Addressing West Georgia Health's Med Rec

An SBTI Case Study

Recently, West Georgia Health (WGH) had patient family feedback where they were unable to integrate patient medication into their system, which ultimately could cause harm to the patient. In fact, this specific example has history going back more than two years with inaccuracies in this patient's last four visits. This highlights that the medication reconciliation process has systemic issues that need addressed. An accurate list is required in order to assure safe and quality care for patients. This integration of patient medication in the health system will also benefit both the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements and WGH's new patient portal functionality.

Background

Traditionally Medication Reconciliation (Med Rec) was performed on all patients that were admitted to the hospital. Approximately three years ago verbiage came from the joint commission indicating that WGH needed to begin expanding Med Rec to all patients that enter the Emergency Department (ED). Based on the increased workload, Nurses began performing Med Rec based on their assessed need. The policy was ED Nursing staff must make a "good faith" effort to obtain a list of current home meds for ALL patients entering the ED. This led to inconsistencies in the Med Rec process as

patients presenting with similar systems may not have had similar Med Rec. The joint commission then backed off on this requirement that also led to inconsistencies. However, the main driver of this inconsistency was the shear volume of patients presenting in the ED. The amount of time required per patient was pretty small, but during peak times it exceeded the capability of the Nursing staff to adequately perform. No staff was ever added to the ED to accommodate this activity. In conclusion, West Georgia Health decided in the past to do a complete list in the ER because they were choosing to not just meet the joint commission standard - but for patient safety reasons they would exceed the requirement. Hence the reason today they are still doing a post-surgical medication reconciliation review which no longer is a joint commission requirement either.

As a result of the pressing patient feedback and the overall history surrounding this process, West Georgia Health reached out to SBTI (Strategy Breakthrough Transformation Innovation), to assist in formulating a plan to solve this problem. SBTI assisted in identifying the necessary data and put forth a plan that required two separate analyses to reach the solution. The team was created in such a way as to allow part of the team to focus on the issues that occur in the ED, while the other team focused on the details related to inpatient. The idea was to explore both areas to understand what they really needed and then come together to create a solution that worked for everyone.

The goal of the project was to be able to complete the Medication Reconciliation (Med Rec) upon admission within the first 24 hours and the ability to discharge with accurate meds from the Emergency Department.

Method

West Georgia Health began by chartering a project that included team members from all impacted areas, which included a Hospitalist, ED Manager and Director, Floor Nurses, Pharmacists and IT. The project was scoped to focus improvements on the floor, but was given permission to explore improvements in the ED. It was determined that a five-

day event should be sufficient to permanently solve this problem given the dedicated participants.

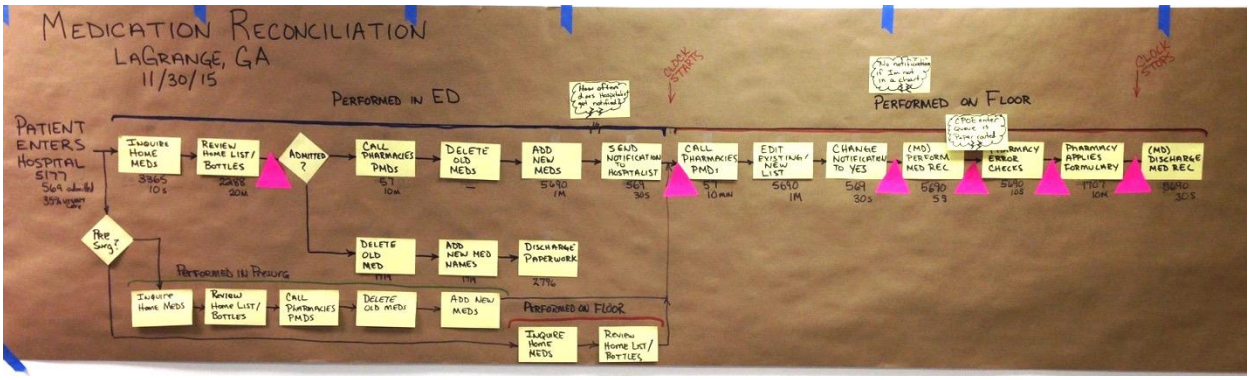
The team was taught basic Lean principles to understand the importance of identifying waste and improving flow. Initially the Hospitalist and ED members were asked to join only part of the five-day agenda. Once the information began to surface, the ED elected to remain a part of the team to see the solution through.

Prior to the week-long event the team walked the process and gathered relevant IT screen shots, key metrics, employee feedback, and a basic “process” understanding. The team discovered during this time that there was inconsistency in the way Medication Reconciliation was measured. This led to the following improved Operational Definitions:

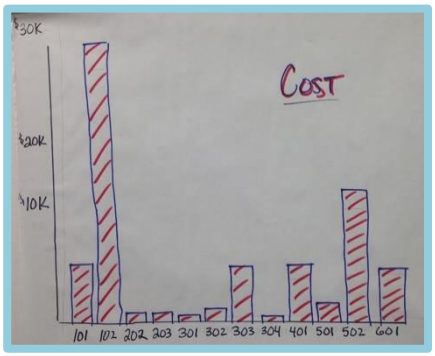
Medication Reconciliation Complete	This means that the medication list is current with medicine name, dosage, frequency, route and last dose taken for each medication listed.
Baseline Medication List Complete	This means that the medication list is current with regards to medicine name only.

Mapping to See

The team started the analysis by process mapping what actually happens in the areas. This became the ongoing reference to assist in understanding how each of the steps could impact the others. The team populated the steps of the process with approximate labor cost, time and quality. This was performed to get an overall feel for where their nurses spent time addressing the medication reconciliation.



The team used this process to discover areas where there was high volume, delays, duplicate work, and steps lacking standard work. Through this discussion several storm clouds were identified and placed on the map for further investigation.

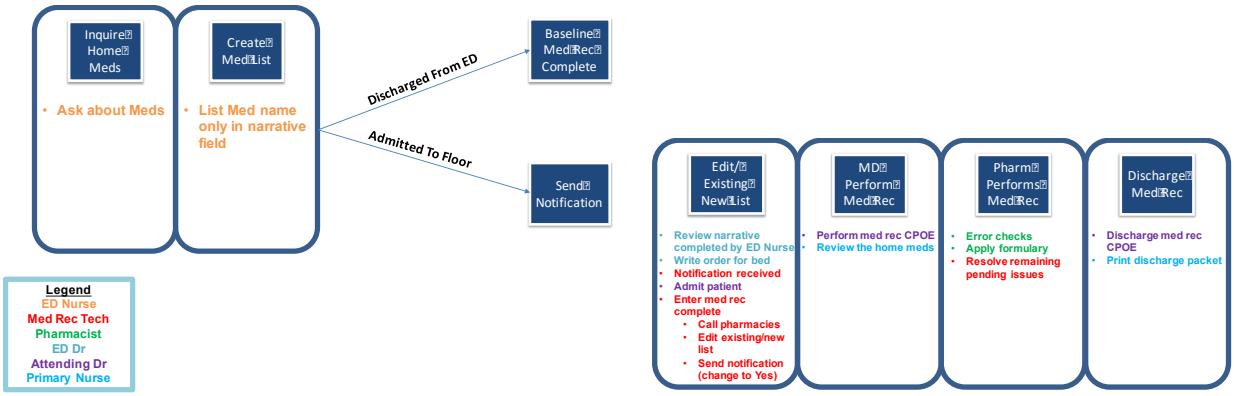


Once the areas of high volume and touch time were understood an approximate cost could be assigned to show the magnitude of the work required by individuals performing this activity. This analysis allowed the team to see the impact each step has on the process. By recognizing that the bulk of the impact is being felt in the ED not the floor allowed WGH to better understand where ultimate solutions needed to be addressed.

The team then focused on brainstorming ideas to address the discovered areas. Each solution was categorized by the step it impacted and then weighted according to an Ease vs. Impact chart.

The team was then split into teams with each team responsible for creating concepts that would solve the issues. The concepts were made up of the above ideas. The concepts were then scored versus patient criteria to determine the best solutions for implementation.

The final solution addressed both the ED and Floors and is reflected in the following flow:



The above solution was then piloted using the Pharmacist in the role of the Med Rec Tech to assure that the process was robust. The pilot concluded successfully and the Director of Pharmacy moved forward with the hiring process. Based on volume it was determined that the ED would perform the above activities 24/7 while the Med Rec Tech would only need to be staffed from 11AM to 11PM. The following issues were uncovered and mitigating actions were assigned:

Need a mobile computer station (computer in rooms are being used)

Interruptions on floor during Med Rec by admission process.

Unsure if admitting doctors are getting the notification that Med Rec has been performed.

There was one minor hurdle that happened after the pilot. Existing Pharmacy Techs desired the newly created positions. While this created a more experienced staff for the new process it also created a void in the current pharmacy roles.

Once the new Med Rec Techs are on boarded the following benefits are expected from this new process flow:

More complete Med Rec list

Decreases work load by being more efficient

Speeds the time patients are required to spend in the ED

CPOE speeds discharge on inpatients

Less potential for medication errors

Better PSO visibility via All scripts