Introduction
Drug related harms contribute to avoidable morbidity, mortality and costs (1). Medicines reconciliation at healthcare interfaces can help minimise drug related risks to patients (2). However, previous work has focused on acute sector interfaces (2,3). As more than 16,000 patients attend NHS Greater Glasgow & Clyde (NHSSGG&C) primary care Community Mental Health Teams (CMHTs) annually, addressing avoidable prescribing risks may have a significant positive impact on patient safety, care and outcomes.

Aim
To increase the proportion of patients with no prescribed psychotropic medicine discrepancies, at the CMHT-general practice interface, to ≥80% by January 2017.

This work supports the Scottish Government’s 2020 Vision: working to assure high standards of safe and effective treatment while minimising avoidable harms in the community setting.

Method
Sample:
• 3 CMHTs participated from October 2015 to January 2017.
• 10 different patients per audit cycle per CMHT were sampled, from all patients attending in the 4 weeks prior to the audit cycle.
• 12 audit cycles were completed for each CMHT.

Data collection and prescriber feedback:
• Routine psychotropic prescribing data were collected from patients’ most recent CMHT psychiatrists’ review letter, using a standardised form and reconciled with the patient’s general practice records.
• Demographic and primary psychiatric diagnosis were recorded.
• Prescribers received individual patient-level feedback for all patients; listing all prescribed psychotropic and non-psychotropic medicines.
• Identified psychotropic discrepancies were highlighted for prescribers to address.
• Run charts, as per Figures 1 & 2, were given to prescribers as part of routine feedback, from the third audit cycle onwards.
• CMHT face to face feedback meetings varied:
  • CMHT-1 requested that interim results be presented and discussed at their multidisciplinary team training day.
  • CMHTs-2 & 3 interim results were presented and discussed with a small group of psychiatrists and senior community psychiatric nurses.

Analysis:
• Small sample size per CMHT audit cycle caused significant variance, therefore rolling means were used to summarise data for analysis (Figure 1 & 2).
• All discrepancies were graded for potential harm, as previously outlined (4) by experienced mental health clinical pharmacists.
• Patient-level deprivation was classified using the Scottish Index of Multiple Deprivation (SIMD) derived from patient’s postcode.
• Where necessary data were aggregated to minimise small cell numbers, <5.
• Where appropriate statistical analysis was performed.

Ethics: Ethical approval was sought. As the work was considered to be service improvement ethical approval was not required.

References