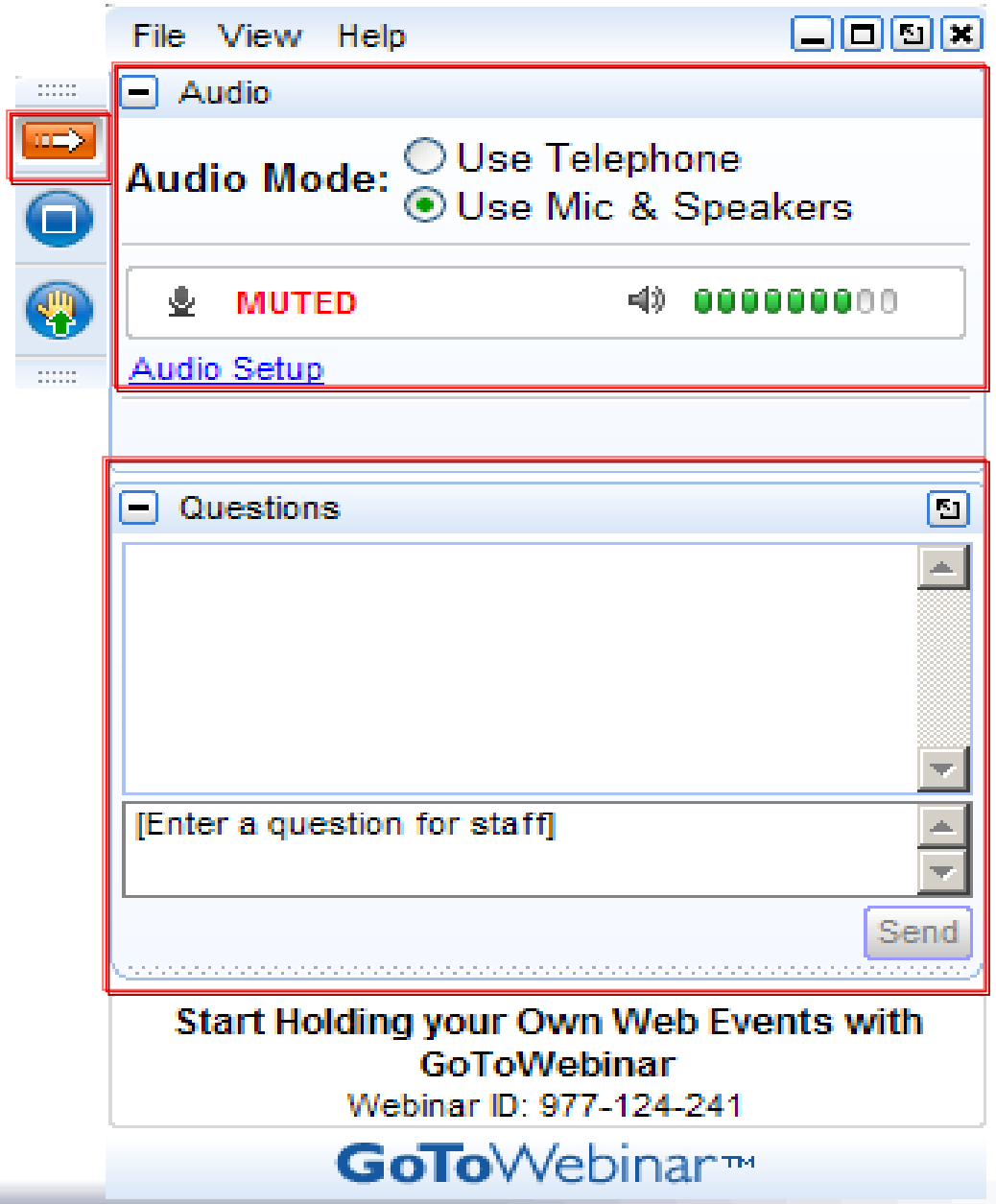
Reconciling Medications at Key Transition Points

Ontario
Health Quality Ontario


Bonjour
Bem-vindos
स्वागतम्
Olá
مرحبا
Willkommen
欢迎光临
Dag
Kamusta
Bienvenido
Hola
你好
Hello
नमस्कार
Salve
Benvenuti
Welcome
Ласкаво просимо!
Вітаємо!
Mabuhay
Hallo
مرحباً
Welkom
Bienvenue

How to Participate Today

- Open and close your Panel
- View, Select, and Test your audio
- Submit text questions
- Raise your hand



Presenter

Kimindra Tiwana

ISMP Canada

Guest Speakers

Dr. Karen Hall Barber

Sherri Elms

Danyal Martin

Queen's Family Health Team Kingston Ontario

4

Presenter Disclosure

Presenter(s)

- Kim Tiwana (ISMP Canada)
- Dr Karen Hall Barber (Queen's FHT)
- Sherri Elms (Queen's FHT)
- Danyal Martin (Queen's FHT)

Relationships with commercial interests:

- Grants/Research Support: Not Applicable
- Speakers Bureau/Honoraria: Not Applicable
- Consulting Fees: Not Applicable
- Other: Not Applicable

Disclosure of Commercial Support

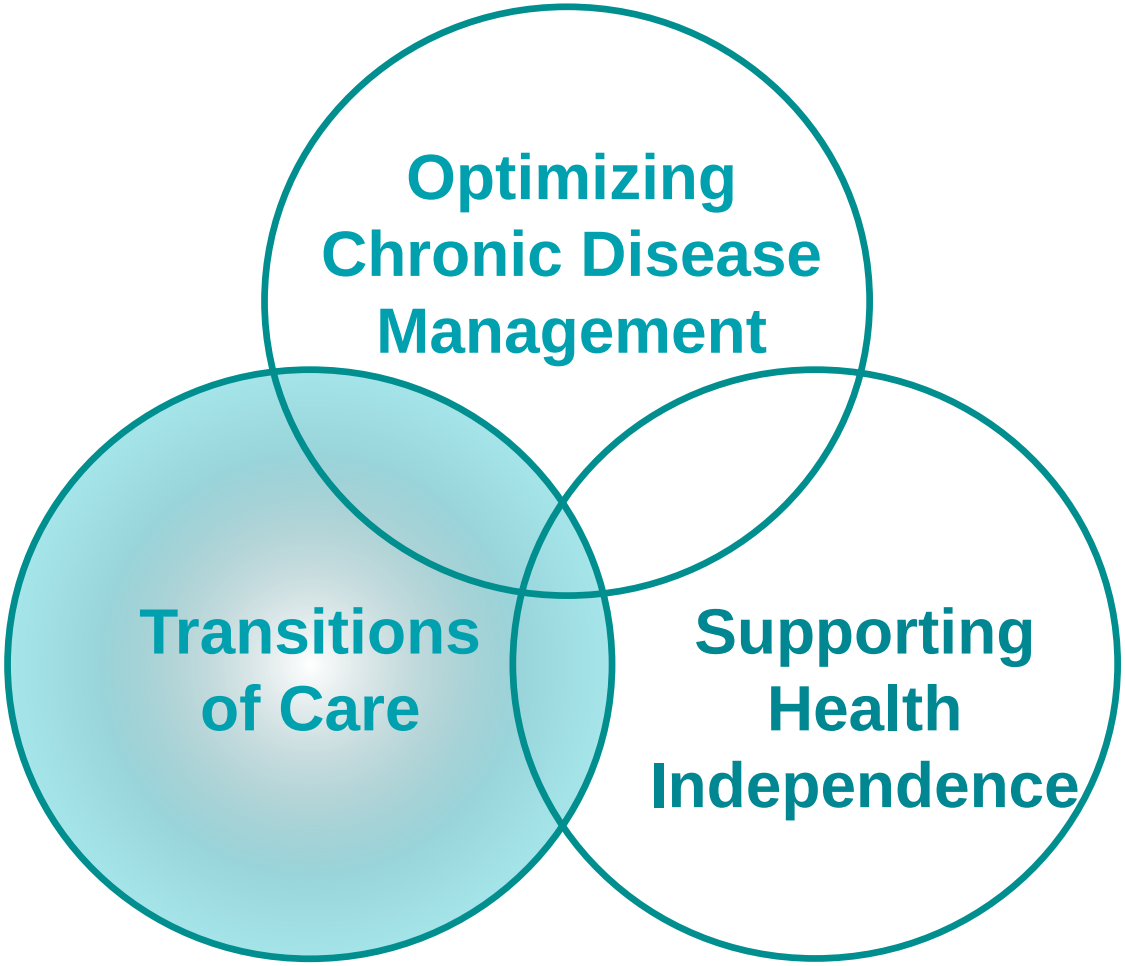
- This program has received no commercial or financial support
- This program has received no in-kind commercial or financial support
- Potential for Conflict(s) of interest:
  - No speaker has received payment or funding from any for-profit organization
  - No organization has a product that will be discussed in the program

Objectives

By the end of this webinar, participants will:

- Understand the importance of Med Rec as a component of medication management
- Be familiar with the role of Med Rec in the context of transitions of care – links to other 3 change concepts in Transitions of Care Improvement Package
- Hear from a “bright spot” in Ontario about their success with Med Rec during transitions of care
- Learn about Med Rec tools that are relevant for your sector
- Share your approach to implement Med Rec within your Health Link

Some helpful resources: HQO improvement packages



Transitions of Care

Call to Action

What: **Better transitions of care for patients**

How: **Having accurate and current medication information communicated between transitions of care**

Who: **All involved in patient's health care team**

When: **Transitions of care**

Why: **Reduce 30 day re-admissions, improve outcomes, satisfaction with care**

Every institution's discharge is another's admission

-Author Unknown

Making the Case for MedRec

- 74% of patients had a discrepancy present between patient-reported and charted medications. (Stewart, 2012)
- Average of 6 discrepancies / patient between EMR and community pharmacy medication lists (Johnson, 2010)
- 12% of ED visits were due to drug-related adverse events of which 83% were preventable (Zed, 2008)

Poll #1

Do you provide separate documentation about medications that is geared towards?

- Patient/family
- Health professionals
- Both
- We don’t provide documentation

Poll #2

How do you know the patient/family understands the information?

- Designated staff speaks with patient
- Designated staff uses ‘teach back’
- Defer to community pharmacist
- Use a patient-friendly version
- None of the above

Medication Reconciliation

- MedRec is a **formal** process in which health care professionals partner with patients to ensure **accurate and complete** medication information is **communicated** consistently at **transitions of care**

- It requires a **systematic and comprehensive review of all the medications** a patient is taking (known as a **BPMH**) to ensure that medications being added, changed or discontinued are carefully evaluated

In other words:

….making sure the right information is communicated about a patient's medications each time the patient moves throughout the healthcare system

Medication Reconciliation

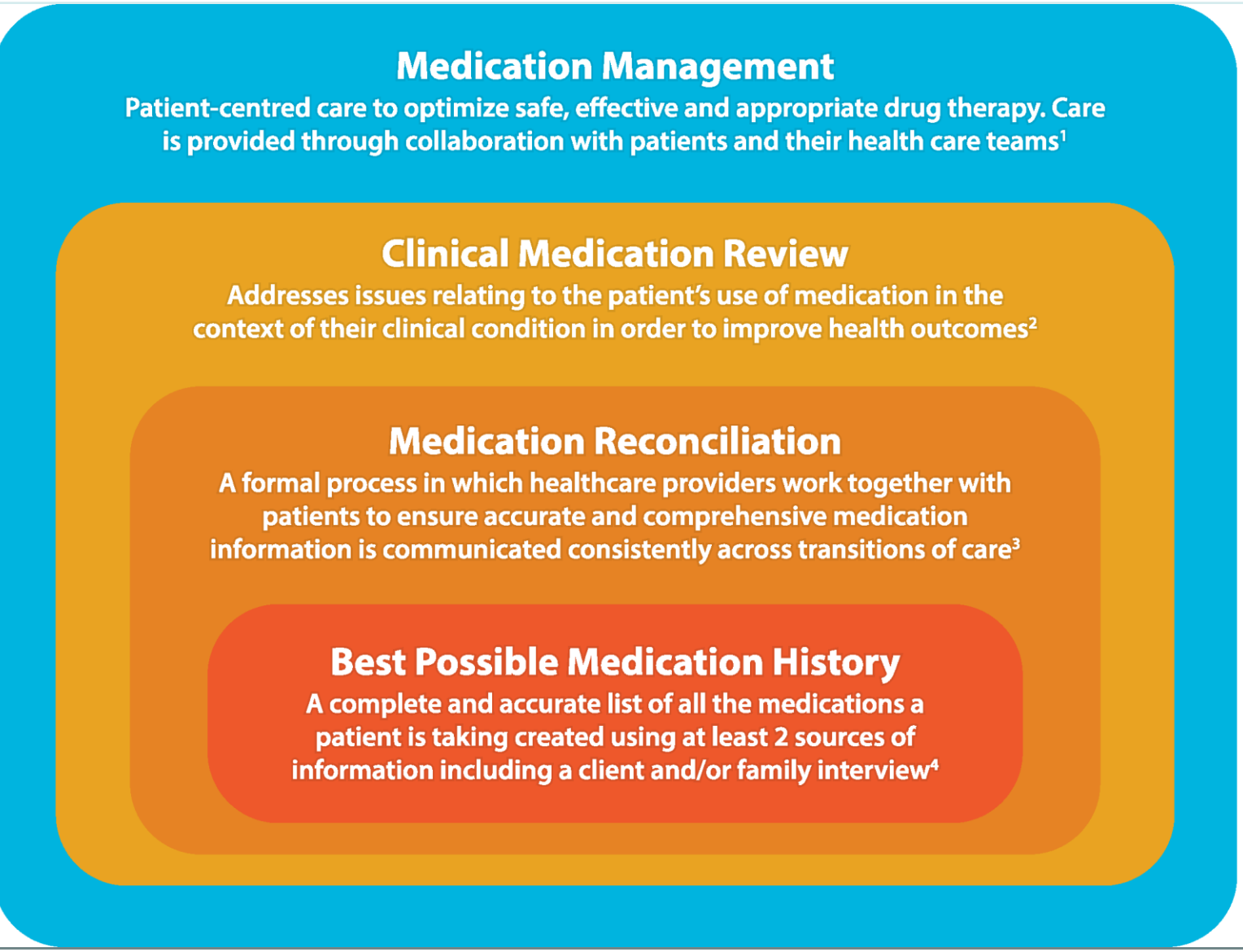
- It is a component of medication management and will inform and enable prescribers to make the **most appropriate prescribing decisions** for the patient
- It is designed to prevent **potential medication errors** and **adverse drug events**

Medication Management

- Medication management is defined as patient-centred care to optimize safe, effective and appropriate drug therapy

- Care is provided through collaboration with patients and their health care teams

Developed collaboratively by the Canadian Pharmacists Association, Canadian Society of Hospital Pharmacists, Institute for Safe Medication Practices Canada, and University of Toronto Faculty of Pharmacy, 2012.



1. Developed collaboratively by the Canadian Pharmacists Association, Canadian Society of Hospital Pharmacists, Institute for Safe Medication Practices Canada, and University of Toronto Faculty of Pharmacy, 2012
2. www.health.gov.bc.ca/pharmacare
3. ISMP Canada. Medication Reconciliation in Acute Care: Getting Started Kit. 2011
4. ISMP Canada. Medication Reconciliation in Acute Care: Getting Started Kit. 2011

Adapted from
Fraser Health, Providence Health Care, Provincial Health Services Authority, Vancouver Coastal Health

Medication Communication Failures Impact EVERYONE!

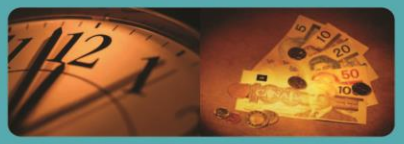
PATIENT & FAMILY

- loss of life
- prolonged disability
- temporary harm
- complicated recovery
- loss of income
- confusion about treatment plan

HEALTHCARE SYSTEM

- prolonged recovery time
- increased cost and staff time due to rework
- avoidable readmissions and Emergency department visits
- reduced access to health services

SOCIETY



- loss of productivity
- workplace absenteeism
- increased cost
- loss of public confidence in the healthcare system

Medication Safety: We all have a role to play.

Safe patient care depends on accurate information. Patients benefit when clinicians work with patients, families, and their colleagues to collect and share current and comprehensive medication information. Medication reconciliation is a formal process to do this at care transitions, such as when patients enter the hospital, are transferred or go home. We all have a role to play.

Accreditation Canada, Canada Health Infoway, the Canadian Medical Association, the Canadian Nurses Association, the Canadian Pharmacists Association, the Canadian Society of Hospital Pharmacists, Patients for Patient Safety Canada, the Royal College of Physicians and Surgeons of Canada, The College of Family Physicians of Canada, Canadian Patient Safety Institute and the Institute for Safe Medication Practices Canada **actively support strategies to improve medication safety and call on all healthcare professionals to contribute to effective communication about medications at all transitions of care to improve the quality and safety of our Canadian healthcare system.**

ACCREDITATION CANADA / AGRÉMENT CANADA — Driving Quality Health Services / Force motrice de la qualité des services de santé

Canada Health Infoway / Inforoute Santé du Canada

Association médicale canadienne / Canadian Medical Association

Canadian Nurses Association / Association des infirmières et infirmiers du Canada

cpsi icsp — Canadian Patient Safety Institute / Institut canadien pour la sécurité des patients

Canadian Pharmacists Association / Association des pharmaciens du Canada

Canadian Society of Hospital Pharmacists / Société canadienne des pharmaciens d'hôpitaux

ismp Canada

Patients for Patient Safety Canada / Patients pour la sécurité des patients Canada

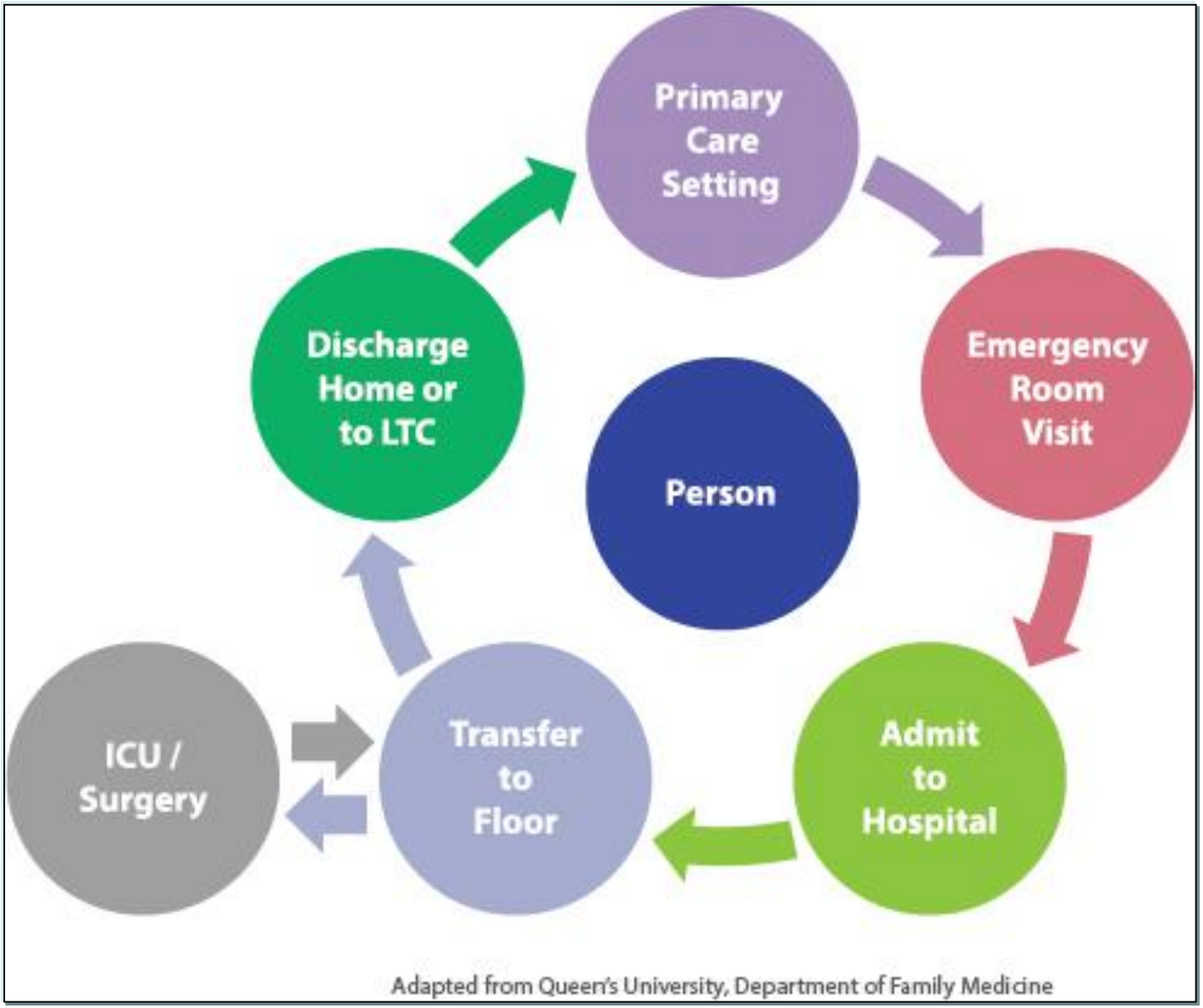
Royal College of Physicians and Surgeons of Canada / Collège royal des médecins et chirurgiens du Canada

The College of Family Physicians of Canada / Le Collège des médecins de famille du Canada

Poll #3

Thinking about medication reconciliation challenges in your Health Link, how often do "miscommunications" happen?

- Never
- Rarely
- Occasionally
- Frequently
- Don't know


Primary Care Setting
Emergency Room Visit
Admit to Hospital
Transfer to Floor
ICU / Surgery
Discharge Home or to LTC
Person
Adapted from Queen's University, Department of Family Medicine

Medication Reconciliation
From Admission to Discharge

1 ADMISSION

AT ADMISSION:

The goal of admission medication reconciliation is to ensure there is a conscious decision on the part of the patient's prescriber to continue, discontinue or modify the medication regime that a patient has been taking at home.

Compare:

Best Possible Medication History (BPMH)

vs.

Admission Medication Orders (AMO)

to identify and resolve discrepancies

2 TRANSFER

AT TRANSFER:

The goal of transfer medication reconciliation is to consider not only what the patient was receiving on the transferring unit but also any medications they were taking at home that may be appropriate to continue, restart, discontinue or modify.

Compare:

Best Possible Medication History (BPMH)

and the

Transferring Unit Medication Administration Record (MAR)

vs.

Transfer Orders

to identify and resolve discrepancies

3 DISCHARGE

AT DISCHARGE:

The goal of discharge medication reconciliation is to reconcile the medications the patient is taking prior to admission and those initiated in hospital, with the medications they should be taking post-discharge to ensure all changes are intentional and that discrepancies are resolved prior to discharge.

Compare:

Best Possible Medication History (BPMH)

and the

Last 24 hour Medication Administration Record (MAR)

plus

New medications started upon discharge

to identify and resolve discrepancies and prepare the Best Possible Medication Discharge Plan (BPMDP)

Adapted from Bernsteiner, J. H. (2005). Medication Reconciliation. American Journal of Nursing, 3(suppl), 31-36. Created by the Institute for Safe Medication Practices Canada (ISMP Canada) for the *Safer Healthcare Now!* campaign.

MEDICATION RECONCILIATION

From Admission to Discharge in Long-Term Care

ADMISSION

AT ADMISSION:

The goal of medication reconciliation at admission is to ensure that all medications ordered are complete, accurate and congruent with what the resident was taking prior to admission to the facility and that any discrepancies with the medications ordered are intentional.

Compare:

Best Possible Medication History (BPMH)

vs

Admission orders

to identify and resolve discrepancies

TRANSFER

AT TRANSFER:

The goal of medication reconciliation at internal transfer is to ensure that all medications orders are completely and correctly transferred with the resident to the transferring unit and that any discrepancies with the medication list are intentional.

Compare:

Most Current Medication List

vs.

New Transfer Orders

to identify and resolve discrepancies

DISCHARGE

AT DISCHARGE:

The goal of medication reconciliation at discharge or external transfer is to communicate an up-to-date, complete and accurate list of the resident's current medications, thereby equipping the next provider of care with adequate information to perform medication reconciliation.

Communicate:

Most Current Medication List

and

Recent changes

(include new medication orders, adjusted doses and discontinued medications)

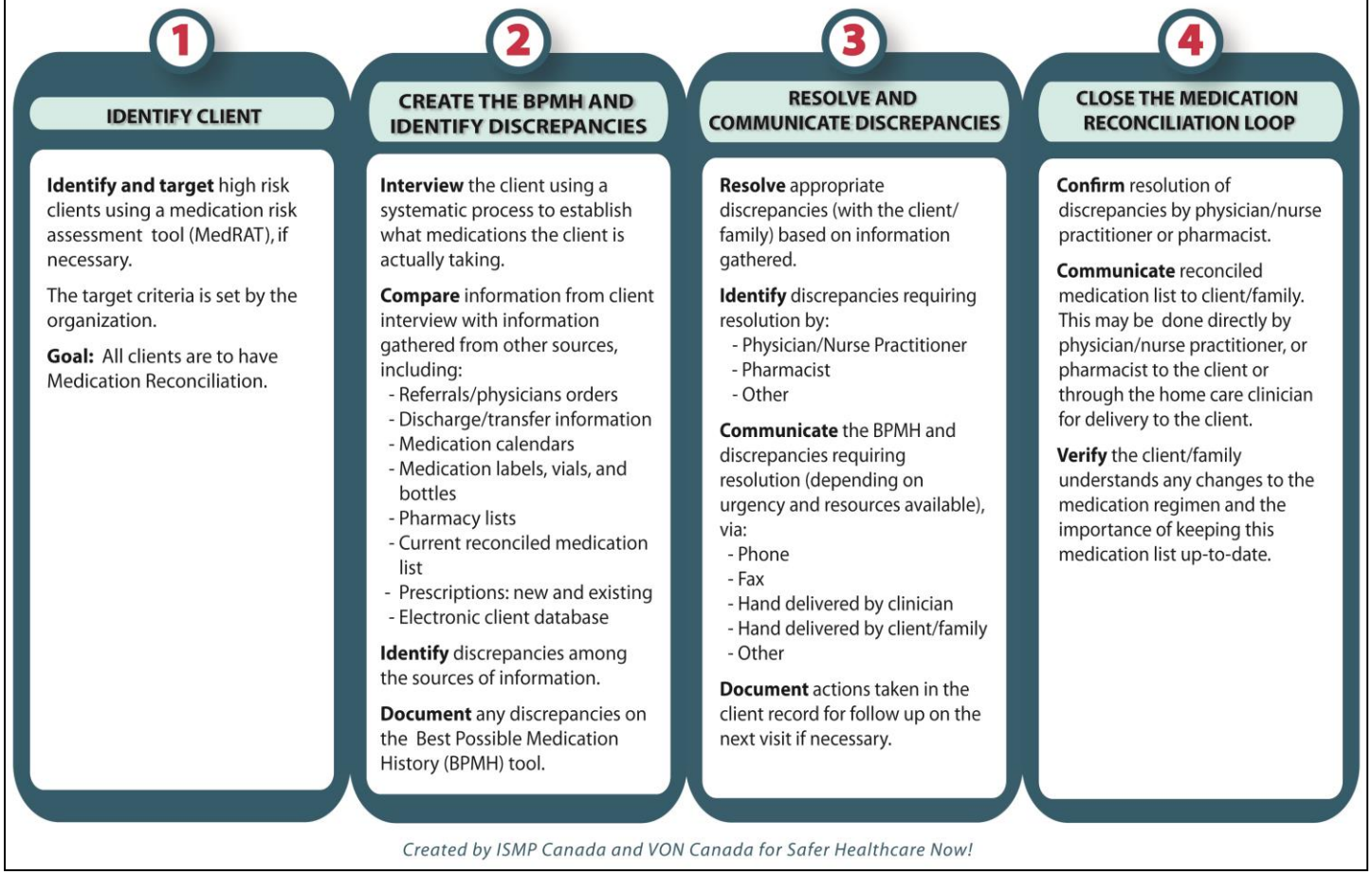
to the next care provider

Adapted from Barnsteiner, J. H. (2005). Medication Reconciliation. American Journal of Nursing, 3(suppl), 31-36. Created by the Institute for Safe Medication Practices Canada (ISMP Canada) for the *Safer Healthcare Now!* campaign.

Primary Care

Adapted from Medication Reconciliation in Home Care Getting Started Kit, January 2011

The Medication Reconciliation Process in Home Care



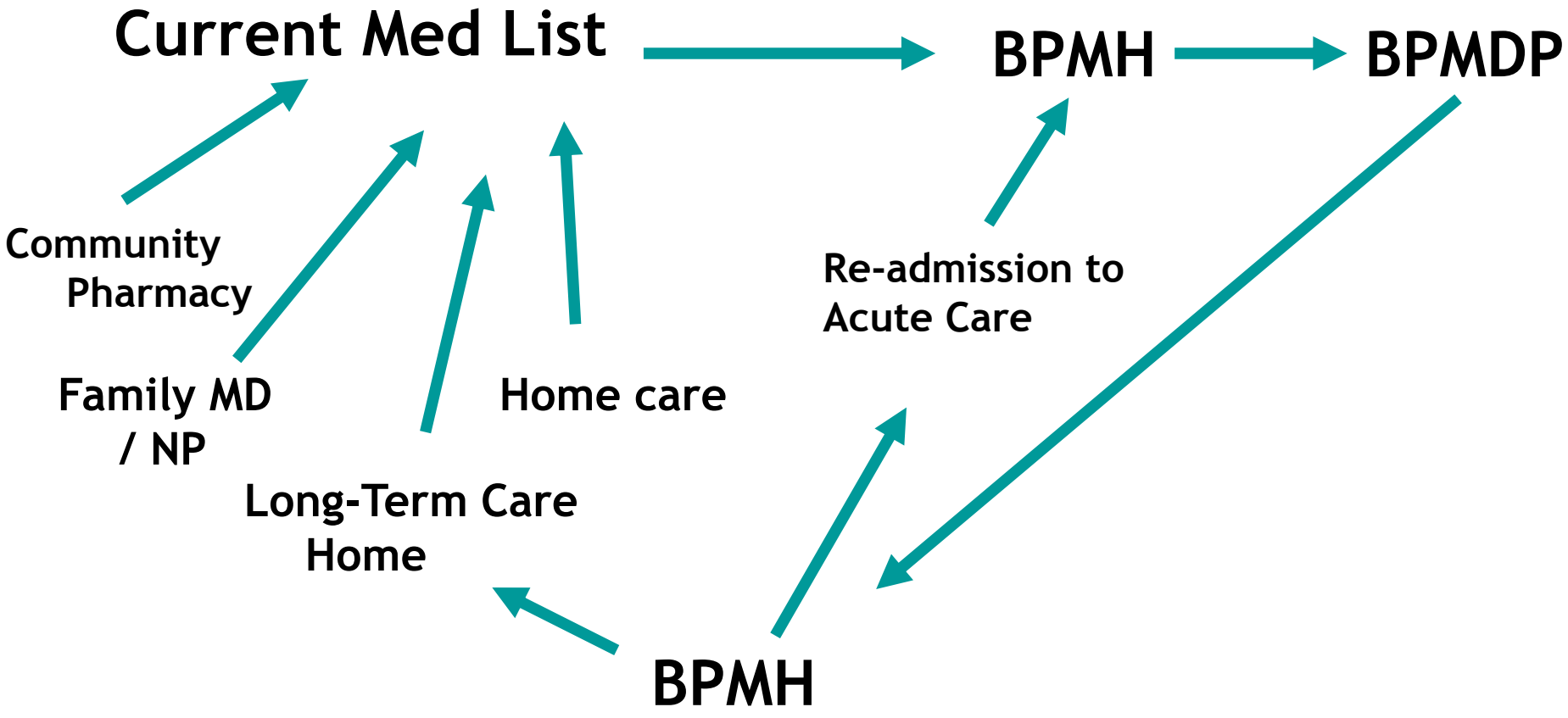
Created by ISMP Canada and VON Canada for Safer Healthcare Now!

Primary Care

- Create a BPMH
- Identify and resolve discrepancies
- Communicate current medication list
- ***Update the current medication list at each patient visit – even if no medication changes were made during the visit***

Best Possible Medication History (BPMH)

- ***Interview*** patient/family using a systematic process
- ***Compare*** the information from this interview with other sources such as:
  - medication bottles / labels
  - patient's own lists / calendars
  - specialist reports
  - community pharmacy lists / MedsCheck
  - discharge summaries / medication lists
  - other
- ***Identify and resolve and discrepancies*** from what the patient is actually taking and what prescribed
- ***Document and communicate*** the updated medication list



BPMH - fundamental cornerstone of MedRec

Drivers

- Strong senior leadership commitment
- Strong physician commitment
- Multi-disciplinary approach
- Clearly defined roles and responsibilities of each participant in the process
- Consumer / patient / resident involvement

Challenges

- Resources – human and fiscal
- Technology – lack of seamless information flow
- Resistance to change
- Variability in processes

Measurement

% of Health Link patients with medications reconciled (i.e. upon discharge from hospital; during a Primary Care visit; on admission to LTC)

% of Health Link patients with at least one outstanding unintentional discrepancy

Tools and Resources

- HQO Quality Compass

  http://qualitycompass.hqontario.ca/

- ISMP Canada MedRec Page

  www.ismp-canada.org/medrec/

- Safer Healthcare Now - Community of Practice

  www.saferhealthcarenow.ca/EN/Interventions/medrec/

- facebook.com/MedicationReconciliation

"Leave it Better Than You Found It"

Medication Reconciliation in Primary Care

Dec 5th 2013 Webinar

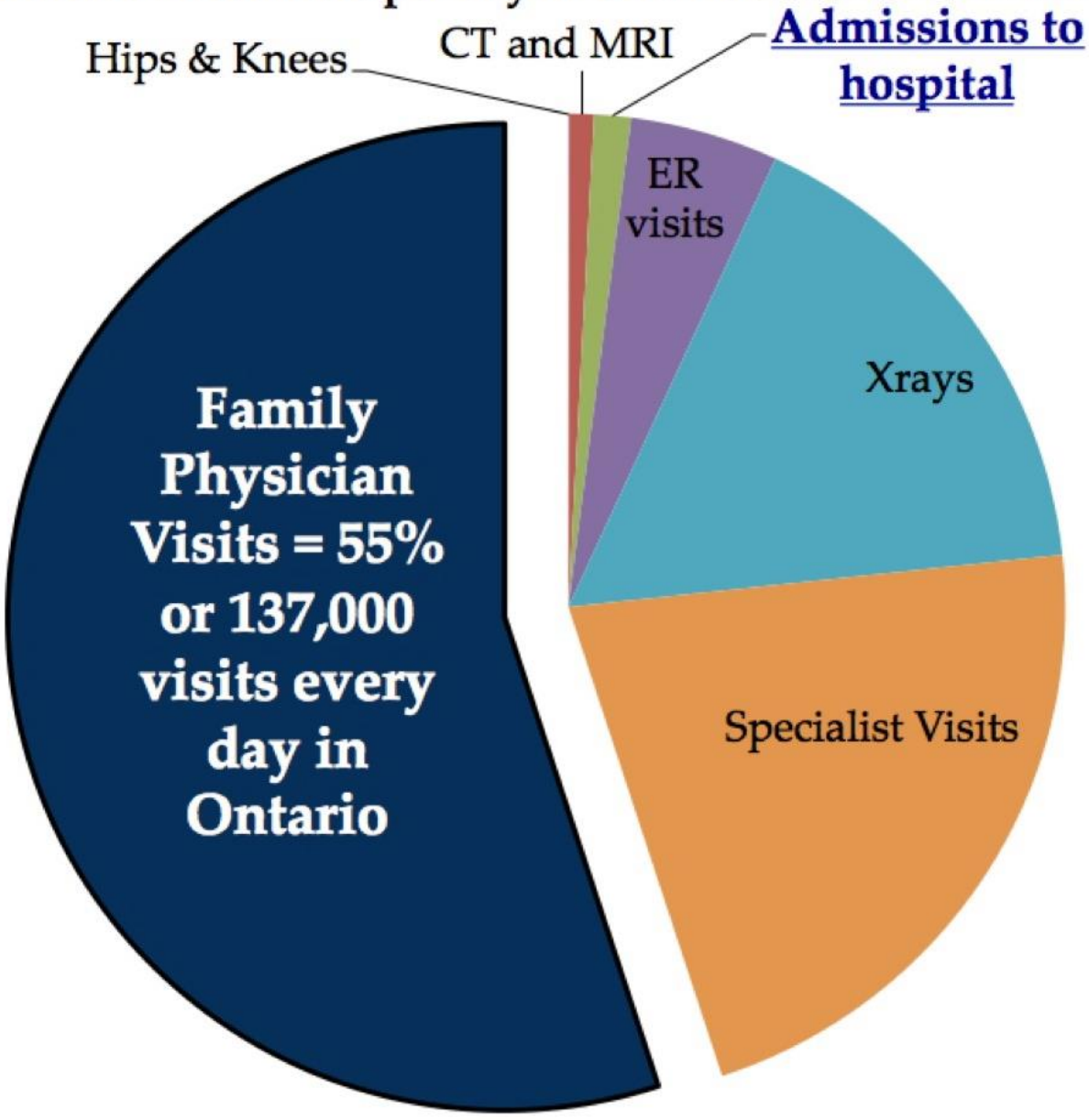
Karen Hall Barber BSc(Hons), MSc(HQ) candidate, MD, CCFP
Sherri Elms BSc(Pharm), MSc(HQ) candidate, ACPR, RPh
Danyal Martin BAH, BEd, MA, MSc(HQ) candidate

Objectives:

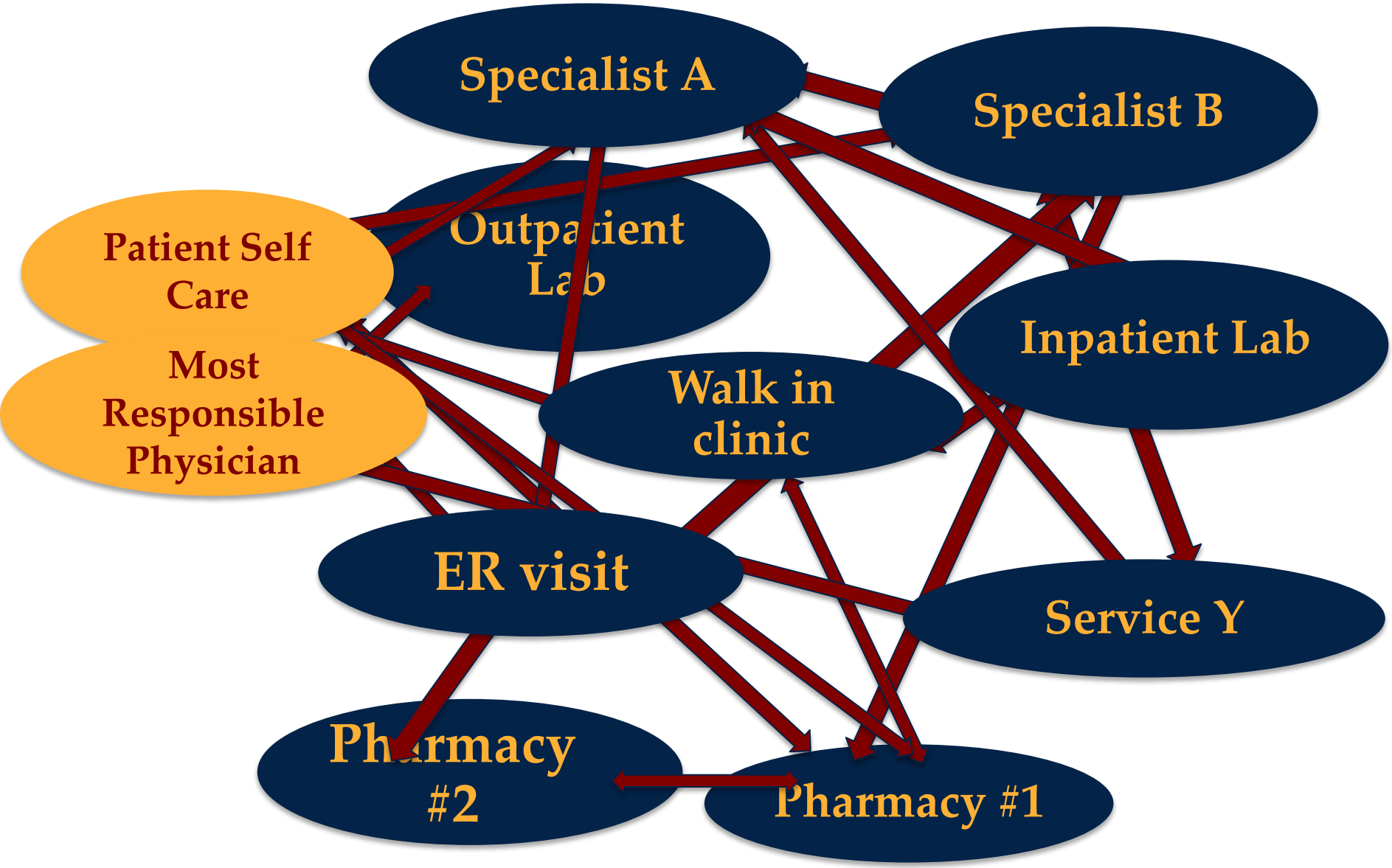
1. Highlight unique features of med rec *in primary care*
2. Explore factors that influence accuracy of medication lists
3. Share our medication reconciliation model

Unique features of medication reconciliation in primary care

Healthcare Encounters per day in Ontario (Institute for Clinical Evaluative Studies 2003)



Patient travel from primary care perspective:



Transfer of care, especially medication reconciliation in primary care, seems largely unmonitored

Rules

College of Physicians and Surgeons of Ontario

- *Prescribing Practices Policy*: "the primary care provider … be aware of all the patient's prescriptions"
- *The Medical Records Policy Statement* states that "physicians should actively maintain the information contained in Cumulative Patient Profile (CPP)" & includes current medications

- College of Physicians and Surgeons of Ontario. "Policy #2-05 Drugs and Prescribing: Prescribing Practices." c2005 [cited 2008 Aug 09]
- College of Physicians and Surgeons of Ontario. "Policy Statement #5-05 Medical Records." c2006 [cited 2008 Aug 09].

Rules:

When writing an Rx in situations of poly-pharmacy, expert recommendation advises us to ensure:

1. **Complete drug list** is verified
2. **Discontinued meds** have actually been stopped.

Rx Files 9th Ed

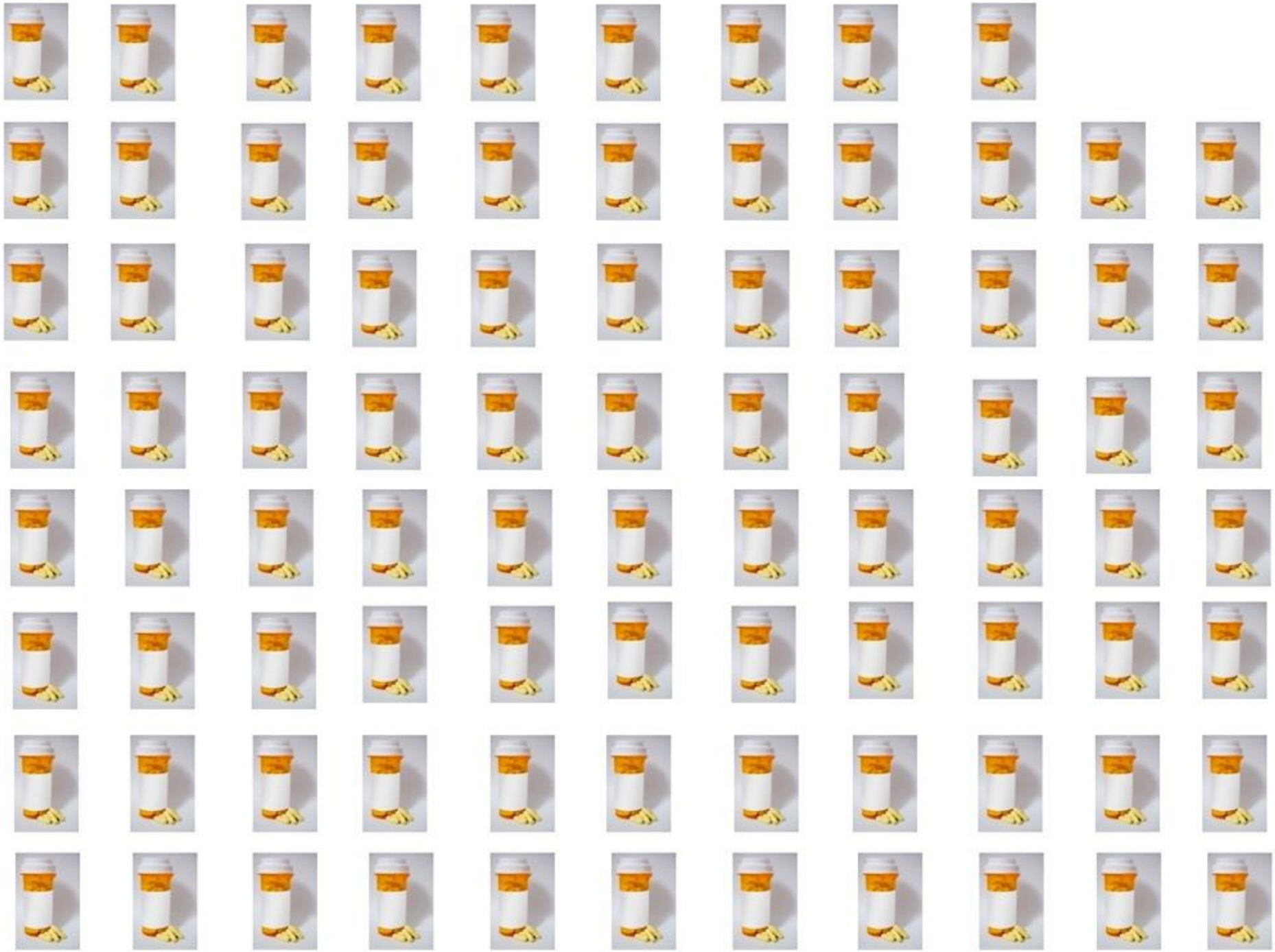
Observations: expectations

- "My family doctor knows what I am on."
- "Call the family doctor's office to find out what the patient is on."
- **"It's in there…"** as patient points to computer when asked to list meds

Observations - Our inaccuracies have included "big ticket" drugs:

- warfarin
- methotrexate,
- digoxin,
- prednisone,
- insulin,
- ACEI,
- NSAIDS,
- DMARDs etc

These have potentially major adverse outcomes



Only

1 out of 86

medication lists

were accurate

Factors that influence accuracy of medication list

Types of Medication List Inaccuracies

1. **Commission Discrepancies**

   Discontinued meds remain as 'active' (eg.metoprolol was stopped 2 months ago and it was not physically 'discontinued' from the med list).

2. **Omission Discrepancies**

   Meds started elsewhere were omitted (eg. warfarin started by a specialist).

3. **Internal Discrepancies within the medication record**

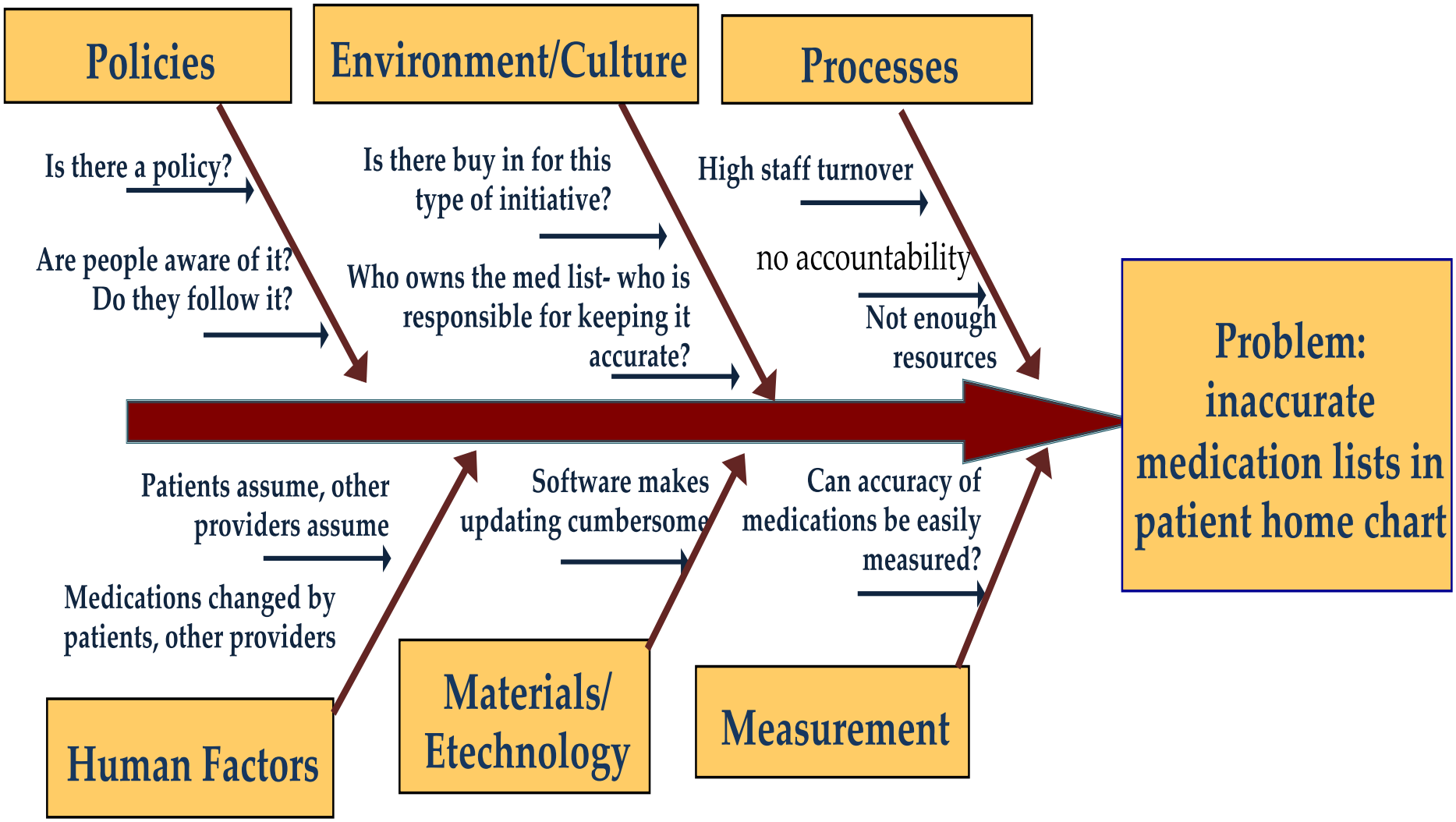
   Incorrect dose, strength, frequency or route

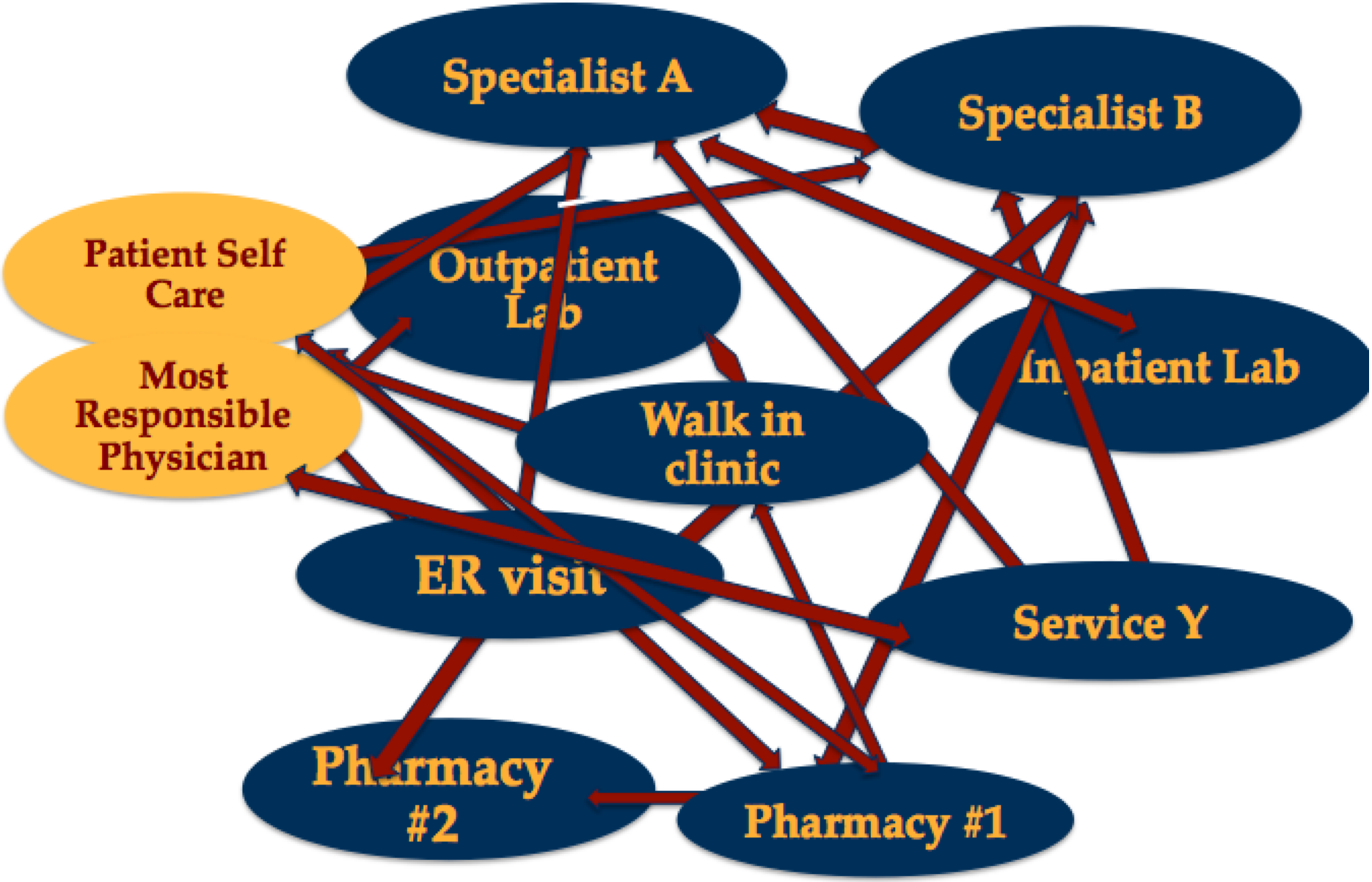
Physician feedback regarding discrepancies

Causes of inaccuracies as reported by physicians:

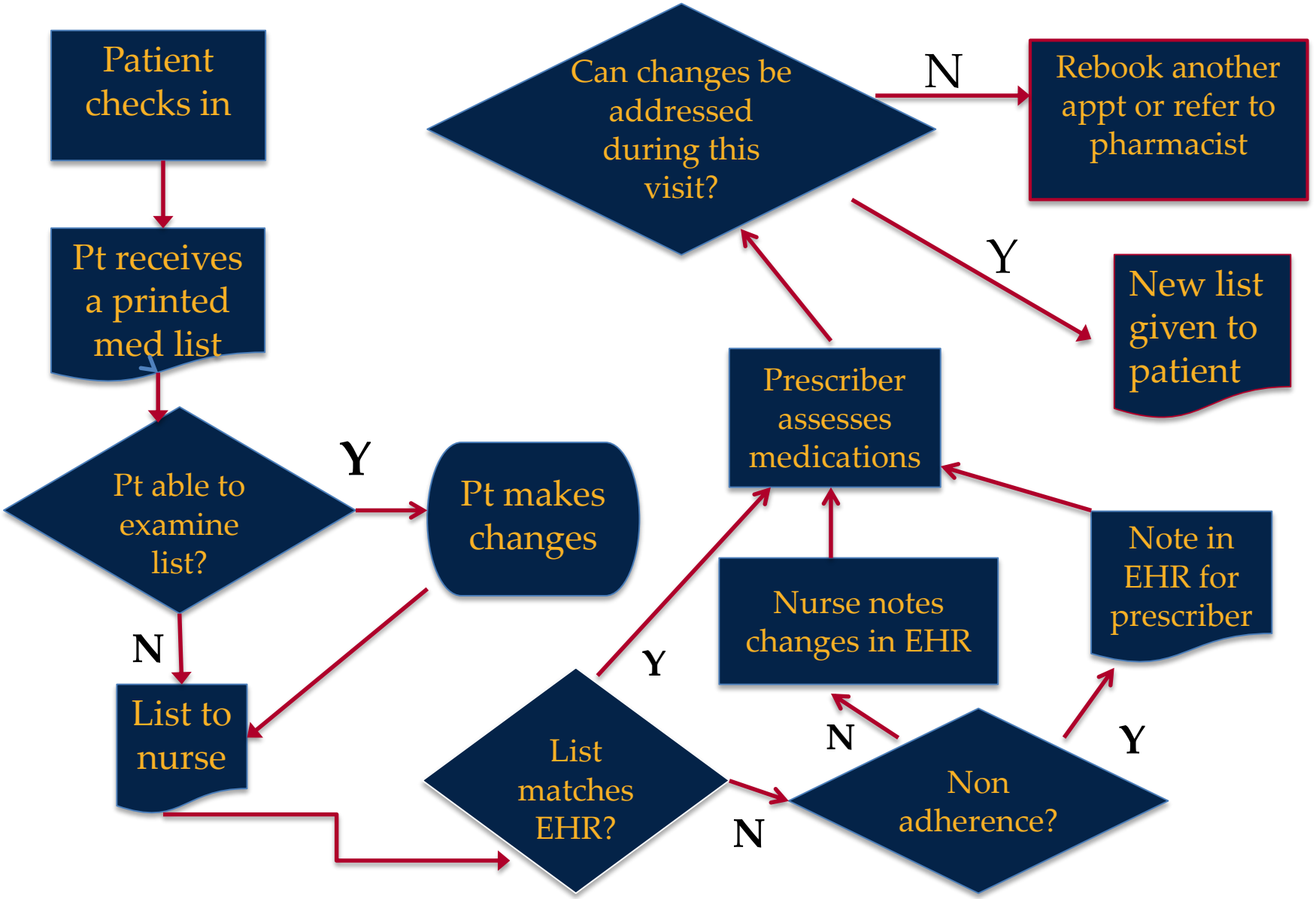
1. Cumbersome software
2. Too time consuming to update/correct
3. Non-EMR clarifications of meds- i.e. verbal orders given to nurse or patient, handwritten 'fax backs' to pharmacies etc
4. Multiple providers for patient eg. External physicians prescribing for patient
5. **Culture: **Medications not routinely reviewed at office visits*****

Factors Influencing Inaccuracy of Primary Care Medication Lists




Specialist A
Specialist B
Patient Self Care
Outpatient Lab
Most Responsible Physician
Walk in clinic
ER visit
Service Y
Pharmacy #2
Pharmacy #1

Verifying medication list in home clinic



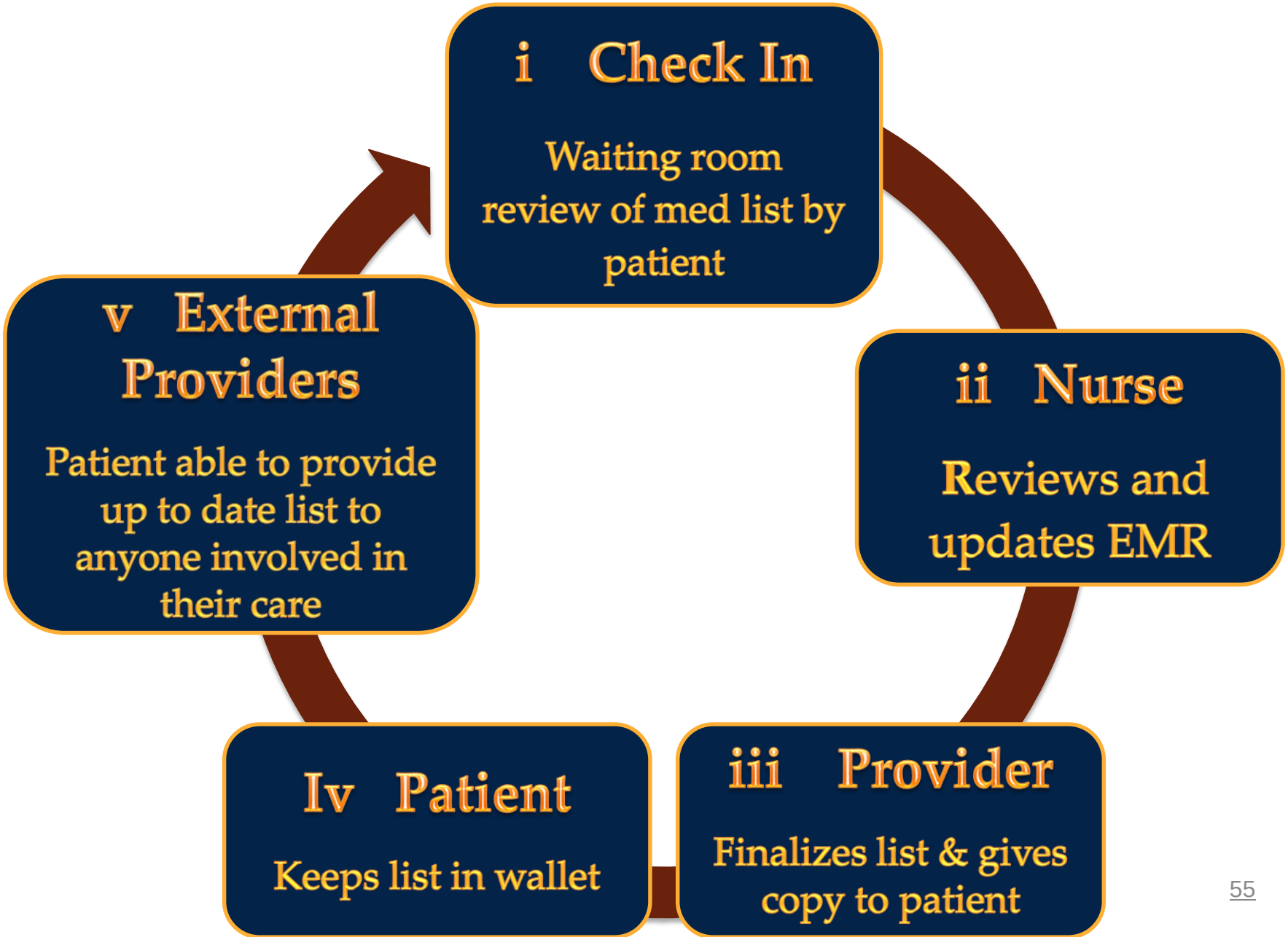
Efficiency - Thoroughness Trade-Off (ETTO)

CAPTAIN SMITH AND OFFICERS S.S. TITANIC.
Lost on 15th April, 1912, after collision with Iceberg in North Atlantic.

Example of primary care medication reconciliation process

Perpetual	• Not a one time blitz or once a year • Apply to all patient 'transition points'
Sustainable	• Use existing resources
Include all in circle of care	• Patient, reception, nurse, learners, clinicians, pharmacy
Standard work	New process becomes the new normal
Measurement/Auditing	New standard work should be measurable

Include entire circle of care



Enable & Educate Support Staff

- Train staff to train patients
- Anticipate questions and push-back – provide tools for front-line staff: FAQs, talking points, verbage etc
- Train how to use the EMR – provide "how-tos" and training sessions

Get "buy in"

- Find a CHAMPION – ideally in a leadership position
- Track results – set parameters, pick a goal report progress and get feedback
- Be tenacious: follow up with folks who are not on board with focused help

Make it easy: "ASAP"

- **A**ctive medications are confirmed
- **S**topped medications are removed
- **A**llergies are updated
- **P**rint off medication lists to give to patient

Engage & Educate Patients

- Encourage patients to bring in their medications in original bottles every visit
- Explain what you are doing and why
- Highlight that inhalers, drops, creams, & over-the-counter pills are included medications
- Use the opportunity to educate in general about medication safety and to notify us if another physician changes their medications
- Provide fresh copy of their list for their wallet at every visit to share with pharmacy & other clinicians

What can primary care do?

- Adopt & adapt hospital based med req to primary care settings
- Develop tools to support BPML in patients' home e-chart
- Advocate for EMR specifications to drive improved primary care med rec
- Accreditation for primary care?
- Education modules for primary care clinicians to promote medication reconciliation
- Patient engagement

Take home points

1. Majority of healthcare transactions take place outside of an institution
2. Care coordination is tremendously complex
3. Medication lists become inaccurate…

Thus,

a) Promotion of medication reconciliation in primary care is the essential starting point
b) Centralized provincial medication list repository is the long term goal

Sharing Experiences
Questions?

www.hqontario.ca