRM PATIENT IS DISCHARGING TO AN ELIGIBLE RACF (refer to #contact list)

PHARMACIST AVAILABLE (i.e. on duty and available for this task)

ARE THE FOLLOWING CRITERIA MET?
- Medication changes are simple additions or cessations
- Able to be charted on a single EDMAR form
- Do not involve high risk medications
AND
- Medication supply can be sourced

EMERGENCY DEPARTMENT PATIENTS:
- Medical, nursing and pharmacist responsibility
- Pharmacist responsibility
- Medical responsibility
- Nursing responsibility

Yes - refer to pharmacist for IMAR production: see flow-chart for inpatients

Refer to Part A (steps 2 - 6):
- Ring RACF to confirm current medications and determine requirement for medication supply
- Complete EDMAR
- Photocopy EDMAR for chart copy
- Arrange appropriate medication supply (script if pharmacy available or take-home pack if after-hours)
- Complete ED discharge letter

Refer to Part C (step 2):
- Document when medications last administered on Medication Administration Clinical Handover form
- Ensure patient has all relevant items in discharge bag for hand-over to QAS

If clinical need for medications then admit patient to SSW or appropriate inpatient unit pending pharmacist review
Lessons Learnt

• RACF patients are vulnerable, especially during transitions of care
• There can be unexpected patient safety risks with current processes, showing the benefit of regular review
• Sustainable education strategies are necessary to ensure longevity

Recommendations:
• Have a discussion about your current practices surrounding the discharge of patients to RACFs
• Utilise any of the solutions presented to assist in addressing any service gaps to improve patient safety
Contact Information

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