Getting Started with Medication Reconciliation in Acute Care

SHN! MedRec National Call
September 29, 2010

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Welcome!

By the end of this teleconference, participants will:

- Understand the key concepts in getting started in medication reconciliation in acute care.

- Learn about available resources and supports to get started with implementation.

- Hear about lessons learned in last 5 years from acute care

- Be ready to start!

Webex Tools Available

- Recording

- Use Chat

- Listen there will be questions

- Yes   No

- Emoticons

- Pointer

- Mute

ISMP CANADA

Independent nonprofit Canadian organization

Dedicated to reducing preventable harm from medications.

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SHN Medication Reconciliation Teams

Currently:

Acute Care: 340

Long Term Care: 106

Home Care: 30

Total = 476 SHN Canadian Teams

What is Medication Reconciliation (MedRec)?

A formal process in which healthcare professionals partner with patients to ensure accurate and complete medication information transfer at interfaces of care

- It is designed to prevent potential medication errors and adverse drug events.

- BPMH is the fundamental cornerstone of the MedRec.

The Case for Medication Reconciliation

- 2005 Canadian study
- "53.6% of 151 patients (>4 meds) had at least one unintended discrepancy. 38.6% had potential to cause moderate to severe discomfort or clinical deterioration"

Cornish PL, Knowles SR, Marcheso R, Tam V, Shadowitz S, Juurlink DN, Etchells EE. Unintended medication discrepancies at the time of hospital admission. *Arch Intern Med.* 2005;165:424-429.

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The Case

- 2004 study, Forster et.al., found "23% incidence of adverse events in patients discharged from internal medicine service, of which 72% were ADEs"

REF: Forster AJ, Clark HD, Menard A, Dupuis N, Chernish R, et. al., Adverse events among medical patients after discharge from hospital. *Can Med Assoc J.* 2004;170(3):345-349.

Vira, T

- Out of 60 patients, 60% of patients had at least one unintentional discrepancy.

- 18% had at least one clinically important discrepancy.

- 75% of the clinically important discrepancies were intercepted by medication reconciliation before patient was harmed.

Vira T, Colquhoun M, Etchells EE. Reconcilable Differences: Correcting medication errors at hospital admission and discharge. Qual Saf Healthcare 2006:000:1-6

The Goal

- **The goal of medication reconciliation is to eliminate:**

  - **Undocumented <u>intentional</u> discrepancies**

  - **<u>Unintentional</u> discrepancies**

  - **Potential Harm to patients**

Why is there a problem?

- Low priority, no clear owner

- Lack of understanding of the problem and potential impact

- No standardized process

- Patients do not know how important it is to know what they are taking

How Do We Do This?

1. Secure Leadership Commitment

2. Form a team

3. Collect Baseline Data

4. Set Aims (Goals and Objectives)

5. Start with small tests of change and learn what will work in your site

6. Continue to implement, measure results and spread the changes

7. Continually evaluate

1. Leadership

- Establish clear goals

- Identify executive sponsor

- Identify and remove potential barriers

- Allocate dedicated resources

- Develop a framework for monitoring and evaluation

- Communicate results continuously with front line staff

2. The Team

- Clinical leaders: physicians, nursing and pharmacy staff

- Front line caregivers from key settings of care, and from all shifts

- Representatives from patient safety (e.g. Patient Safety Officer, Quality Improvement/Risk Management, Patient Representatives, Pharmacy and Therapeutics committee)

Conceptual Framework

- PMH – primary medication history

- AMO – admission medication orders

- BPMH – best possible medication history

- Discrepancies – <u>intentional</u> & <u>unintentional</u>, documented and undocumented

Best Possible Medication History (BPMH)

A **Best Possible Medication History (BPMH)** is a medication history obtained by a clinician which includes a thorough history of all regular medication use (prescribed and non-prescribed), using a number of different sources of information.

The BPMH is different and more comprehensive than a routine **primary medication history.**

3. Collect Baseline Data – Concurrent Chart Audits

- Identifies patients at 'hazard' while at 'hazard' and immediate actions for improvement can be made.

- *Measures* Discrepancies

  - Mean # undocumented <u>intentional</u> discrepancies

  - Mean # <u>unintentional</u> discrepancies

How to Collect Baseline Data

- **Review medication histories and admission medication orders on 10 - 20 current cases over the course of one week.**

  - Let the normal process of taking a medication history **(primary medication history (PMH)** occur.

  - Get a **best possible medication history (BPMH).**

  - **Compare** the *admission medication orders* (AMO) with the *best possible medication history* (BPMH) to identify any discrepancies.

  - Identify and count <u>Unintentional</u> Discrepancies (the potential for patient harm) and Undocumented Intentional Discrepancies

  - Clarify discrepancies with the ordering or most responsible physician

Intentional Discrepancy

An *intentional discrepancy* is one in which the physician has made an intentional choice to add, change or discontinue a medication and their choice is clearly documented. This is considered to be 'best practice' in medication reconciliation.

<u>Undocumented</u> <u>Intentional</u> Discrepancy

An *<u>undocumented</u> <u>intentional</u> discrepancy* is one in which the physician has made an intentional choice to add, change or stop a medication but this choice is not clearly documented.

An Unintentional Discrepancy

An _unintentional discrepancy_ is one in which the physician unintentionally changed, added or omitted a medication the patient was taking prior to admission.

Example of the Individual BPMH Record and Audit Tool

Individual BPMH Record and Audit Tool
Use the results to compete the measurement worksheets

Implementation Stage:		
☐ Baseline ☐ Early implementation ☐ Full implementation		Patient Identification
Patient Sample:		

INSTRUCTIONS:

- A clinical pharmacist or designate compiles the Best Possible Medication History (BPMH) based on patient interview, medication vial review, patient medication list, community pharmacist, family physician, etc. .
- Compare the BPMH to all prescription medication ordered (AMOs) for this patient within the first 24 hours of the index hospital stay. This includes new medications.
- To complete the BPMH Discrepancy columns for each medication, check the appropriate box. Type 0= NO discrepancy; Type 1= Intentional discrepancy; Type 2= Undocumented Intentional Discrepancy; Type 3= Unintentional Discrepancy and comment as applicable.
- For all additional medications found during the BPMH process, and not captured on AMO, note '**ADDITIONAL' at the end of the list, record medications and score discrepancies appropriately.

Best Possible Medication History (BPMH) Medication name, dose, route & frequency (prescription meds only)				NO discrepancy	Intentional Discrepancy	Undocumented Intentional Discrepancy	Unintentional Discrepancy	Resolved	Discrepancy Comments
Medication	Dose	Route	Frequency	0	1	2	3		Clarification of discrepancies should be recorded in Patient Record
Digoxin	0.125mg	po	daily	✓				✓	
Enalapril	20 mg	po	bid				✓	✓	Incorrect dose 10 mg bid was ordered
Metformin	500 mg	2 tabs	at brkfst	✓				✓	
Metformin	500 mg	2 tabs	at supper	✓				✓	
Metformin	500 mg	i tab	at lunch		✓			✓	Reduce dose based on blood glucose
ECASA	325mg		qhs	✓				✓	
Temazepam	30 mg	po	daily	✓				✓	
Anuzinc		oint	tid	✓				✓	
Zinc Oxide		oint	to vulva daily	✓				✓	
**ADDITIONAL									
Lactulose	667 mg/mL 30 mL		qhs			✓			
Furosemide	60 mg	po	bid			✓			
BPMH Discrepancy Total				7	1	2	1		
BPMH Discrepancy Type				0	1	2	3		

Type 1= Intentional discrepancy - physician has made an intentional choice to add, change or discontinue a medication and is clearly documented.
Type 2= Undocumented Intentional Discrepancy - physician has made an intentional choice to add, change or discontinue a medication but this choice is not clearly documented.
Type 3= Unintentional Discrepancy - physician unintentionally changed, added or omitted a medication the patient was taking prior to admission.

22

Share your baseline data!!!

- Your stories generate commitment

- Your examples generate support for resources and changing the process

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Improving our Medication Reconciliation Process:
A Safer Healthcare Now! Initiative

Issue #1: JUNE 2007

A RQHR Story: Mrs. K was admitted pre-operatively in preparation for a mastectomy. Upon admission Mrs. K was asked about the prescription medications she was taking at home. During the operation Mrs. K began to bleed profusely, resulting in a critical situation, requiring a significant amount of blood products. There was no indication in the chart that Mrs. K was taking any type of medication that would thin her blood. The surgical team was able to manage the blood loss and finished the surgery. After the surgery the surgeon shared with her what had happened and explained the confusion. Mrs. K shared that she was taking several herbal products, and upon further investigation it was found that one product significantly thins the blood.

What is Medication Reconciliation?
A formal process of obtaining a complete & accurate list of patients' current home medications, including name, dose, frequency & route and comparing to physicians' admission, transfer and/or discharge orders. This list must include herbal products and over-the-counter medications.

Meet the Medication Reconciliation Project Team:

Dr Stewart McMillan: *Department Head, Family Medicine*
Jane Bowman: *Executive Director, Medical Care & Pharmacy Admin*
Murray Wolfe: *Director, Pharmacy Services*
Julie Johnson: *Quality Improvement Consultant*
Don Kuntz: *Team Leader, Pharmacy*
Tricia Engel: *Nurse Manager 4A*
Mary Ellen Gummeson, Nancy Sellers, Denae Elford & Tricia Wilhelm: *Charge Nurses 4A*
Brenda Tunstead & Kathy Massett: *Unit Clerks*
Sandy From: *IT technical expert*

IT'S HERE, IT'S HERE! The system we have all been waiting for: The Saskatchewan Pharmaceutical Information Program, or "PIP", has been created to link all community pharmacies in the province. The team will be piloting a consolidated list of prescribed medications available when a patient is admitted to hospital, which will enhance the patient interview upon admission.

Used with Permission From Regina Qu'Appelle Health Region

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4. Set Aims

- E.g. Conduct a BPMH on all patients with greater than 5 medications within 24 hours of admission and reconcile discrepancies

- Reduce the percentage of <u>unintentional</u> discrepancies at admission on pilot unit by 75% in 3 months
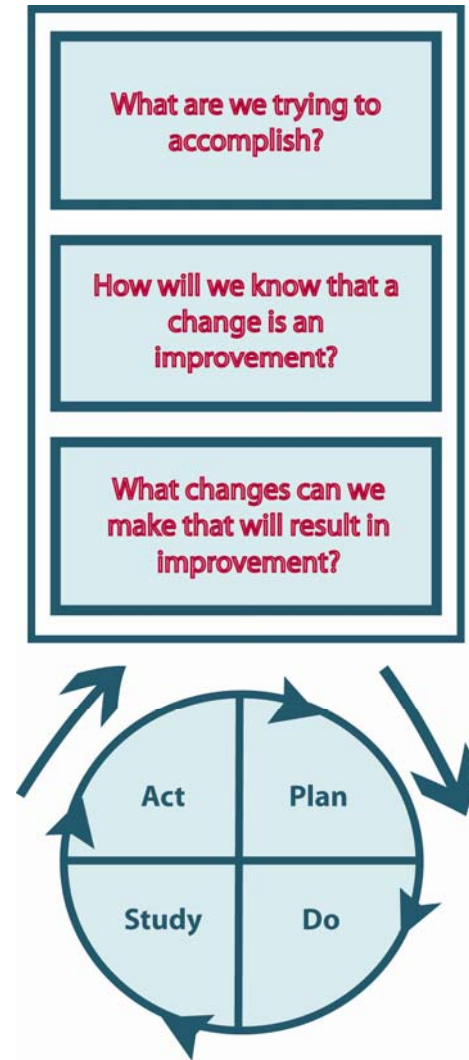
5. Testing Changes

- Suggest start with admission in an appropriate area (e.g. many meds, Emerg.)

- Construct a high level process map

- Decide how your process will work e.g using a medication reconciliation form

- Continue testing and changing to ensure that a reliable process is designed

6. Roll Out

- **Pilot Test**
  - PDSA Model for Improvement

- **Implement** –
  - Define patient groups
  - Define criteria
  - Test tools

- **Spread**

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

Act | Plan
Study | Do

7. Evaluate

- Reconciliation process and measurement process are actually distinct and different activities

- After collecting baseline data, teams measure **after** reconciliation process is complete

- This measures result of reconciliation (are any discrepancies left?)

Med Rec Models

Several similar interdisciplinary practice models or processes possible

Important to distinguish for measurement purposes

1. Proactive Reconciliation
2. Retroactive Reconciliation
3. Hybrid model of 1 and 2

Proactive MedRec Model

Occurs when the BPMH is conducted <u>before </u>writing admission medication orders

STEP 1	STEP 2	STEP 3
BPMH **LEADS TO** →	Admission Medication Orders (AMO)	Verify every medication in BPMH has been assessed by prescriber.
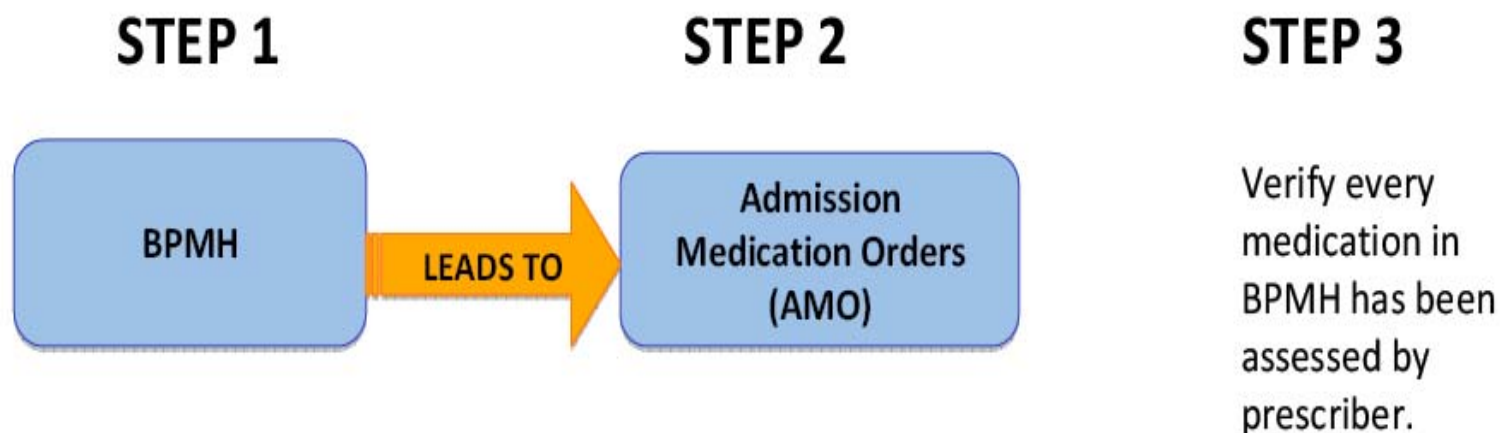
1. Create the BPMH

2. Using the BPMH, admission medication orders (AMOs) are written by the prescriber

3. Verify that the prescriber has assessed every medication on the BPMH, identifying and resolving any outstanding discrepancies with the prescriber

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Retroactive MedRec Model

occurs when the BPMH along with formal admission reconciliation occurs <u>after</u> admission medication orders are written

STEP 1	STEP 2	STEP 3	STEP 4
Primary Medication History	**LEADS TO** → Admission Medication Orders (AMO)	BPMH	Compare BPMH with AMOs and resolve any discrepancies
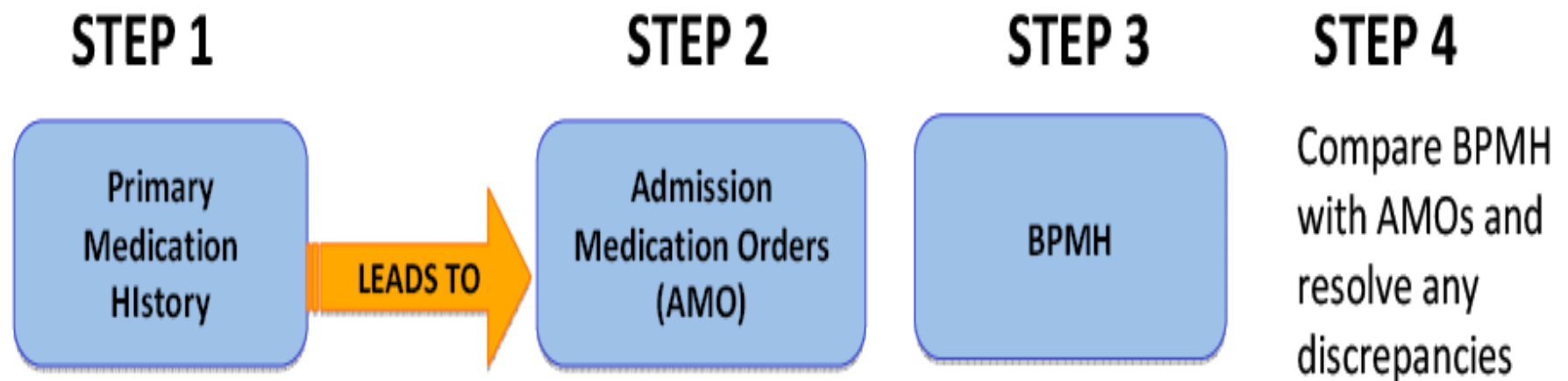
Primary medication history is taken

1. AMOs are written by prescriber

2. Create the BPMH

3. Compare the BPMH against the patient's AMOs, identify and resolve discrepancies

When should you measure ?
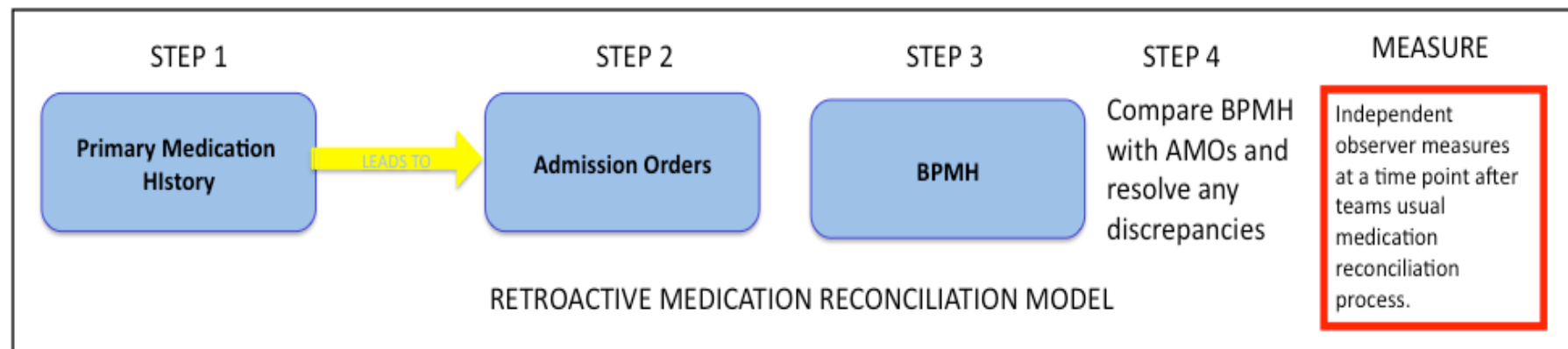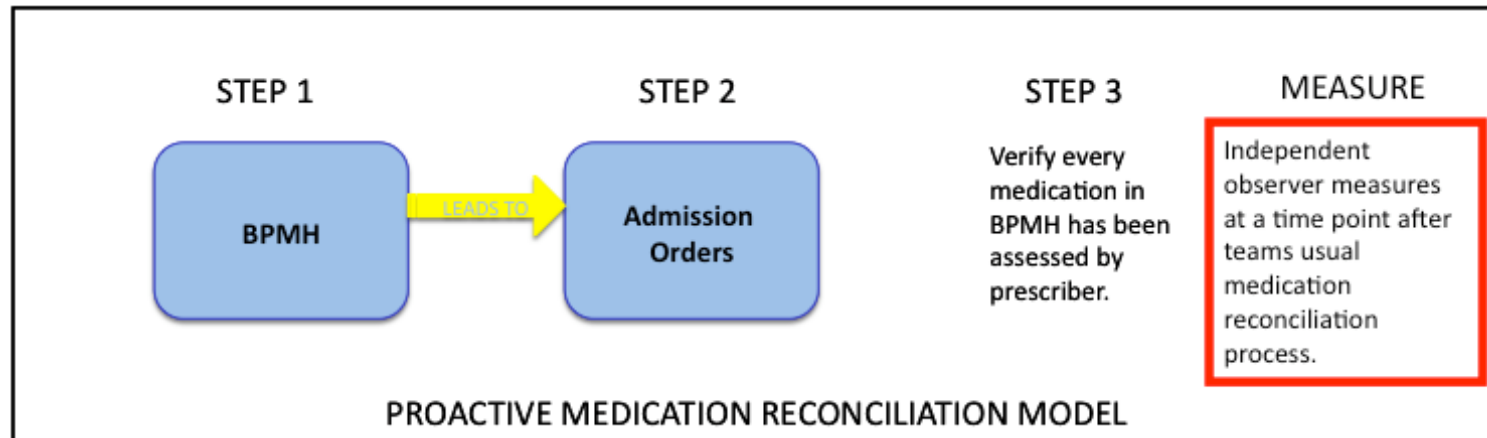
Core Measures
for Acute Care

1. Percentage of Patients reconciled at admission (Aligned with Accreditation Canada)
2. Mean number of undocumented intentional discrepancies per patient
3. Mean number of unintentional discrepancies per patient

Measures 2,3 are collected monthly until teams have reached and maintained goal for 6 months. focus on measure 1.

How long are discrepancies measured?

- At **baseline** the comparison of BPMH and orders **prior** to reconciliation

- When process is changed discrepancies are measured **AFTER** medication reconciliation has occurred thus ensuring the quality of reconciliation

- There should no longer be discrepancies and measures the quality of the medrec.

- When success is achieved, change to measuring % reconciled.

New! Sampling for MedRec Indicators

- Teams in each service area should collect data for a sample of 20 charts per month.

- If the number of admissions to the service area is less than 20, teams should collect data for all admissions.

- Larger service areas may choose to review more charts each month depending on patient volumes. Charts reviewed should be taken from a random sample.

Target Populations for MedRec Indicators

- If organizations are not able to conduct medication reconciliation for all clients, they are permitted to select target populations of clients for formal medication reconciliation at admission.

- Defined target populations are shown on Accreditation Canada's organizational portal, and are based on evidence, e.g. risk, volume.

- Target populations of clients may not be applied to the denominator. This will permit valid comparisons and trending over time for performance measure data.

Emergency Department

- Formal medication reconciliation is implemented for clients with a decision to admit.

Run Charts

- Improvement takes place over time.

- Run charts are graphs of data over time and are one of the single most important tools in performance improvement.

  "You can't change what you can't measure"

  – A Banker

Benefits of Run Charts

- Help improvement teams formulate aims by depicting how well (or poorly) a process is performing

- Help in determining when changes are truly improvements by displaying a pattern of data that you can observe as you make changes

- Give direction as you work on improvement and information about the value of the particular changes

Run Chart

- A line graph display of data over time.

- Data kept in time order.

- Helps answer questions:

  - How much variation do we have?

  - Is process changing significantly over time?

  - Has our change resulted in an improvement?

  - Did I hold the improvement?

How Do We Tell If A Change Is An Improvement

- Run charts speak for themselves

- Analyze with probability based rules for evidence of statistically significant change

  - Improvement or degradation

    - Murray, Sandra k. Using Data for Improvement: The Toolkit.

Sample Run Chart

MedRec 2 - Mean Number of **UNINTENTIONAL** Discrepancies
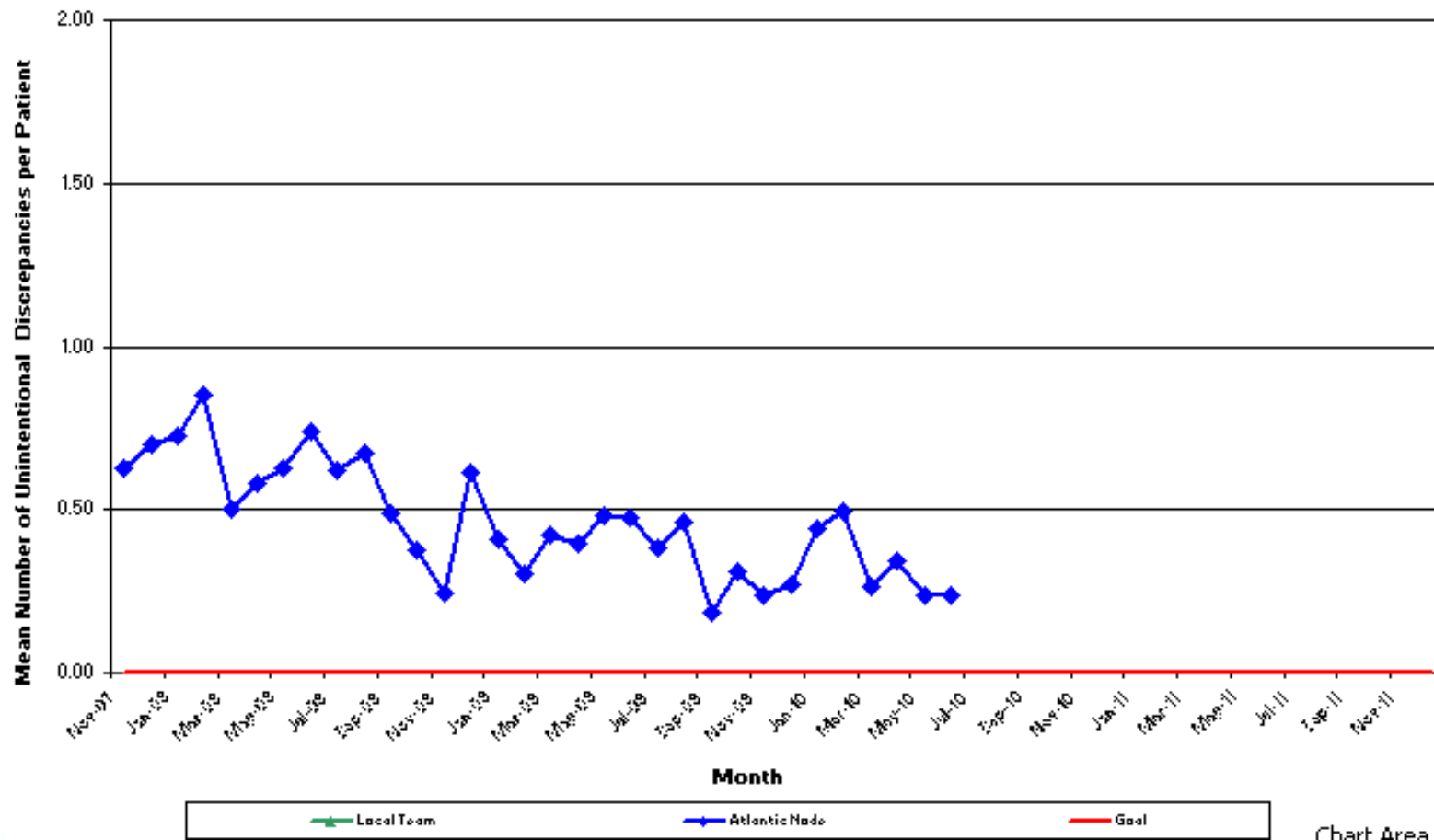
What We've Learned

- MedRec decreases the potential for ADEs

- MedRec requires training

  - Why MedRec?

    - Get your own cases, use your own data

  - How it is done in your organization

  - BPMH training is vital

- People are beginning to expect MedRec

Critical Success Factors

- Get Baseline data

- Share the data

- Use teaching moments

- Create your own stories

- Requires patient/family participation

- Use different health disciplines appropriately
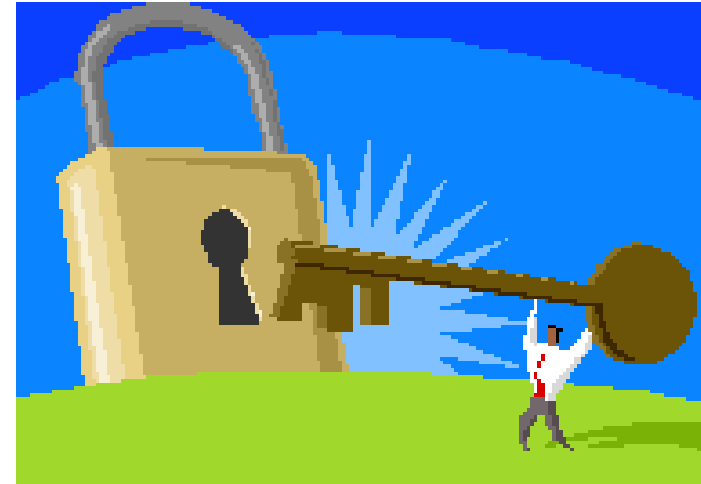
Critical Success Factors cont'd:

- Start small – begin your pilot test with one nurse, one patient, one ordering physician

- Measure results

- Work towards IT solutions

- Embed the medication reconciliation process into normal processes of care and work towards reconciliation forms that result in orders

- Provide documentation tools

Success Stories

- "We are currently undergoing negotiations to move a pharmacist from the distribution system into medication reconciliation.

- This demonstrates leadership to the other teams and commitment and also advances the premises of pharmaceutical care and not only patient safety on med rec but avoiding errors that are drug related that don't fall under the network/net of med rec."

St. Joseph's Health Care London

Medication Form Facilitates Continuity of Care for the Surgical Patient

To minimize drug-related problems upon admission and to ensure the appropriate surgical management of a patient, St. Joseph's Health Care London is using a standardized document to record a patient's home medications as well as the patient's compliance with pre-operative instructions.

This patient medication list is recognized by staff as the primary authoritative source of patient medication information in the patient's chart, incorporating documentation of important surgery-related information that is relevant to the various team members involved in the care of the patient.

The list also contains home medications for all elective surgery patients seen through the Pre-admission Clinic. It integrates documentation of pre-operative instructions provided to the patient regarding their home medications, and any applicable pre-operative anticoagulation and bowel prep protocols. Pre-operative confirmation of medications discontinued before surgery and/or those taken pre-operatively are also recorded on the form in the Surgical Day Care Unit.

The patient medication list allows specific multi-layered documentation of medication-related information on the same form, and functions as an interdisciplinary communication tool. It was designed to be accessible to the different health care professionals involved in the patient's care, following the patient through the system.

Though the patient medication list was developed to address pharmaceutical care issues and continuity of care concerns surrounding the peri-operative management of routine medications, it is very similar in concept to the medication reconciliation model, where a "best possible medication history" is also used to verify and validate admission orders.

Success Stories

47

LEAMINGTON DISTRICT MEMORIAL HOSPITAL

Your Hospital
Your Health
- Our Priority!

From Hospital to Community: Discharge Prescription Form for Continuity of Care

When a patient's medication changes during his or her hospital stay, retail pharmacies and family physicians are not always kept informed. But Leamington District Memorial Hospital is closing this information gap by implementing the use of a Seamless Discharge Prescription (SDRx) form.

The project involved creating a form on which the patient's current medications are documented at the time of admission. The same form is used upon discharge to ensure that all medications are listed, either for continuation or discontinuation. The form also documents the addition of new medications and serves as the prescription to be filled at the pharmacy. A copy of the SDRx is also sent to the family physician, improving the information flow between the patient's health care providers.

Before using the SDRx form throughout the hospital, the project team first researched available discharge forms and created a pilot form that was later revised based on feedback. With a working form in order, retail pharmacies and family physicians were sent letters explaining the initiative. In March 2005, the SDRx form was introduced hospital wide.

To date, Leamington District Memorial Hospital has found the use of the SDRx form helpful in streamlining the prescription writing process for the discharging physicians, improving the continuity of care by addressing each of a patient's medications from admission to discharge, and improving the information flow from the hospital to the family physicians and retail pharmacists in the community it serves.

Success Stories

Filling Information Gaps Increases Medication Safety

Medication errors are a well-documented source of injury to hospital patients, and often, the gaps in patient information are to blame. At Markham Stouffville Hospital, staff undertook an initiative to reconcile patients' medications with their histories in an effort to tackle this problem.

Medication reconciliation is the collection of information regarding medication regimens taken at home and comparing those to medication orders received for patients at all interfaces of care, such as at admissions, during transfers and at the time of discharge.

When a team at the hospital conducted a study to discover the effect a medication reconciliation tool could have on its patients, it was surprised by the results. The study showed significant variances when reconciling these medication differences, namely more than 50% of patients had at least one medication variance upon being admitted to hospital.

What began as a paper document for the collection and documentation of medication histories eventually became part of the hospital's electronic patient chart. With this tool, pharmacists can easily verify medication histories on patients admitted to general medicine and intensive care via the emergency department, confirming the history obtained by the nurse or physician. These histories are then reconciled with orders written by the physician.

So far, the tool has facilitated the hospital's continuity of care and reduced the time spent on reconciling medications for patients being discharged. Medication reconciliation continues to be a valuable tool for patient safety at Markham Stouffville Hospital, allowing staff to successfully and precisely identify instances of therapeutic inadequacy, duplication or error.

Markham Stouffville Hospital

Success Stories

MEDICINE MATTERS

Because patient safety is a top priority at the Stollery Children's Hospital, it is important for us to know what medicines your child takes at home. Remember, medicine matters.

My child does take medicine at home. What should I do?

- A short chat with the pharmacist is all that is required. A pharmacist will visit you and your child within a day of admission to hospital.
    - Tell the pharmacist what medicines or remedies your child is taking.
    - It is important to include ALL medicines – those prescribed by a doctor and those you have bought yourself. Some examples are:
        - prescription medications
        - non-prescription medicines like Tylenol, Sudafed or Robitussin
        - dietary supplements like vitamins, natural or herbal remedies and alternative therapies like acupuncture
    - The pharmacist will also want to know if your child has any allergies, especially to medicines
- The pharmacist will then prepare a list of these medications for your child's chart.
- The list will be available for all healthcare team members to use throughout your child's hospital stay.
    - The list will help ensure that your child receives the correct medicines.

When do I meet with the pharmacist?
Please be in your child's room around _____ AM/PM on _____.
                                            (Time)   (Date)

For more information, please talk to a member of your child's healthcare team.

Enroll Today

http://www.saferhealthcarenow.ca/EN/enroll/Pages/ParticipantSignup.aspx

Join SHN Communities of Practice

Getting Started Kit
Medication Reconciliation in
Acute Care
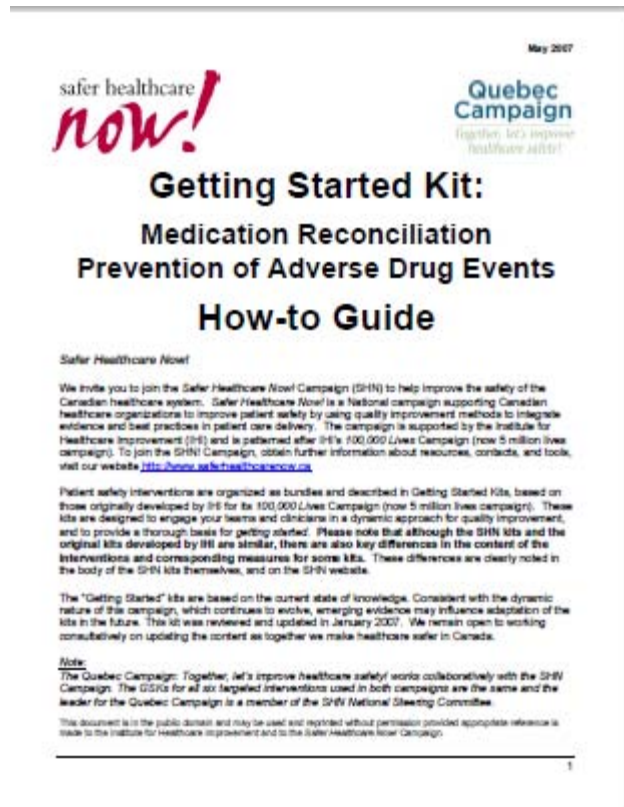
- Step-by-step guide to the process

- Model for Improvement

- Tools and Tips

- Samples

- Website: www.saferhealthcarenow.ca

SHN Mentorship Program

- **Mentorship program** links successful teams to teams that require assistance with their programs

- Facilitates a one-on-one institution partnerships with teams/ institutions that have learnings/successes they can share to mentor other teams

- **Mentorship program** links successful teams to teams that require assistance with their programs

Contact us if you are interested in participating

BPMH Resources

Top 10 Practical Tips

How to Obtain an Efficient, Comprehensive and Accurate Best Possible Medication History (BPMH)

1 **Be proactive.** Gather as much information as possible prior to seeing the patient. Include primary medication histories, provincial database information, and medications vials/ lists.

2 **Prompt questions about non-prescription categories:** over the counter drugs, vitamins, recreational drugs, herbal/traditional remedies.

3 **Prompt questions about unique dosage forms:** eye drops, inhalers, patches, and sprays.

4 **Don't assume patients are taking medications according to prescription vials** (ask about recent changes initiated by either the patient or the prescriber).

5 **Use open-ended questions:** ("Tell me how you take this medication?").

6 **Use medical conditions as a trigger** to prompt consideration of appropriate common medications.

7 **Consider patient adherence with prescribed regimens** ("Has the medication been recently filled?").

8 **Verify accuracy:** validate with at least two sources of information.

9 **Obtain community pharmacy contact information:** anticipate and inquire about multiple pharmacies.

10 **Use a BPMH trigger sheet** (or a systematic process / interview guide). Include efficient order/optimal phrasing of questions, and prompts for commonly missed medications.

Adapted with permission from O. Fernandes PharmD, University Health Network, 2008

Medications: More Than Just Pills

Prescription Medicines

These include anything you can only obtain with a doctor's order such as heart pills, inhalers, sleeping pills.

Over-The-Counter Medicines

These include non-prescription items that can be purchased at a pharmacy without an order from the doctor such as aspirin, acetaminophen, laxatives, other bowel care products, **herbs** like garlic and Echinacea or **vitamins** and **minerals** like calcium, B12 or iron.

DON'T FORGET THESE TYPES OF MEDICATIONS

Eye/Ear Drops	Inhalers	Nasal Spray	Patches

Liquids	Injections	Ointments/Cream

Prompt the patient to include medicines they take **every day** and also ones taken **sometimes** such as for a cold, stomachache or headache.

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Adapted from Vancouver Island Health Authority

Best Possible Medication History Interview Guide

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Prevent Adverse Drug Events through Medication Reconciliation

Introduction

- Introduce self and profession.
- I would like to take some time to review the medications you take at home.
- I have a list of medications from your chart/file and want to make sure it is accurate and up to date.
- Would it be possible to discuss your medications with you (or a family member) at this time?
  - Is this a convenient time for you? Do you have a family member who knows your medications that you think should join us? How can we contact them?

Medication Allergies

- Are you allergic to any medications? If yes, what happens when you take (allergy medication name)?

Information Gathering

- Do you have your medication list or pill bottles (vials) with you?
- *Use show and tell technique when they have brought the medication vials with them*
  - How do you take (medication name)?
  - How often or When do you take (medication name)?
- *Collect information about dose, route and frequency for each drug. If the patient is taking a medication differently than prescribed, record what the patient is actually taking and note the discrepancy.*
- Are there any prescription medications you (or your physician) have recently stopped or changed?
- What was the reason for this change?

Community Pharmacy

- What is the name and location of the pharmacy you normally go to? *(Anticipate more than one).*
  - May we call your pharmacy to clarify your medications if needed?

Over the Counter (OTC) Medications

- Do you take any medications that you buy without a doctor's prescription? *(Give examples, i.e., Aspirin).* If yes, how do you take (OTC medication name)?

Vitamins/Minerals/Supplements

- Do you take any vitamins (e.g. multivitamin)? If yes, how do you take (vitamins name(s))?
- Do you take any minerals (e.g. calcium, iron)? If yes, how do you take (minerals name(s))?
- Do you use any supplements (e.g. glucosamine, St. John's Wort)? If yes, how do you take (supplements name(s))?

Eye/Ear/Nose Drops

- Do you use any eye drops? If yes, what are the names? How many drops do you use? How often? In which eye?
- Do you use ear drops? If yes, what are the names? How many drops do you use? How often? In which ear?
- Do you use nose drops/nose sprays? If yes, what are the names? How do you use them? How often?

Inhalers/Patches/Creams/Ointments/Injectables/Samples

- Do you use inhalers?, medicated patches?, medicated creams or ointments?, injectable medications (e.g. insulin)? For each, if yes, how do you take (medication name)? *Include name, strength, how often.*
- Did your doctor give you any medication samples to try in the last few months? If yes, what are the names?

Antibiotics

- Have you used any antibiotics in the past 3 months? If so, what are they?

Closing

This concludes our interview. Thank you for your time. Do you have any questions?

If you remember anything after our discussion please contact me to update the information.

Note: *Medical and Social History, if not specifically described in the chart/file, may need to be clarified with patient.*

Adapted from University Health Network

Together we will reduce potential adverse outcomes of care related to medications

Questions?