



Implementation of Safe Clinical Practices in the Project „European Union Network for Patient Safety and Quality of Care“

Lena Mehrmann, **Liat Fishman**,
Christian Thomeczek
German Agency for Quality in Medicine
(AQuMed / AEZQ)

2nd World Congress of Clinical Safety, Heidelberg
12-13 September 2013

PaSQ European Union Network
for Patient Safety and
Quality of Care



Funded by
the Health Programme
of the European Union

Work Package 5 – Patient Safety Initiatives Implementation

Content

- Implementation of selected Safe Clinical Practices (SCPs) in Healthcare Organisations (HCOs) in 17 participating countries
- Compilation of one tool box per SCP
- Monitoring and assessment of implementation process

Results

- Report on implementation experiences
- Tested tool boxes – to what extent have they been helpful?



Work Package 5 Partners

- **Austria:** Gesundheit Österreich GmbH (GOEG)
- **Croatia:** Agency for Quality and Accreditation in Health Care and Social Welfare (AQAH)
- **Denmark:** Danish Society for Patient Safety (DSPS)
- **Finland:** National Institute for Health and Welfare (THL)
- **France:** Haute Autorité de Santé (HAS)
- **Germany:** Agency for Quality in Medicine (AQUMED)
- **Greece:** National and Kapodistrian University of Athens (NKUA)
- **Hungary:** National Institute for Quality and Organisational Development in Healthcare and Medicines (GYEMSZI)
- **Italy:**
 - Ministry of Health (ITMoH)
 - Istituto Oncologico Veneto (IOV)
- **Latvia:** Riga East University Hospital (REUH)
- **Lithuania:** State Health Care Accreditation Agency (VASPVT)
- **Netherlands:**
 - Nederlands Instituut voor Onderzoek van de Gezondheidszorg (NIVEL)
 - Dutch Institute for Healthcare Improvement (CBO)
 - National Institute for Public Health and the Environment (RIVM)
- **Norway:** Norwegian Knowledge Center for Health Services (NOKC)
- **Poland:** National Center for Quality Assessment in Healthcare (NCQA)
- **Romania:** National School of Public Health and Health Management (NSPHM)
- **Slovakia:** Ministry of Health (SKMoH)
- **Spain:** Spanish Ministry of Health, Social Services and Equality (MSSSI)
- **UK:** NHS (formerly NHS Institute for Innovation and Improvement)



- 6 European stakeholder organisations (e.g. representation of physicians, nurses, pharmacists, patients)
- Collaborating Partners (e.g. WHO)

Work Package 5 Schedule

Activity	Start and termination of activity by month
I. Collection and Selection of Safe Clinical Practices (SCPs) for Implementation	M4-M10 (July 2012-January 2013)
II. Collection and Compilation of Implementation Tools	M11-M15 (February-June 2013)
III. Recruiting of Healthcare Organisations (HCOs) for Implementation	M11-M15 (February-June 2013)
IV. Training of Multipliers	M16-M33 (July 2013-December 2014)
V. Monitoring and Assessment of Implementation Process	M16-M33 (July 2013-December 2014)
VI. Final Report	M34 (January 2015)



 **Start of implementation in HCOs: July 1st-September 1st 2013**

SCP Selection Criteria

1. Demonstrated effectiveness
2. Transferability
3. Feasibility
4. Existing implementation tools
5. Patient Involvement



Selected SCPs

- WHO Surgical Safety Checklist



Surgical Safety Checklist		
World Health Organization Patient Safety A World Alliance for Safer Health Care		
Before induction of anaesthesia	Before skin incision	Before patient leaves operating room
(with at least nurse and anaesthetist)	(with nurse, anaesthetist and surgeon)	(with nurse, anaesthetist and surgeon)
<p>Has the patient confirmed his/her identity, site, procedure, and consent?</p> <input type="checkbox"/> Yes	<p><input type="checkbox"/> Confirm all team members have introduced themselves by name and role.</p> <p><input type="checkbox"/> Confirm the patient's name, procedure, and where the incision will be made.</p> <p>Has antibiotic prophylaxis been given within the last 60 minutes?</p> <input type="checkbox"/> Yes <input type="checkbox"/> Not applicable	<p>Nurse Verbally Confirms:</p> <input type="checkbox"/> The name of the procedure <input type="checkbox"/> Completion of instrument, sponge and needle counts <input type="checkbox"/> Specimen labelling (read specimen labels aloud, including patient name) <input type="checkbox"/> Whether there are any equipment problems to be addressed
<p>Is the site marked?</p> <input type="checkbox"/> Yes <input type="checkbox"/> Not applicable	<p>Anticipated Critical Events</p> <p>To Surgeon:</p> <input type="checkbox"/> What are the critical or non-routine steps? <input type="checkbox"/> How long will the case take? <input type="checkbox"/> What is the anticipated blood loss?	<p>To Surgeon, Anaesthetist and Nurse:</p> <input type="checkbox"/> What are the key concerns for recovery and management of this patient?
<p>Is the anaesthesia machine and medication check complete?</p> <input type="checkbox"/> Yes	<p>To Anaesthetist:</p> <input type="checkbox"/> Are there any patient-specific concerns?	
<p>Is the pulse oximeter on the patient and functioning?</p> <input type="checkbox"/> Yes	<p>To Nursing Team:</p> <input type="checkbox"/> Has sterility (including indicator results) been confirmed? <input type="checkbox"/> Are there equipment issues or any concerns?	
<p>Does the patient have a:</p> <p>Known allergy?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes	<p>Is essential imaging displayed?</p> <input type="checkbox"/> Yes <input type="checkbox"/> Not applicable	
<p>Difficult airway or aspiration risk?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes, and equipment/assistance available		
<p>Risk of >500ml blood loss (7ml/kg in children)?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes, and two IVs/central access and fluids planned		
<p><small>This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.</small></p>		
<p><small>Revised 1 / 2009 © WHO, 2009</small></p>		

14 countries



Selected SCPs

- WHO Surgical Safety Checklist
- Medication Reconciliation

9 countries

Med Rec is a formal process comparing:

Best Possible Medication History



Medication Orders

Discrepancies brought to attention of healthcare team

Find out more in Panel (5), 13.09.13 10:40-10:55, Presentation NA078



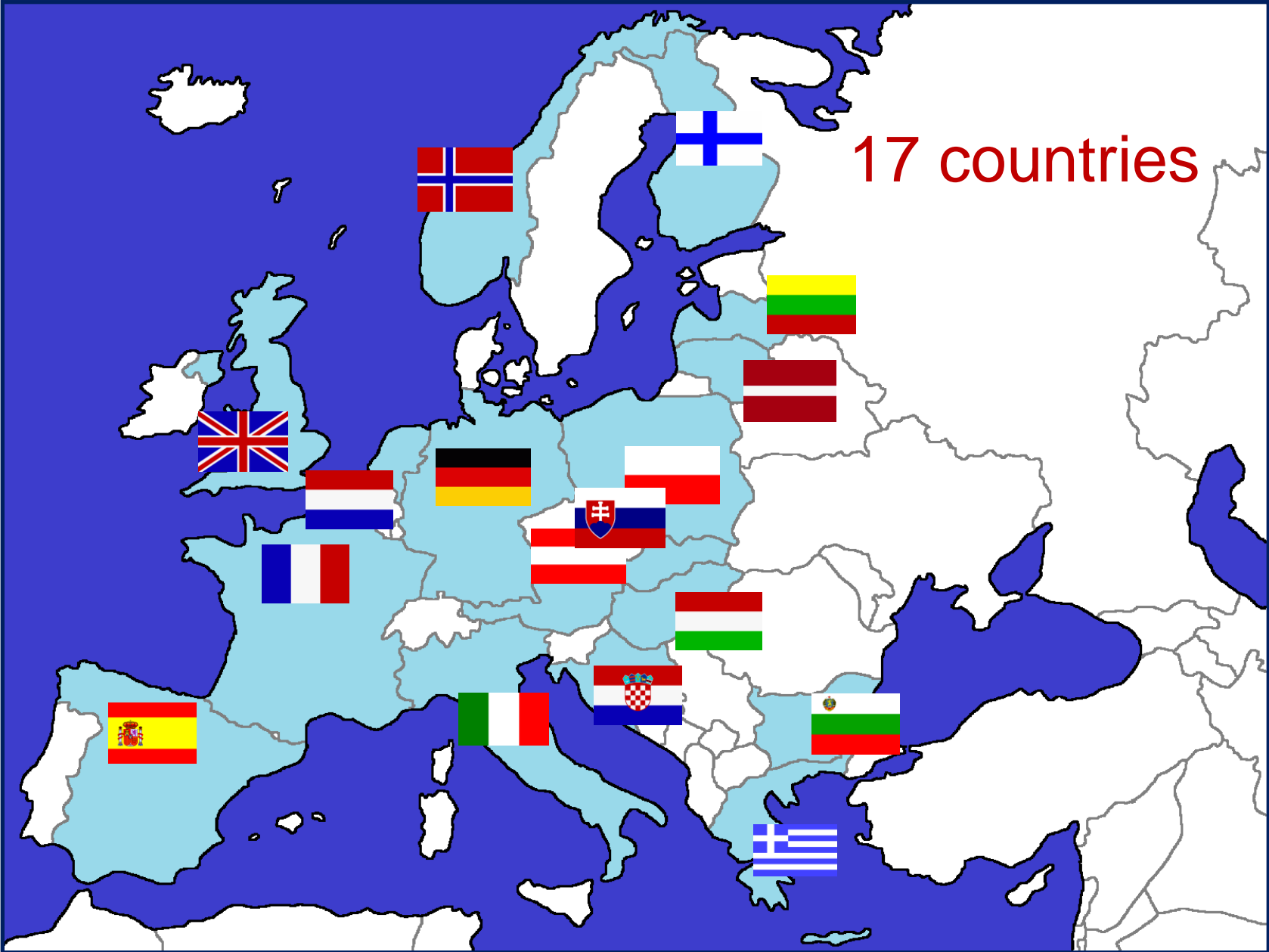
Selected SCPs

- WHO Surgical Safety Checklist
- Medication Reconciliation
- Multimodal intervention to increase hand hygiene compliance

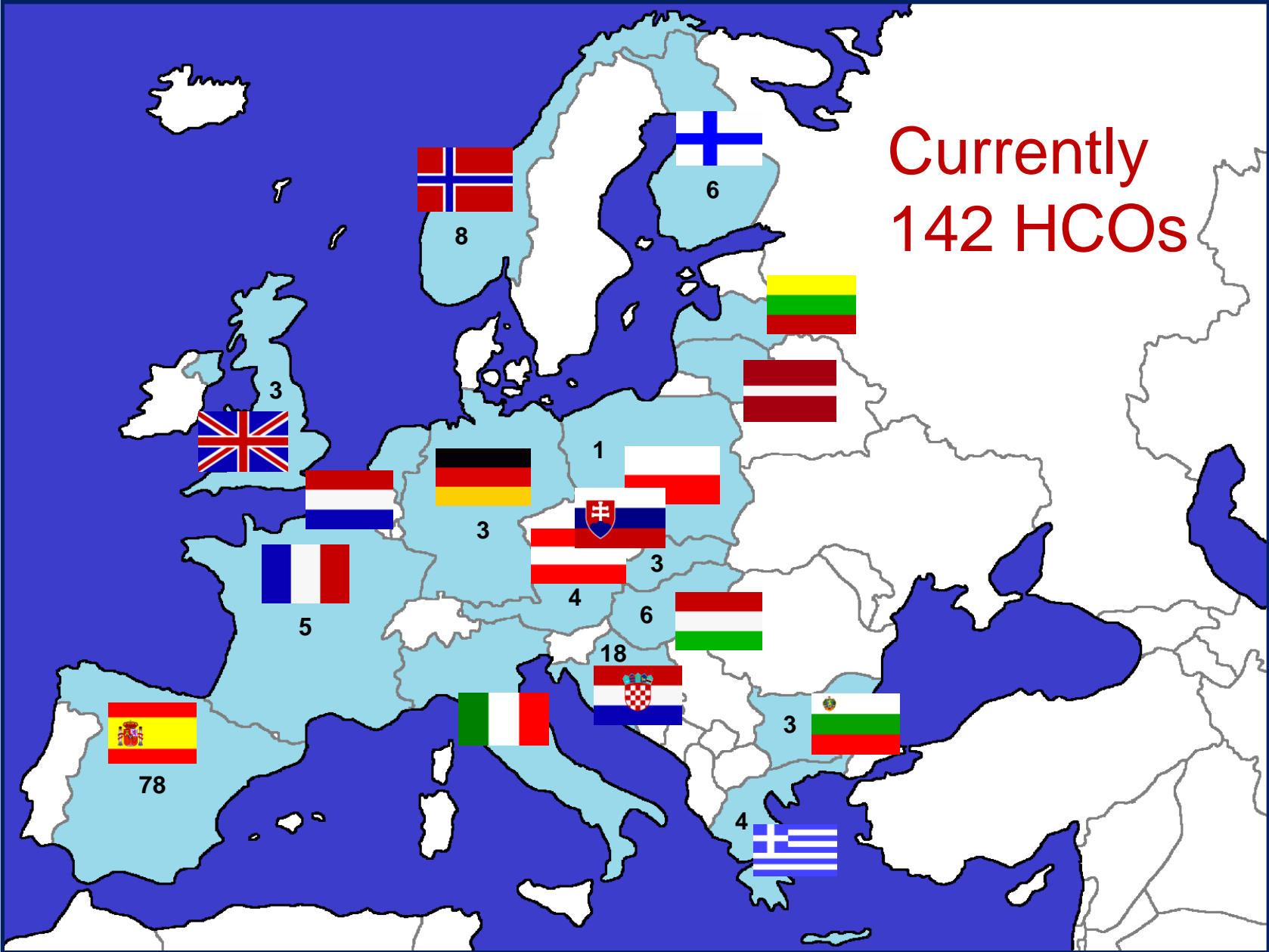
9 countries



Number of participating HCOs per country



Number of participating HCOs per country



Instruments to support implementation

- Implementation **tool box** for each SCP

publicly available on:

<http://www.pasq.eu/Wiki/SCP/WorkPackage5ToolBoxes>



The screenshot shows the PaSQ website interface. At the top, there is a navigation menu with links for Home, Project, Partners, Wiki, News & Events, Links, Forum, FAQ, and Contact. The main content area is titled 'Work Package 5 Tool Boxes for Implementation of Safe Clinical Practices'. Below the title, there is a list of tool boxes: 'Tool Box for WHO Surgical Safety Checklist', 'Tool Box for Medication Reconciliation', 'Tool Box for Multimodal intervention to increase hand hygiene compliance', and 'Tool Box for Paediatric Early Warning Scores (PEWS)'. The page also includes a 'Print' button and a 'Share' button.

Instruments to support implementation

- Content of the **tool boxes**

Medication Reconciliation ► Innovator

SCP: Medication Reconciliation Innovator of the SCP and country of origin

Medication Reconciliation has been established in the past decade particularly in the USA, Canada and Australia. The majority of publications come from the USA and Canada; further publications are available from Europe.

Medication Reconciliation

The aim of this Safe Clinical Practice (SCP) is to identify and correct medication errors (unintentional medication discrepancies) across transitions of care.

Transitions in care such as admission to and discharge from the hospital put patients at risk for errors due to poor communication and inadvertent information loss. Up to 87% of patients admitted to the hospital have unintended medication discrepancies, and these discrepancies remain common at discharge (Kwan et al 2013). Almost one-third of medication discrepancies occurring at hospital admission or discharge have the potential to cause patient harm (i.e., potential adverse drug events) (Mueller et al 2012). Adverse drug events associated with medication discrepancies can prolong hospital stays and, in the postdischarge period, may lead to emergency department visits, hospital readmissions, and use of other health care resources (Mueller et al 2012).

For **more information** have a look at the following links:

Innovator of the SCP and country of origin

Short description of the SCP and information on implementation

Stepwise approach to implementation

Information on needed resources

Summary of evidence for effectiveness

References

Specific Tools

[PDF version](#) of the information on the SCP WHO Medication Reconciliation.



Instruments to support implementation

■ Content of the **tool boxes**

Medication Reconciliation ▶ Short Description

SCP: Medication Reconciliation

Short description of the SCP and information on implementation

Medication Reconciliation is the process of identifying the most accurate list of all medications a patient is taking and using this list to provide correct medications for patients within the health care system (IHI 2011).

The majority of the available literature on Medication Reconciliation focuses on hospital-based transitions in care (Kwan et al 2013). For this reason, the below information is most applicable to hospital care. However, Medication Reconciliation can also be implemented in facilities in other settings i.e. primary care, long-term care and home care (see below for more information).

Health care organisations (HCOs) which will implement this SCP within Work Package 5 of the PaSQ Project are expected to introduce the following three-step Medication Reconciliation process (ISMP Canada 2011):

- 1. Create a complete and accurate Best Possible Medication History (BPMH)** of all the patient's prescribed and nonprescribed medications including name, dosage, route and frequency. More comprehensive than a routine primary medication history, the BPMH involves two steps:
 - I. a systematic process of interviewing the patient/family and
 - II. verification of this information with at least one other reliable source of information (for example, patient medication lists, a community pharmacy, a primary care physician, a government medication database, medication vials)

Medication Reconciliation

The aim of this Safe Clinical Practice (SCP) is to identify and correct medication errors (unintentional medication discrepancies) across transitions of care.

Transitions in care such as admission to and discharge from the hospital put patients at risk for errors due to poor communication and inadvertent information loss. Up to 87% of patients admitted to the hospital have unintended medication discrepancies, and these discrepancies remain common at discharge (Kwan et al 2013). Almost one-third of medication discrepancies occurring at hospital admission or discharge have the potential to cause patient harm (i.e., potential adverse drug events) (Mueller et al 2012). Adverse drug events associated with medication discrepancies can prolong hospital stays and, in the postdischarge period, may lead to emergency department visits, hospital readmissions, and use of other health care resources (Mueller et al 2012).

For **more information** have a look at the following links:

Innovator of the SCP and country of origin

Short description of the SCP and information on implementation

Stepwise approach to implementation

Information on needed resources

Summary of evidence for effectiveness

References

Specific Tools

[PDF version](#) of the information on the SCP WHO Medication Reconciliation.



Instruments to support implementation

■ Content of the **tool boxes**

Medication Reconciliation ▶ Stepwise approach to implementation

SCP: Medication Reconciliation Stepwise approach to implementation

The following outlines the **key steps** for getting started on the implementation of Medication Reconciliation (modified from the „Medication Reconciliation in Acute Care Getting Started Kit“, ISMP Canada 2011). More detailed information can be found within the tools included in this tool box (e.g. Getting Started Kits of ISMP Canada).

1. Secure senior leadership commitment

Implementing a successful Medication Reconciliation process requires clear commitment and direction from the highest level of the organisation.

2. Form a team

Teamwork is an integral part of the Medication Reconciliation process. Medication Reconciliation is not owned by one discipline. Clinical champions can contribute significantly to successful implementation.

Representation of the coordination team could include:

- Senior Administrative leadership (executive sponsor)
- Clinical leaders representing physicians, nursing and pharmacy staff
- Front line caregivers from key settings of care, and from all shifts
- Representatives from other work units or committees whose responsibilities/mandates include the improvement of patient safety (e.g. Patient Safety Officer, representatives from Quality Improvement/Risk Management, Patient Representatives, Pharmacy and Therapeutics committee)
- Patient and/or family member

Medication Reconciliation

The aim of this Safe Clinical Practice (SCP) is to identify and correct medication errors (unintentional medication discrepancies) across transitions of care.

Transitions in care such as admission to and discharge from the hospital put patients at risk for errors due to poor communication and inadvertent information loss. Up to 87% of patients admitted to the hospital have unintended medication discrepancies, and these discrepancies remain common at discharge (Kwan et al 2013). Almost one-third of medication discrepancies occurring at hospital admission or discharge have the potential to cause patient harm (i.e., potential adverse drug events) (Mueller et al 2012). Adverse drug events associated with medication discrepancies can prolong hospital stays and, in the postdischarge period, may lead to emergency department visits, hospital readmissions, and use of other health care resources (Mueller et al 2012).

For **more information** have a look at the following links:

Innovator of the SCP and country of origin

Short description of the SCP and information on implementation

Stepwise approach to implementation

Information on needed resources

Summary of evidence for effectiveness

References

Specific Tools

[PDF version](#) of the information on the SCP WHO Medication Reconciliation.



Instruments to support implementation

■ Content of the tool boxes

Medication Reconciliation ► Needed Resources

SCP: Medication Reconciliation Information on needed resources

The implementation of Medication Reconciliation is resource-intensive. This is especially true if pharmacists are involved in conducting Medication Reconciliation, because this requires substantial investment of resources beyond usual care. Nevertheless, a systematic review of economic analyses of patient safety strategies came to the conclusion that pharmacist-led Medication Reconciliation is one of five economically attractive strategies for improving patient safety (Etchells et al 2012). In one model-based study, which was included in the systematic review, the authors estimated the cost for implementing pharmacist-led Medication Reconciliation at £ 1897 (ca. € 2200 as of March 14th 2013) per 1000 prescription orders (Karon et al 2009).

Medication Reconciliation can be integrated into applications as Computerized Physician Order Entry (CPOE) and Electronic Medical Records (EMR), although it can also be conducted paper-based if such systems have not been introduced in the facility.

Thorough training of staff, e.g. on creating the BPMH, is of utmost necessity.

Medication Reconciliation

The aim of this Safe Clinical Practice (SCP) is to identify and correct medication errors (unintentional medication discrepancies) across transitions of care.

Transitions in care such as admission to and discharge from the hospital put patients at risk for errors due to poor communication and inadvertent information loss. Up to 87% of patients admitted to the hospital have unintended medication discrepancies, and these discrepancies remain common at discharge (Kwan et al 2013). Almost one-third of medication discrepancies occurring at hospital admission or discharge have the potential to cause patient harm (i.e., potential adverse drug events) (Mueller et al 2012). Adverse drug events associated with medication discrepancies can prolong hospital stays and, in the postdischarge period, may lead to emergency department visits, hospital readmissions, and use of other health care resources (Mueller et al 2012).

For **more information** have a look at the following links:

Innovator of the SCP and country of origin

Short description of the SCP and information on implementation

Stepwise approach to implementation

Information on needed resources

Summary of evidence for effectiveness

References

Specific Tools

[PDF version](#) of the information on the SCP WHO Medication Reconciliation.



Instruments to support implementation

■ Content of the **tool boxes**

Medication Reconciliation ► Summary of Evidence

SCP: Medication Reconciliation Summary of evidence for effectiveness

The effect of hospital-based Medication Reconciliation on medication errors and (potential) adverse drug events has been investigated in many studies and summarized in systematic reviews (Mueller et al 2012, Kwan et al 2013). Both reviews come to the conclusion that Medication Reconciliation is a potentially promising intervention.

The systematic review by Mueller et al 2012 included 26 controlled studies and reasoned that Medication Reconciliation consistently reduced medication discrepancies, potential adverse drug events (i.e., clinically significant discrepancies) and adverse drug events. The impact on post discharge health care utilization (i.e., readmissions) was inconsistently shown. Key aspects of a successful intervention included pharmacy staff involvement and focusing on a high risk patient population. The study quality was judged to be poor in fifteen of the 26 studies (Mueller et al 2012).

The systematic review by Kwan et al 2013 included eighteen studies evaluating 20 interventions. Inclusion criteria were more restrictive than in the previously described review; only studies evaluating clinically significant unintended discrepancies or emergency department visits and readmission within 30 days of discharge were considered. The authors come to the conclusion that hospital-based Medication Reconciliation at care transitions frequently identifies unintended discrepancies; however few of these discrepancies seem to have a clinical significance. Furthermore, Medication Reconciliation alone probably does not reduce postdischarge hospital utilization within 30 days but may do so when bundled with other interventions that improve discharge coordination¹. Like the previously described review, this review also found that pharmacists play a major role in successful interventions; however, contrary to the other review, focusing on high risk patients did not seem to consistently improve the effect of Medication Reconciliation (Kwan et al 2013).

A systematic review on the effectiveness of Medication Reconciliation in the

Medication Reconciliation

The aim of this Safe Clinical Practice (SCP) is to identify and correct medication errors (unintentional medication discrepancies) across transitions of care.

Transitions in care such as admission to and discharge from the hospital put patients at risk for errors due to poor communication and inadvertent information loss. Up to 67% of patients admitted to the hospital have unintended medication discrepancies, and these discrepancies remain common at discharge (Kwan et al 2013). Almost one-third of medication discrepancies occurring at hospital admission or discharge have the potential to cause patient harm (i.e., potential adverse drug events) (Mueller et al 2012). Adverse drug events associated with medication discrepancies can prolong hospital stays and, in the postdischarge period, may lead to emergency department visits, hospital readmissions, and use of other health care resources (Mueller et al 2012).

For **more information** have a look at the following links:

Innovator of the SCP and country of origin

Short description of the SCP and information on implementation

Stepwise approach to implementation

Information on needed resources

Summary of evidence for effectiveness

References

Specific Tools

[PDF version](#) of the information on the SCP WHO Medication Reconciliation.



Instruments to support implementation

- Content of the **tool boxes**

Medication Reconciliation ► References

SCP: Medication Reconciliation

References

Bayoumi I, Howard M, Holbrook AM, Schabert I. Interventions to improve medication reconciliation in primary care. *Ann Pharmacother*. 2009;43(10):1667-75

Etchells E, Koo M, Daneman N, McDonald A, Baker M, Matlow A, Krahn M, Mittmann N. Comparative economic analyses of patient safety improvement strategies in acute care: a systematic review. *BMJ Qual Saf*. 2012; 21(6): 448- 56

Institute for Healthcare Improvement. Medication Reconciliation Review. 2011. Available from: <http://www.ihq.org/knowledge/Pages/Tools/MedicationReconciliationReview.aspx> (Accessed March 14th 2013)

Institute for Safe Medication Practices Canada (ISMP Canada). Medication Reconciliation in Acute Care Getting Started Kit. Version 3.0. 2011. Available from: <http://www.ismp-canada.org/medrec/> (Accessed March 14th 2013)

Karnon J, Campbell F, Czoski-Murray C. Model-based cost-effectiveness analysis of interventions aimed at preventing medication error at hospital admission (medicines reconciliation). *J Eval Clin Pract*. 2009;15:299-306

Kwan JL, Lo L, Sampson M, Shojania KG. Medication Reconciliation During Transitions of Care as a Patient Safety Strategy. A Systematic Review. *Ann Intern Med*. 2013;158:397-403. Available from: <http://annals.org/article.aspx?articleid=1656444> (Accessed March 14th 2013)

Mueller SK, Sponsler KC, Kripalani S, Schnipper JL. Hospital-Based Medication Reconciliation Practices. A Systematic Review. *Arch Intern Med*. 2012;172(14):1057-69

Medication Reconciliation

The aim of this Safe Clinical Practice (SCP) is to identify and correct medication errors (unintentional medication discrepancies) across transitions of care.

Transitions in care such as admission to and discharge from the hospital put patients at risk for errors due to poor communication and inadvertent information loss. Up to 87% of patients admitted to the hospital have unintended medication discrepancies, and these discrepancies remain common at discharge (Kwan et al 2013). Almost one-third of medication discrepancies occurring at hospital admission or discharge have the potential to cause patient harm (i.e., potential adverse drug events) (Mueller et al 2012). Adverse drug events associated with medication discrepancies can prolong hospital stays and, in the postdischarge period, may lead to emergency department visits, hospital readmissions, and use of other health care resources (Mueller et al 2012).

For **more information** have a look at the following links:

Innovator of the SCP and country of origin

Short description of the SCP and information on implementation

Stepwise approach to implementation

Information on needed resources

Summary of evidence for effectiveness

References

Specific Tools

[PDF version](#) of the information on the SCP WHO Medication Reconciliation.



Instruments to support implementation

■ Content of the **tool boxes**

The following **specific tools** were submitted during the questioning of the PaSQ MS:

Name of the tool	Type of tool
→ ACADEMIA	<ul style="list-style-type: none"> • Tool for evaluation and feedback • Tool for reminding staff in the workplace
→ Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation	<ul style="list-style-type: none"> • Tool for promotion of a safety culture
→ Poster to prompt patients to bring their list of medications with them to Wexford General Hospital and outpatient clinics	<ul style="list-style-type: none"> • Tool for promotion of a safety culture • Tool for information of patients and relatives
→ START (screening tool to alert doctors to the right treatment)	<ul style="list-style-type: none"> • Tool for reminding staff in the workplace
→ STOPP (Screening Tool of Older Persons' Prescriptions)	<ul style="list-style-type: none"> • Tool for reminding staff in the workplace

Medication Reconciliation

The aim of this Safe Clinical Practice (SCP) is to identify and correct medication errors (unintentional medication discrepancies) across transitions of care.

Transitions in care such as admission to and discharge from the hospital put patients at risk for errors due to poor communication and inadvertent information loss. Up to 87% of patients admitted to the hospital have unintended medication discrepancies, and these discrepancies remain common at discharge (Kwan et al 2013). Almost one-third of medication discrepancies occurring at hospital admission or discharge have the potential to cause patient harm (i.e., potential adverse drug events) (Mueller et al 2012). Adverse drug events associated with medication discrepancies can prolong hospital stays and, in the postdischarge period, may lead to emergency department visits, hospital readmissions, and use of other health care resources (Mueller et al 2012).

For **more information** have a look at the following links:

Innovator of the SCP and country of origin

Short description of the SCP and information on implementation

Stepwise approach to implementation

Information on needed resources

Summary of evidence for effectiveness

References

Specific Tools

[PDF version](#) of the information on the SCP WHO Medication Reconciliation.



Instruments to support implementation

- Content of the **tool boxes**

Specific Tools ► Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation

Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation

Contact information:	NHS England, UK Lynne Caley, unitedkingdom@pasq.eu
Originally developed by:	Agency for Healthcare Research and Quality
Country of origin:	Maryland, USA
Year of development:	2012
Last updated:	2012
Next update:	No information available
Available in the following languages:	English

Type of tool: tool for promotion of a safety culture

http://www.pasq.eu/Portals/PaSQ/Dokumente/Toolbox/MATCH_MedRec_Toolkit.pdf

Short description

This toolkit will help you evaluate the effectiveness of any existing medication reconciliation process in your institution, as well as identify and respond to any gaps. It promotes a successful approach to medication management and reconciliation, emphasising standardisation of the process for doctors, nurses and pharmacists within the hospital. It aims to document and confirm a patient's home medication list upon admission, ensuring that the most accurate, complete medication history is documented for each patient; all the inpatient and home medications are reconciled, and the information is accessible to the entire health team.

Target audience

Doctors, nurses, pharmacists

Applicability (setting e.g. inpatient care, outpatient care, long term care etc.)

Applicable in all healthcare settings

Information on how the tool has been applied/tested in practice

Developed within a research context and widely tested and evaluated. Furthermore the toolkit is regularly used in practice.

Medication Reconciliation

The aim of this Safe Clinical Practice (SCP) is to identify and correct medication errors (unintentional medication discrepancies) across transitions of care.

Transitions in care such as admission to and discharge from the hospital put patients at risk for errors due to poor communication and inadvertent information loss. Up to 87% of patients admitted to the hospital have unintended medication discrepancies, and these discrepancies remain common at discharge (Kwan et al 2013). Almost one-third of medication discrepancies occurring at hospital admission or discharge have the potential to cause patient harm (i.e., potential adverse drug events) (Mueller et al 2012). Adverse drug events associated with medication discrepancies can prolong hospital stays and, in the postdischarge period, may lead to emergency department visits, hospital readmissions, and use of other health care resources (Mueller et al 2012).

For **more information** have a look at the following links:

Innovator of the SCP and country of origin

Short description of the SCP and information on implementation

Stepwise approach to implementation

Information on needed resources

Summary of evidence for effectiveness

References

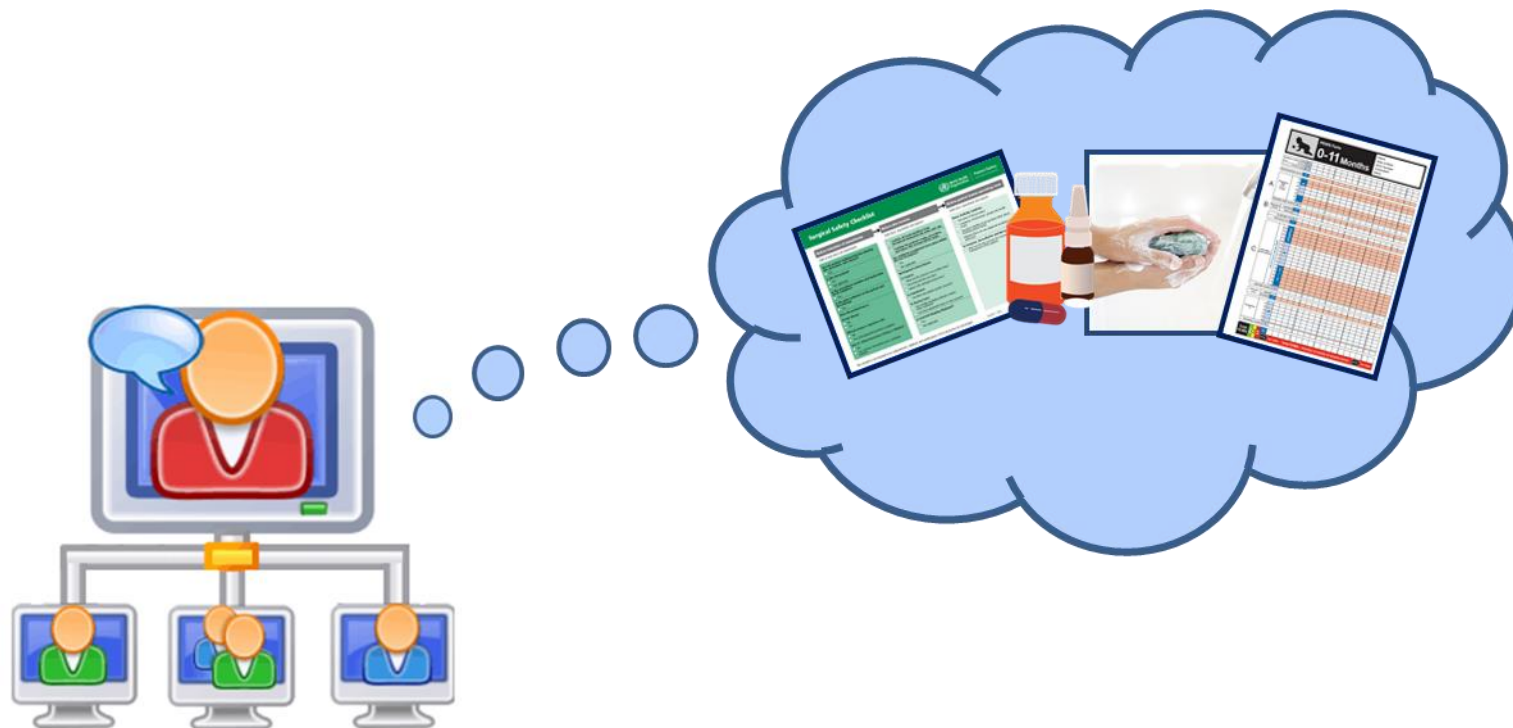
Specific Tools

[PDF version](#) of the information on the SCP WHO Medication Reconciliation.



Instruments to support implementation

- **Webinars** will be organised for each SCP



Instruments to evaluate implementation

- Baseline questionnaires: September 2013
- Endline questionnaires: September 2014

PaSQ
European Union Network for Patient Safety and Quality of Care

Baseline questionnaire on Medication Reconciliation practice

Demographic data

* 1. Details of the person completing this questionnaire

1. First and last name

2. Position

3. Phone

4. E-mail

* 2. Details of your Health Care Organisation (HCO)

1. Name

2. Address: street, no.

3. City

4. Country

* 3. Treatment spectrum of your HCO

1. HCO treating in-patients only

2. HCO treating out-patients only

3. HCO treating in-patients as well as out-patients

Powered by **SurveyMonkey**
Check out our [sample survey](#) and create your own now!

PaSQ
European Union Network for Patient Safety and Quality of Care

Baseline questionnaire on Medication Reconciliation practice

Level of implementation of Medication Reconciliation

* 5. On which scale is Medication Reconciliation already being conducted in your HCO?

Note:
For HCOs treating in-patients, "being conducted" means that the practice is being done at least at one of the transition points admission, transfer and discharge.

1. Medication Reconciliation is not yet being conducted in the HCO.

2. Medication Reconciliation is already being conducted in the entire HCO.

3. Medication Reconciliation is already being conducted only in the following area(s) of the HCO. Please complete the information required by the next question on the following page.

Prev Next

Powered by **SurveyMonkey**
Check out our [sample survey](#) and create your own now!



Thank you for your attention.



PaSQ_Germany@azq.de



PaSQ

European Union Network
for Patient Safety and
Quality of Care



L. Fishman
2nd WCCS
Heidelberg 2013



Funded by
the Health Programme
of the European Union