Hospital to Home

Facilitating Medication Safety at Transitions

A Toolkit for Healthcare Providers

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Patient Stories

Identified by home visiting pharmacists

After discharge, an elderly patient's caregiver daughter gave her a newly prescribed antihypertensive medication alongside her regular medications. Two of her home medications had been discontinued in hospital, but **these changes were not communicated to the daughter**. She was only given a prescription for the new medications.

A patient was admitted for an upper gastrointestinal bleed and possible stroke. A computer discharge prescription was generated, signed, and given to the patient. One critical medication prescribed was not covered by the provincial drug plan, so **the patient decided to not pick it up due to cost**. Fortunately, the home visiting pharmacist intervened 5 days after discharge so that patient would receive the appropriate and necessary treatment.

Once home from the hospital, Mrs. M resumed the medications she was taking prior to hospitalization. She was given new bag of medications from the hospital, but decided not to take them – after all, **no one explained why she needed to make any changes** to her regimen.

Many gaps and breakdown points are evident with medication transitions.

MEDICATION RECONCILIATION is a key component to clearly communicating medications at discharge. But it is just a starting point.

Leverage medication reconciliation as an opportunity to enhance medication safety:

- Review for appropriateness
- Streamline or simplify the regimen
- Assess patient and caregiver understanding
- Delivering appropriate counseling

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SOLUTIONS are required

Rationale for creating a toolkit and medication safety checklist at transitions:

- Reduces conflicting information on discharge documents
- Engages patient in the plan
- Identifies reasons for non-adherence prior to going home
- Connects the patient with primary care prescriber for appropriate medication follow-up

Step 1:

Define and identify patients at risk for a medication-related readmission

Patients at risk of a medication-related readmission:

- Taking 5 or more medications
- Multiple medication changes while in hospital
- Taking high-risk medications
- Previously hospitalized for an adverse drug reaction
- Over 75 years of age
- Limited care supports at home
- If non-adherence would cause therapeutic failure

Step 2:

Involve the entire care team

- Enlist team members
- Assign roles to each player
- Involve pharmacists for complex patients
- Handover to community partners

Key Players - Roles and Responsibilities

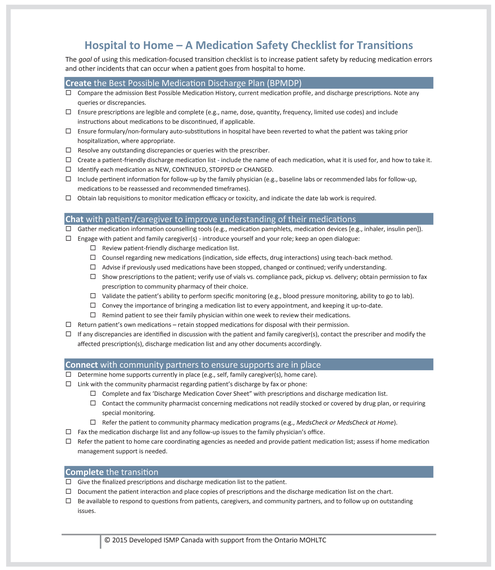
Transitioning patients from hospital to home is an interdisciplinary process. Below is a chart outlining some of the steps required with medications at transition – and those involved with the activity. It is important that everyone understands their role and responsibilities. It is recommended that hospitals map out their current discharge process to determine if activities need to be added or realigned to a more appropriate staff member.

Activity	Prescriber	Registered Nurse	Pharmacist	Pharmacy Technician	Discharge Planner	Support Staff
Notifying team of upcoming discharge		X			X	X
Generating discharge reports (e.g., prescriptions, patient friendly medication lists)	X	X	X	X	X	X
Ensuring prescription are complete (limited use codes, frequencies, quantities)	X		X			
Comparing the medication sources to identify discrepancies to be resolved	X	X	X	X	X	
Creating a patient-friendly medication list		X	X	X	X	X
Addressing concerns identified with patient or prescriptions with prescriber		X	X		X	
Dialoguing with the patient about medications	X	X	X		X	
Completing a final check to ensure no conflicting information between prescription, verbal instructions and written medication list	X	X	X		X	
Implementing post discharge follow-up care (e.g., referrals to CCAC, MedsCheck)	X	X	X		X	
Faxing documents – to home care, community pharmacist, family doctor						X

Step 3:

Follow the Checklist

This checklist identifies the key process to facilitate the transition of patients and their medications safely home.



Hospital to Home – A Medication Safety Checklist for Transitions

The *goal* of using this medication-focused transition checklist is to increase patient safety by reducing medication errors and other incidents that can occur when a patient goes from hospital to home.

Create the Best Possible Medication Discharge Plan (BPMDP)

- ☐ Compare the admission Best Possible Medication History, current medication profile, and discharge prescriptions. Note any queries or discrepancies.
- ☐ Ensure prescriptions are legible and complete (e.g., name, dose, quantity, frequency, limited use codes) and include instructions about medications to be discontinued, if applicable.
- ☐ Ensure formulary/non-formulary auto-substitutions in hospital have been reverted to what the patient was taking prior hospitalization, where appropriate.
- ☐ Resolve any outstanding discrepancies or queries with the prescriber.
- ☐ Create a patient-friendly discharge medication list - include the name of each medication, what it is used for, and how to take it.
- ☐ Identify each medication as NEW, CONTINUED, STOPPED or CHANGED.
- ☐ Include pertinent information for follow-up by the family physician (e.g., baseline labs or recommended labs for follow-up, medications to be reassessed and recommended timeframes).
- ☐ Obtain lab requisitions to monitor medication efficacy or toxicity, and indicate the date lab work is required.

Chat with patient/caregiver to improve understanding of their medications

- ☐ Gather medication information counselling tools (e.g., medication pamphlets, medication devices [e.g., inhaler, insulin pen]).
- ☐ Engage with patient and family caregiver(s) - introduce yourself and your role; keep an open dialogue:
  - ☐ Review patient-friendly discharge medication list.
  - ☐ Counsel regarding new medications (indication, side effects, drug interactions) using teach-back method.
  - ☐ Advise if previously used medications have been stopped, changed or continued; verify understanding.
  - ☐ Show prescriptions to the patient; verify use of vials vs. compliance pack, pickup vs. delivery; obtain permission to fax prescription to community pharmacy of their choice.
  - ☐ Validate the patient's ability to perform specific monitoring (e.g., blood pressure monitoring, ability to go to lab).
  - ☐ Convey the importance of bringing a medication list to every appointment, and keeping it up-to-date.
  - ☐ Remind patient to see their family physician within one week to review their medications.
- ☐ Return patient's own medications – retain stopped medications for disposal with their permission.
- ☐ If any discrepancies are identified in discussion with the patient and family caregiver(s), contact the prescriber and modify the affected prescription(s), discharge medication list and any other documents accordingly.

Connect with community partners to ensure supports are in place

- ☐ Determine home supports currently in place (e.g., self, family caregiver(s), home care).
- ☐ Link with the community pharmacist regarding patient's discharge by fax or phone:
  - ☐ Complete and fax "Discharge Medication Cover Sheet" with prescriptions and discharge medication list.
  - ☐ Contact the community pharmacist concerning medications not readily stocked or covered by drug plan, or requiring special monitoring.
  - ☐ Refer the patient to community pharmacy medication programs (e.g., *MedsCheck or MedsCheck at Home*).
- ☐ Fax the medication discharge list and any follow-up issues to the family physician's office.
- ☐ Refer the patient to home care coordinating agencies as needed and provide patient medication list; assess if home medication management support is needed.

Complete the transition

- ☐ Give the finalized prescriptions and discharge medication list to the patient.
- ☐ Document the patient interaction and place copies of prescriptions and the discharge medication list on the chart.
- ☐ Be available to respond to questions from patients, caregivers, and community partners, and to follow up on outstanding issues.

Step 4:

Refer for Follow-Up

Remember to refer patients for follow-up with their community pharmacist (MedsCheck Follow-up or a MedsCheck at Home) or their primary care provider to ensure they are able to put their new medication regimen into action.

To access the toolkit and checklist go to www.ismp-canada.org/transitions/

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