

P 35

A REVIEW OF MEDICATION RELATED INFORMATION IN PAEDIATRIC GASTROENTEROLOGY OUT-PATIENT CLINIC LETTERS

Monisha Sahni,¹ Jeff Aston,² David Terry^{1,2}. ¹Aston University; ²Birmingham Children's Hospital NHS Foundation Trust

10.1136/archdischild-2015-308634.43

Aims The aim of this study was to evaluate the accuracy and completeness of medication related information provided in out-patient clinic letters.

Method Single-site, cross-sectional, retrospective study. The medication related information included in 50 gastroenterology out-patient clinic letters was reviewed. The evaluation criteria used was adapted from the Sheffield Assessment Instrument for Letters.^{1 2} Clinic letters were assessed against five key themes: patient details, diagnosis/current medical issues, medication name(s), completeness of medication details and changes to the patient's care plan. Each letter was scored against these five criteria, where each criterion was awarded a value between 0 and 2. Therefore each clinic letter was scored out of ten. A perfect score of ten indicated no errors or omissions. The information provided in the clinic letters was reconciled with the corresponding out-patient prescription. Data were analysed using MS-Excel 2010 to obtain descriptive statistics.

Results 46 (92%) out-patient letters were associated with at least one error/omission. In total, 94 errors/omissions were identified. The most common omission was a lack of allergy/sensitivity information in 46/50 (92%) cases. Medication related information included 41/94 (43.6%) errors/omissions. These included a lack of formulation (26/41, 63.4%), omission of strength/concentration (8/41, 19.5%) and a lack of dose regimen (4/41, 9.8%). Errors/omissions were identified in patient details including a missing weight in 5/50 (10%) cases. No errors/omissions were identified in the details of diagnosis/current medical conditions.

The mean score achieved was 8.2 (range 6–10). Four clinic letters achieved a score of 10 (error/omission free).

Conclusion Out-patient clinic letters are a way of communicating information about patients' medicines. This study demonstrates that these letters contain omissions/errors that may be

important when patient care is shared or managed across health-care sectors. It is known that when patients move between care providers the risk of miscommunication and unintended changes to medicines remains a significant problem.³ The most common medication omissions/errors (allergy status, drug formulation, strength, dosage regimen) might be reduced by involving pharmacists in communicating medication related information or using a standardised clinic letter designed to facilitate a complete record of medication use. Further research is needed to determine the extent of inaccurate discharge letters in other specialties and how this form of communication may be optimised.

REFERENCES

- 1 Crossley GM, Howe A, Newble D, *et al*. Sheffield Assessment Instrument for Letters (SAIL): performance assessment using outpatient letters. *Med Educ* 2001;35:1115–24.
- 2 Chindamai P, Bush J, Gupta R *et al*. Evaluation of Outpatient Clinic Letters for Medication Errors. *Eur J Hosp Pharm* 2014;21:A14
- 3 Royal Pharmaceutical Society. Keeping patients safe when they transfer between care providers –getting the medicines right. <http://www.rpharms.com/current-campaigns-pdfs/rps-transfer-of-care-final-report.pdf> (accessed 2 Jul 2014).