Getting Started with Medication Reconciliation in Long Term Care

SHN! MedRec Teleconference
September 14, 2010
1200-1300 EST
Welcome!

By the end of this teleconference, participants will:

• Understand the key concepts in medication reconciliation in long-term care.

• Learn how to access the available resources and supports to get started with implementation.

• Gain insight from long-term care teams who have started medication reconciliation and learn how they are doing it.

• Have fun!
Our Guest Speakers

• Jeanette Cameron R.N – Inverary Manor - Director of Resident Care

• Jo-Anne Thompson R.N - South Eastman region – Patient Safety Officer

• Renee Claire Fox R.N - Quality and Risk Management at the Health and Social Services Centre Jeanne-Mance
Getting Started with Medication Reconciliation in Long Term Care

Margaret Colquhoun, R.Ph., B.Sc.Phm., FCSHP
SHN Intervention Lead Medication Reconciliation Project Leader ISMP Canada
SHN Medication Reconciliation Teams

Currently:

Acute Care: 340
Long Term Care: 106
Home Care: 30

Total = 476 SHN! Canadian Teams
Medication Reconciliation in LTC

Medication Reconciliation in long-term care is a formal process of:

- At admission, obtaining a complete list of each resident’s current (and pre-admission medications if coming from acute care) – including name, dosage, frequency and route (BPMH).

- Using the BPMH to create admission orders or comparing the list against the resident’s admission orders, identifying and bringing any discrepancies to the attention of the prescriber for resolution.

- Any resulting changes in orders are documented and communicated to the relevant providers of care and resident or family member wherever possible.
Case for Med Rec in LTC

• In a 2004 study by Boockvar the incidence of ADEs caused by medication changes at transfer between facilities was 20%.

• ADEs due to medication changes occurred most often upon transfer from the hospital back to the LTC facility.

• Incomplete or inaccurate communication between facilities was identified as a potential factor in these occurrences.

Case for Med Rec in LTC

• Incomplete or inaccurate medication information is a critical issue reflected in a growing number of LTC studies. A 2007 survey of continuing care nurses and pharmacists in Alberta found:
  • **75%** of the time medication information was NOT legible and complete
  • **90%** of the time information was NOT available to tell if the prescribed medications were appropriate for the resident’s diagnoses.
  • **40%** of the time medication information DID NOT arrive the same day as the resident’s admission.

Earnshaw, K et. al. Perspectives of Alberta Nurses and Pharmacists on Medication Information Received. July 29, 2007
MEDICATION RECONCILIATION
From Admission to Discharge in Long-Term Care

1. 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

2. 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

3. 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

Proactive MedRec Model

Occurs when the BPMH is conducted before writing admission medication orders

**STEP 1**
- Create the BPMH

**STEP 2**
- Using the BPMH, admission medication orders (AMOs) are written by the prescriber
- Verify that the prescriber has assessed every medication on the BPMH, identifying and resolving any outstanding discrepancies with the prescriber

**STEP 3**
- Verify every medication in BPMH has been assessed by the prescriber.

Used with permission from High 5s: Action on Patient Safety Medication Reconciliation Getti.
Getting Started Kit
Medication Reconciliation in Long-Term Care

• Step-by-step guide to the process
• Model for Improvement
• Tools and Tips
• Samples from Canadian teams
• Website: www.saferhealthcarenow.ca
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.

Adapted from Vancouver Island Health Authority
Introduction
- Introduce self and profession.
- 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 (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
Enroll Today

http://www.saferhealthcarenow.ca/EN/enroll/Pages/ParticipantSignup.aspx
Join SHN Communities of Practice
Critical Success Factors

• Get Baseline data
• Share the data
• Use teaching moments
• Create your own stories
• Requires resident/family participation
• Use different health disciplines appropriately
Most Current Medication List and Transfer/Discharge Orders

Jeanette Cameron RN, BScN (Director Resident Care)
Debbie Le Lievre RN, BScN (Unit Manager, ER/OR/DEC/SPD/Oncology)
Who We Are

- Inverary Manor is a 60 bed Long Term Care facility. We are located in a rural area of Cape Breton, N.S., directly behind the hospital.

- Inverness Consolidated Memorial Hospital is a 39 bed hospital and a busy Emergency/Ambulatory Care Department, with 16,236 (10,052 ER & 6184 Amb Care) visits per year. (2008-2009 Stats)
Who we are

• The two facilities will soon be connected by a link which will include a new 71 bed LTC facility and renovations to the hospital so this is very exciting for everyone.
To develop a tool to facilitate more efficient and safer transfer of residents from one facility to another. More specifically, transfers from Inverary Manor to Inverness Consolidated Memorial Hospital.
• Inverary Manor was introduced to medication reconciliation for admissions in May, 2008. This has extremely successful and we now needed help with transfers.

• ICMH initiated Medication Reconciliation for Admissions, Transfers and Discharge in February of 2008 as a Required Organizational Practice (ROP) for patient safety, but we needed to expand with LTC.
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• ICMH initiated Medication Reconciliation for Admissions, Transfers and Discharge in February of 2008 as a Required Organizational Practice (ROP) for patient safety, but we needed to expand with LTC.
Goals

To improve communication and documentation between facilities

To decrease the potential for medication misinterpretation and errors

To provide the safest delivery of care to residents
How we got Started

• A workshop was held in May, 2009, facilitated by Safer Healthcare Now Advisor, Dannie Currie.

• This was a collaboration between staff from both facilities which included RN’s, LPN’s, nurse managers and the hospital pharmacist.
Needs Identified

• Hospital staff expressed the need for a clear and concise medication list upon receiving resident.

• Up to this time, Inverary Manor would photocopy MAR sheets to send with resident. Although these were clear to Manor staff, they were confusing to ICMH.
Inverary Manor staff expressed the need for clear discharge medication orders.

• Up to this time, there would be discrepancies from the original med list and it wasn’t always clear if changes were intended or not intended.

• For emergencies, no time to write out a med list, so MARS sent.
• There was wonderful discussion, sharing of ideas and understanding of each others point of view which lead to the development of this new tool.

• Little did we know it was so new and innovative!!
• The following two slides will show the old format that Manor would photocopy the MAR sheets and send with resident. Some residents would have 5-6 sheets which would be very confusing.

• The third slide is the form the hospital would send back to Manor with resident. Very difficult to read the orders!
<table>
<thead>
<tr>
<th>Medication</th>
<th>Times</th>
<th>Initials</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magnolia Magnesium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senokot S</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colace Capsules</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Names' Signature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initials</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
- A - ABSENT
- H - HOLD
- R - REFUSED
- B - DISPENSED/UNSUPERVISED
- P - DAY PROGRAM
- L - LEAVE
- Q - HOSPITAL
|----------------------|-------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
Hospital Medical Report for Local
Re-approval and Re-admission to Homes for Special Care

INSTRUCTIONS: Hospital completes Sections 2 and 3 of this form if any of the following conditions are applicable:
   a) The applicant has not been in the Hospital for more than 30 days and
   b) The applicant has not had a major change in his/her condition, level of functioning, or behavior necessitating a reclassification, etc.

If these conditions do not apply, see a Form A Medical must be completed and submitted to the local Classification Officer. If any disputes regarding this patient, the local Classification Officer must be contacted.

SECTION 1 — To be completed by the Home and to accompany the resident to hospital.

Name of Resident:
Date of Birth:
Health Card:
Type of Care:

SECTION 2 — To be completed by the Hospital at the end of treatment and sent to the Receiving Home with a copy retained by the hospital in order to complete Section 3 after the patient has been re-admitted.

Name of Hospital:

Diagnosis:

Medications Required:

COMPLETE IF AND WHEREVER APPLICABLE:

Date of Surgery:
Date Surgeries to be Removed:

(Please list all past and present surgical procedures and dates of removal if applicable)

(Please list all drugs used to treat the patient's condition)

Date:

Movement Code:

Based on the information provided on this form, the Home has agreed to re-admit the above-mentioned person.

SIGNED FOR THE HOME:

Since this is a combined approval and re-admission form no further re-admission information is to be submitted by the Home.

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What nurses looked like before!
Implementing Form

- Once form was printed, it was circulated to all managers, nursing staff, physicians and pharmacists along with a cover letter on how it came about and how to use it properly.
How list is compiled

• List of medications is taken from the medication sheets and include time of last dose. These are the medications that resident takes daily.

• We are confident this list is current as they are checked monthly when they arrive from pharmacy and any new orders or changes are double checked nightly.
# How it Works

## Inventory Manor

### Most Current Medication List and Transfer/Discharge Orders

File this form with the Physician Orders at Manor. Copy to receiving facility.

<table>
<thead>
<tr>
<th>Weight:</th>
<th>Adverse Reactions:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Most Current Medication List

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Dose/Frequency</th>
<th>Route</th>
<th>Time of Last Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physician Orders: To complete upon discharge from Hospital

<table>
<thead>
<tr>
<th>New Order</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Completed by Sending Facility**

**Completed by Receiving Facility**
How it Works

List compiled by: ____________________________
Date: ____________________ Time: ____________

List reviewed by: ____________________________
Date: ____________________ Time: ____________

Updated by: ________________________________
Date: ____________________ Time: ____________

Prescribing Physician: ______________________
Date: ____________________ Time: ____________

How the form might work:

1. At the home a monthly update of current medication will be compiled by a nurse on the nightshift. The list may be generated and signed by a pharmacy and confirmed by the nurse.
2. Prior to discharge the nurse at the home will copy the list, complete the last dose column and send it to the hospital and signed the list reviewed by
3. When the resident is ready to return to the home the nurse will update the list to indicating if the meds are to continue/discontinue and any changes including new orders and sign the ‘updated by’
4. The physician will review the updated list and prescribe the medication as indicated by signing the form in the ‘prescribing physician’ section.
5. The completed form (new physician orders) will be returned to the nursing home.
6. A new ‘most current’ list will be generated using the information on the form.
## Most Current Medication List

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage/Frequency</th>
<th>Route</th>
<th>Time of Last Dose</th>
<th>Continue</th>
<th>Discontinue</th>
<th>New Order</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metoprolol (0.5 mg)</td>
<td>0.5 mg OD</td>
<td>PO</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>Cardiac CD 12/0</td>
</tr>
<tr>
<td>Atenolol (50 mg)</td>
<td>50 mg PO</td>
<td>PO</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin (EC)</td>
<td>81 mg OD</td>
<td>PO</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td>Cycle 800 1/15</td>
</tr>
<tr>
<td>Tylenol 325 mg</td>
<td>65 mg TD</td>
<td>PO</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prekancer (50 mg)</td>
<td>50 mg PO</td>
<td>PO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorazepam (0.5 mg)</td>
<td>0.5 mg BD</td>
<td>PO</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Steptolol-S</td>
<td>325 mg BD</td>
<td>PO</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Coza Cap (25 mg)</td>
<td>25 mg PO</td>
<td>PO</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Dronedarone (200 mg)</td>
<td>200 mg PO</td>
<td>PO</td>
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<td>✓</td>
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<td>Dopar (20 mg)</td>
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<td>PO</td>
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<td></td>
<td>✓</td>
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<tr>
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<td>PO</td>
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<tr>
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<td>35 mg BD</td>
<td>PO</td>
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<td></td>
<td>✓</td>
<td></td>
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<tr>
<td>Vetricort 0.1%</td>
<td>0.1%</td>
<td>Topical</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
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<tr>
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<td>PO</td>
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<td>PO</td>
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<td>✓</td>
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<td>Dopar (20 mg)</td>
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<td>PO</td>
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<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

**List Compiled:** [24th Jun 2019]
**List Reviewed by:** [24th Jun 2019]
**Updated by:** [24th Jun 2019]
**Prescribing Physician:** [24th Jun 2019]

**Total Page:** 38
What were some barriers?

• There were no real barriers, everyone worked in collaboration and education was provided.

• The form was well received and all comments have been positive, from all Health Care providers.
After the form, a happy nurse!
Things we learned

- One oversight was the prescription of narcotics cannot be filled without duplicate copy so still need separate Rx for those. (Doesn’t occur often)
- This tool has simplified transfers for nurses and physicians but the greatest feeling is working together to provide the best, safest care possible for our residents.
We leave you with a photo of Inverness Beach.
Contact Information

Names: Jeanette Cameron RN, BScN
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902-258-2842

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(902) 258-1934 ext 1133 or (902)258-7616 (cell)
MEDICATION RECONCILIATION

Jo-Anne Thompson RN
Patient Safety Officer
South Eastman Health
There are 11 regional health authorities in Manitoba.
SOUTH EASTMAN RHA

population 66,984
(6% of MB)

Source: Manitoba Health (June 2009)
PERSONAL CARE HOME BEDS

N = 334

St. Adolphe 42
Ste. Anne 66
St. Pierre-Jolys 22
Steinbach 60
Grunthal 40
Vita 44
SOUTH EASTMAN’S MED. REC. STEERING COMMITTEE

Jo-Anne Thompson (Chair) - Patient Safety Officer
Jan Gunness (Executive Sponsor) - Manager of Quality & Corporate Planning
Cecile Dumesnil - Regional Director of Pharmacy
Lothar Dueck – Pharmacist
Dr. S. Migally – Physician
Brenda Barkman – Clinical Resource Nurse (CRN) Rehab Unit
Donna Bella – Home Care Case Coordinator
Charleen Barkman – Staff Development Coordinator-LTC
Shirley Bezditny – Staff Development Coordinator- Acute Care
Tannis Nickel-Director of Nursing (DON) Rest Haven Nursing Home
Public Health, Mental Health (Reps needed)
WHAT ARE WE TRYING TO ACCOMPLISH?

Develop and implement a regional Medication Reconciliation process throughout the continuum of care, which will help prevent medication errors from occurring and reduce the potential for harm to patients.

It has started in Acute Care (Phase I) and will continue to spread to all other areas of service i.e.) Long Term Care, Home Care, Community etc…

Phase II commenced Spring 2009.
Pilot site: Rest Haven Nursing Home.
HOW WILL WE DO THIS?

PDSA (Plan-Do-Study-Act) Improvement Model

**PLAN:** Creating forms that work within South Eastman Health

**DO:** Testing the forms on the pilot sites
- Rest Haven Nursing Home (LTC)

**STUDY:** Evaluating and modifying the forms.

**ACT:** Implementing changes on the forms and planning for the next cycle.
The team is currently performing baseline chart audits in order to measure our successes.

Discrepancies between the home medications and the admission orders are measured.

The goal of the Med.Rec. project is to reduce these discrepancies over time. Ongoing testing will occur at various points of the project to assess the impact of the Med.Rec. process.
WHAT ARE WE MEASURING?

No discrepancies

**Intentional discrepancies** – Physician has made an intentional choice to add, change or discontinue a medication and is clearly documented.

**Undocumented Intentional Discrepancy** – Physician has made an intentional choice to add, change or discontinue a medication but this choice is not clearly documented. i.e) *Nitro-patch put on hold or discontinued but no reason given.* * This captures the accuracy in documentation*

**Unintentional Discrepancy** – Physician unintentionally changed, added or omitted a medication the patient was taking prior to admission. * This reflects the ‘errors’ that inadvertently occur when writing orders.

The primary goal is to eliminate the undocumented intentional and unintentional discrepancies through the medication reconciliation process.
GOAL

The area of focus will be to decrease the mean # of undocumented intentional discrepancies on patients admitted to the hospital & LTC facilities by 75%, as well as the unintentional discrepancies by 75%.
SO HOW DO WE KNOW THAT WE ARE SUCCEEDING?

To know that we are succeeding in LTC the undocumented & unintentional discrepancies will need to meet the set goal line over 6 consecutive months to master this process.

LTC is tracking the percentage of residents reconciled at admission which coincides with Accreditation Canada standards which is 100%.
MedRec-LTC 1 - Mean Number of Undocumented Intentional Discrepancies in LTC

Rest Haven

Month

Mean

Nov 2007
Feb 2008
May 2008
Aug 2008
Nov 2008
Feb 2009
May 2009
Aug 2009
Nov 2009
Feb 2010
May 2010
Aug 2010
Nov 2010
Feb 2011
May 2011
Aug 2011
Nov 2011

Actual
Goal
MedRec-LTC 2 - Mean Number of Unintentional Discrepancies in LTC

Rest Haven

Month

Actual Goal
MedRec-LTC 3 - Percentage of Long-Term Care Residents Reconciled at Admission

Month

Actual
Goal
What Does the Audit results reveal for our 4 sites.

**Medication Reconciliation Baseline Audit**

**February 2008**

<table>
<thead>
<tr>
<th>Chart #</th>
<th>MedRec Process Implemented</th>
<th>MedRec Process NOT Implemented</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No Discrepancy</td>
<td>Intentional Discrepancy</td>
</tr>
<tr>
<td>1</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Med process not used, no nursing Hx and M.D. orders?</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Med process used but no reconciliation done. No discharge process completed.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>Med Rec not completed, patient transferred out.</td>
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<tr>
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<tr>
<td>8</td>
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<td>16</td>
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<tr>
<td>17</td>
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<tr>
<td>18</td>
<td>Patient not on meds.</td>
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<td>19</td>
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<tr>
<td>20</td>
<td>Med Rec not done.</td>
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<td>5</td>
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</tbody>
</table>
POSITIVE GAINS WITH THE PROCESS

Earlier identification of issues with patient home medications

Developed a Medication Risk Assessment Tool used on admission that engages Pharmacists by referral

Increased documentation of allergies

Decreased duplication in recording medication histories (Both for Physician & Nurse)

Improved communication of medication histories to all disciplines

Improved communication to next healthcare provider for changing or not ordering home medications
CHALLENGES

As we progress in spread challenges may present itself. The steering committee team will work on resolving issues on an ongoing basis.

Continuous Education for all new employee’s hired
Team work involves the Patient/Client/Families, Nurses, Physicians and Pharmacists

Working as a team in South Eastman Health we can make a difference by improving patient safety and reducing potential adverse outcomes of care related to medications
REFERENCES

Canadian Patient Safety Institute

Manitoba Institute for Patient Safety

Safer Healthcare NOW!
MEDICATION RECONCILIATION

LONG-TERM CARE

Renée Claire Fox, B.A., M.Sc. Inf.
Sept 14 2010
Health and Social Services
Centre Jeanne-Mance

7 LONG-TERM CARE FACILITIES
1200 beds

3 CLSC
population 138000

Affiliated with the U of Mtl
teaching and research
Objective

- Sharing our journey of medication reconciliation implementation in long-term care
Leadership commitment

- Central clinical planning committee:
  - Associate Director General long-term care
  - Associate Director General community services, public health, teaching and research
  - Director of Nursing
  - Director Professional services, Quality and Risk Management
  - Medical Director
Fundamental question

Planning and implementation in more than 1 sector

Planning and implementation in 1 sector only
Med Rec
Steering Committee

- Nurse clinician
- Representatives long-term care:
  - Nurse
  - Manager
  - Physician
  - Pharmacist
- Representatives home care services:
  - Nurse
  - Manager
  - Physician
  - Pharmacist from community
- Quality and risk management coordinator
- Representatives of specialty areas
  - link with partners, communication, archives, IT
Challenges

- It’s not just about a new form, it’s about changing the way we do things around here.

- Engagement of an Interdisciplinary team

- Participation of community pharmacists

- Information Transfers from acute care

- Information technology

- Organisational context
Considerations for Planning

- Volume of admissions/ transfers
- Nurse/resident ratio
- Time needed to complete BPMH
- Roles: nurse, physician, and pharmacist
- Admission/transfer processes in use before Med Rec
- Present functioning of pharmacies (3)
- Getting doctors on board
- Tools: no duplication, less transcribing
- Types of discrepancies
- Medication profiles from private pharmacies in community and from acute care facilities
- Communication plan
- Link to risk management
Team members

- Pharm. technician
- Pharmacist
- Client
- Nurse
- Physician
Med Rec Model

Proactive process

All admissions

Long-term care

Transfers/discharge
• to home care
• to other long-term care facility
Med Rec Processes

Long-term care

Role: nurse
Role: phys
Role: pharm

Long-term care

admission
transfers
Data collection
Indicators

CLINIBASE

% Med Rec long-term care at admission and transfer/discharge

Data for Board members and management
And the discrepancies?

ACCESS

- Analyse data
- Make recommendations
Measure and evaluation

- Audit tools for:
  - BPMH
  - Reconciliation
Management and spread

- Plan for management to oversee/support Med Rec in each long-term care facility

- Global management plan to spread Med Rec to all long-term cares facilities within Centre Jeanne-Mance
Tools

- Tool for Admission Med Rec
- Tool for clinical information
# Bilan Comparatif des Médicaments à l'Admission

**Sources d'information**

<table>
<thead>
<tr>
<th>S.I. (#)</th>
<th>INFO DU RÉSIDÉNT</th>
<th>LISTE EX ANTÉRIEURES</th>
<th>L.PHARM., COMMUNAUTAIRE</th>
<th>TEL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>INFO DE LA FAMILLE</td>
<td>FÉDÉRALE</td>
<td>FÉDÉRALE</td>
<td>TEL:</td>
</tr>
<tr>
<td>2.</td>
<td>FÉDÉRALE</td>
<td>FÉDÉRALE</td>
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<td></td>
</tr>
<tr>
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<td>FÉDÉRALE</td>
<td>TEL:</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>FÉDÉRALE</td>
<td>FÉDÉRALE</td>
<td>TEL:</td>
<td></td>
</tr>
</tbody>
</table>

## Meilleure Histoire Médicamenteuse Possible (MHMP)

<table>
<thead>
<tr>
<th>S.I. (#)</th>
<th>Médication prescrite ou en vente libre et produits naturels</th>
<th>Dernière dose</th>
<th>Complication</th>
<th>Ordonnances</th>
<th>Ordonnances</th>
<th>BCM</th>
<th>Divergences</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>précisez dose, voie, fréquence</td>
<td></td>
<td></td>
<td>précisez dose, voie, fréquence</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Médication cessée

<table>
<thead>
<tr>
<th>Site</th>
<th>Équipe</th>
<th>Signature de l'infirmière</th>
<th>an/mois/jour/hour</th>
<th>Note complémentaire</th>
<th>Sign. du médecin</th>
<th>matricule</th>
<th>an/mois/jour/hour</th>
<th>Pharmacie</th>
<th>an/mois/jour</th>
</tr>
</thead>
</table>

**Remarques**

- Entrez ici toutes les médicaments et interventions administrées par l'infirmerie.
- Utilisez la rubrique des divergences pour noter toute information importante.

**Nombre de pages**

81
Informations complémentaires à la MHMP à l’admission

(Télétransmission Médicamenteuse Possible)

SAD ☐
URFI ☐
Hébergement permanent ☐
Hébergement temporaire ☐
Date de départ:__________

Poids: ________
Taille: ________
Amputation: ________
Fonte musculaire: ________

Cl créatinine _____ ou créatinine _________ / /  Année mois jour
Nd de créatinine RX ou ____ □

Diagnostics principaux:
Source: CTMHP ☐ Terrible comateux ☐
□ EPC ☐

Compléments:
Préciser les écarts entre l’ordonnance et la prise réelle de la médication et les raisons évoquées par le client

Effets secondaires indésirables:

Allergies :

Particularités :

Médecin traitant au CSSS:

Particularités à l’administration:
- Donner avec de l’eau □
- Donner avec du jus □
- Donner avec confiture □
- Donner avec compote □

Date laissée au service des AE chères:

Informations complémentaires à la MHMP à l’admission

À l’usage du service des AE chirurgiens

Année mois jour
J’ai pris connaissance des informations formelles
□ Médecins □ Pharmaciens □
Questions?