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.

Boockvar K, Fishman E, Kyriacou CK, et al. Adverse events due to discontinuations in drug use and dose changes in patients transferred between acute and Long-term care facilities. Arch Intern Med. 2004;164:545-550

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

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

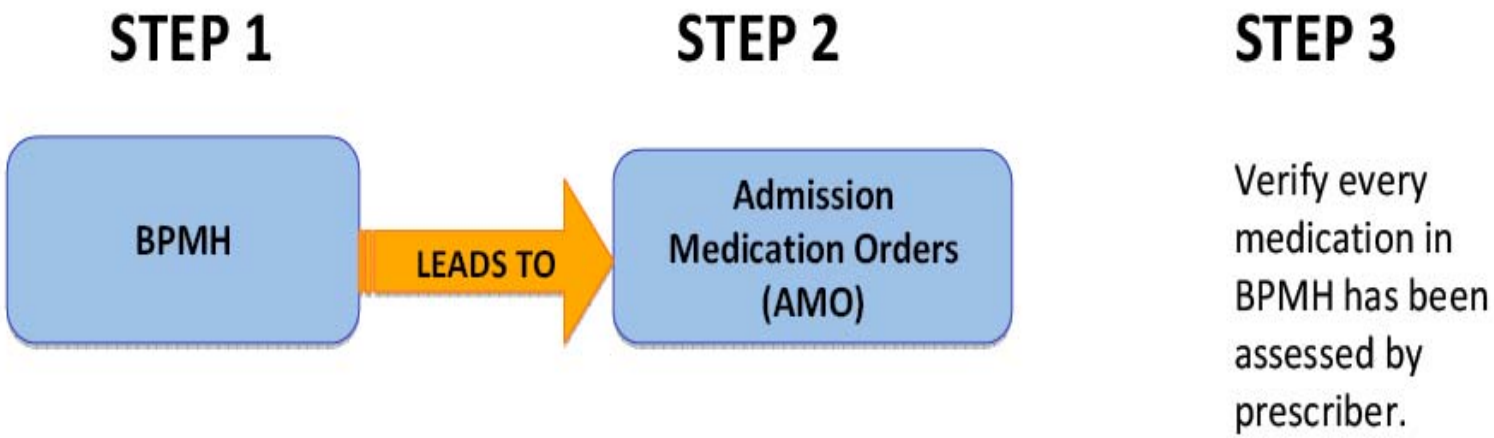
(include new medication orders, adjusted doses and discontinued medications)

to the next care provider

Adapted from Bainsteiner, 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.

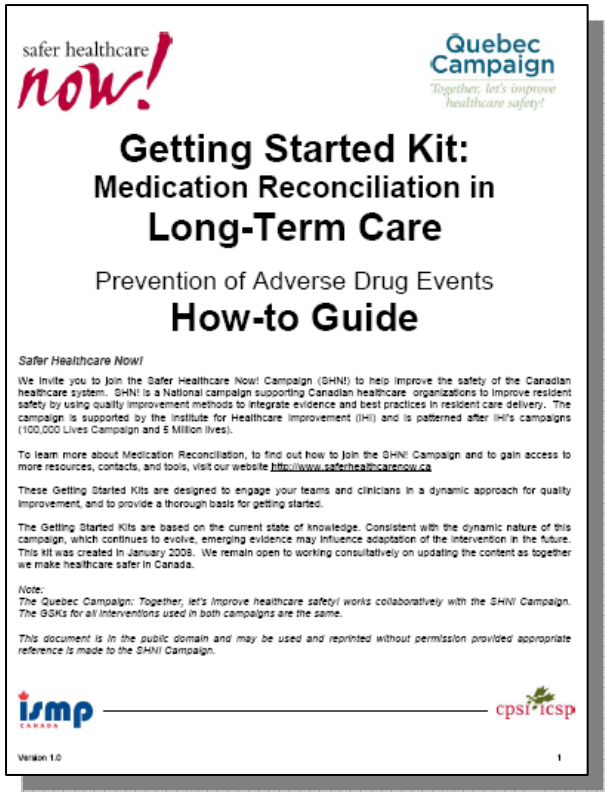
Proactive MedRec Model

Occurs when the BPMH is conducted before writing admission medication orders



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

Getting Started Kit
Medication Reconciliation in Long-Term Care



safer healthcare now!

Quebec Campaign
Together, let's improve healthcare safety!

Getting Started Kit:
Medication Reconciliation in Long-Term Care

Prevention of Adverse Drug Events
How-to Guide

Safer Healthcare Now!

We invite you to join the Safer Healthcare Now! Campaign (SHN!) to help improve the safety of the Canadian healthcare system. SHN! is a National campaign supporting Canadian healthcare organizations to improve resident safety by using quality improvement methods to integrate evidence and best practices in resident care delivery. The campaign is supported by the Institute for Healthcare Improvement (IHI) and is patterned after IHI's campaigns (100,000 Lives Campaign and 5 Million lives).

To learn more about Medication Reconciliation, to find out how to join the SHN! Campaign and to gain access to more resources, contacts, and tools, visit our website http://www.saferhealthcarenow.ca

These Getting Started Kits are designed to engage your teams and clinicians in a dynamic approach for quality improvement, and to provide a thorough basis for getting started.

The Getting Started Kits are based on the current state of knowledge. Consistent with the dynamic nature of this campaign, which continues to evolve, emerging evidence may influence adaptation of the intervention in the future. This kit was created in January 2008. We remain open to working consultatively on updating the content as together we make healthcare safer in Canada.

Note:
The Quebec Campaign: Together, let's improve healthcare safety! works collaboratively with the SHN! Campaign. The GSKs for all interventions used in both campaigns are the same.

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Version 1.0 1

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

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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

www.SaferHealthcareNow.ca

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

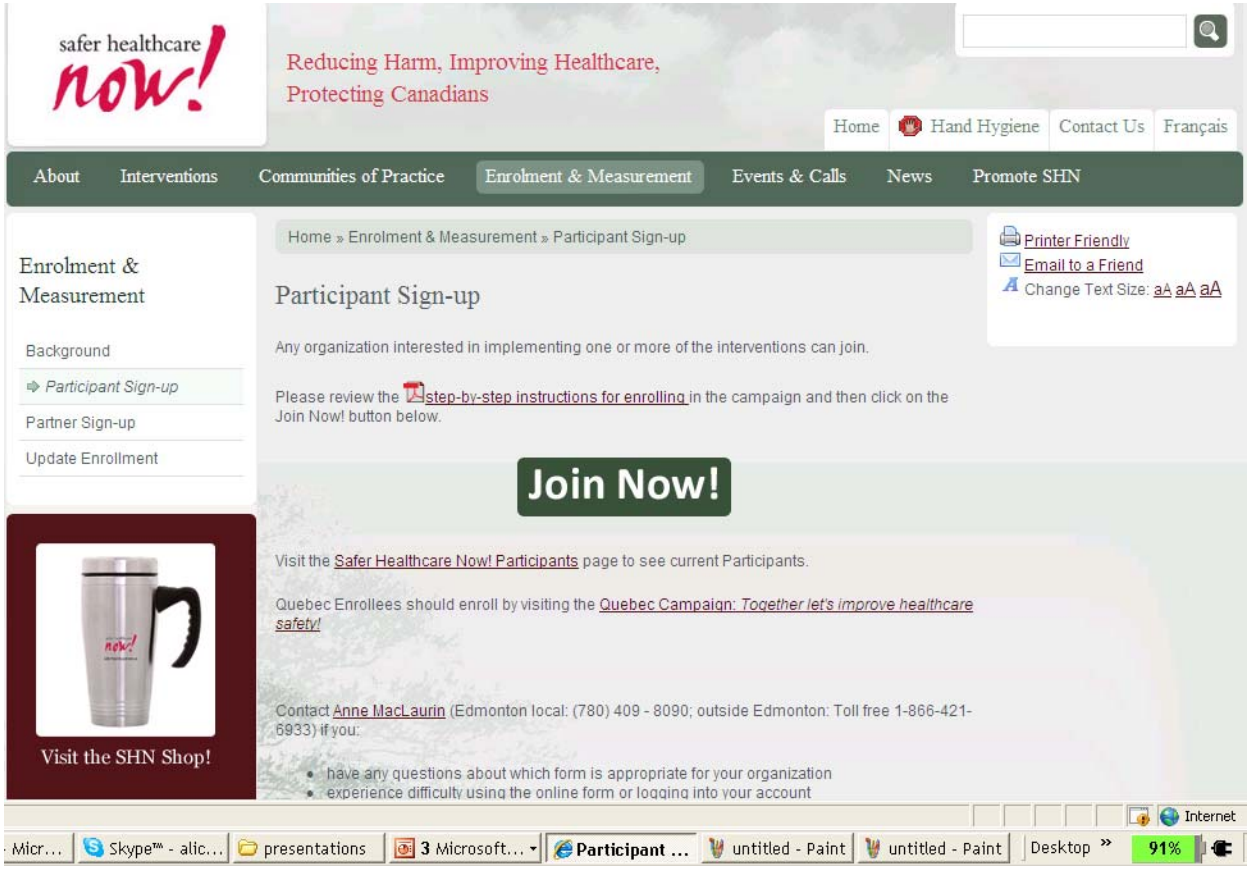
This concludes our interview. Thank you for your time. Do you have any questions?

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.*

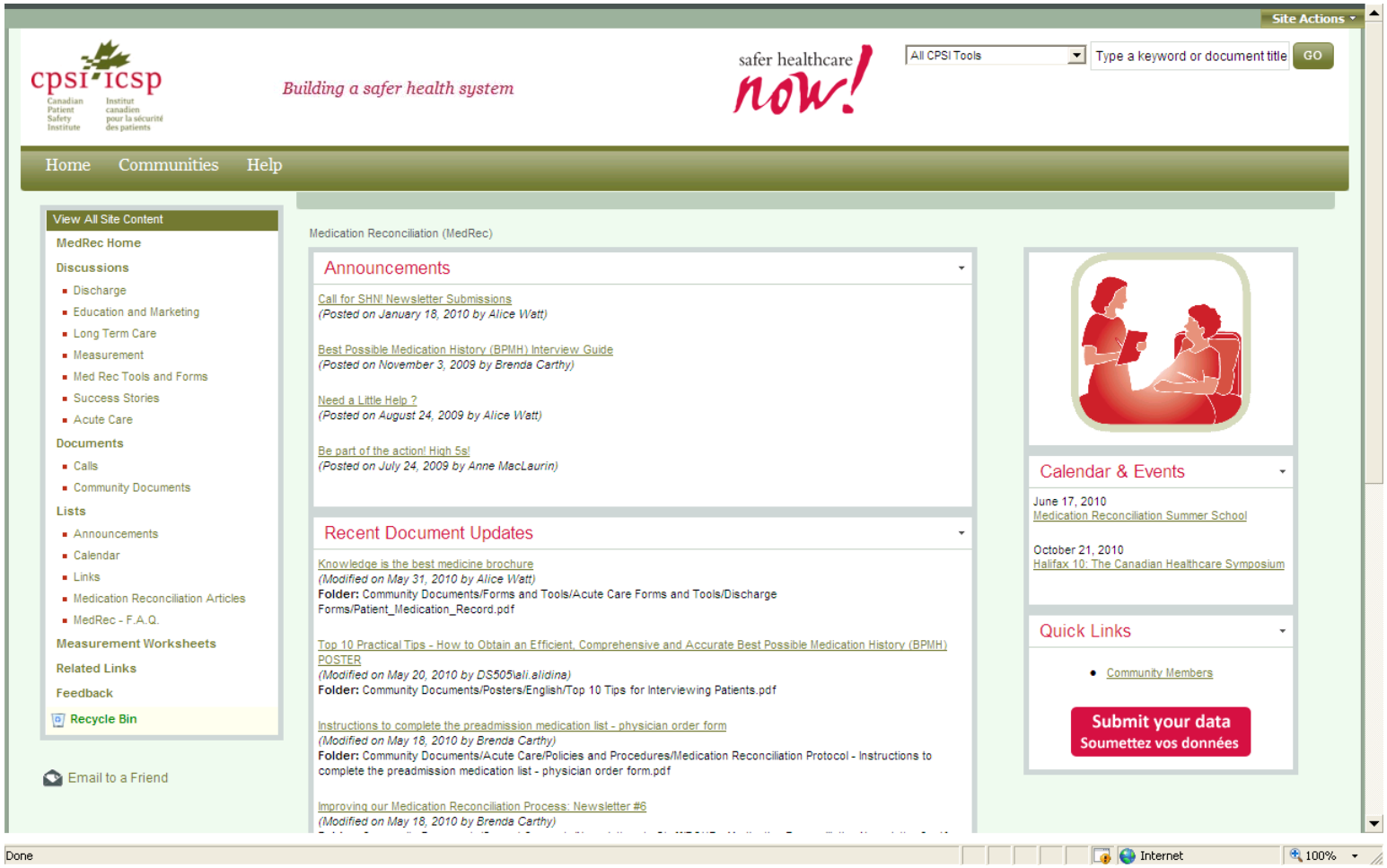
Adapted from University Health Network

Enroll Today

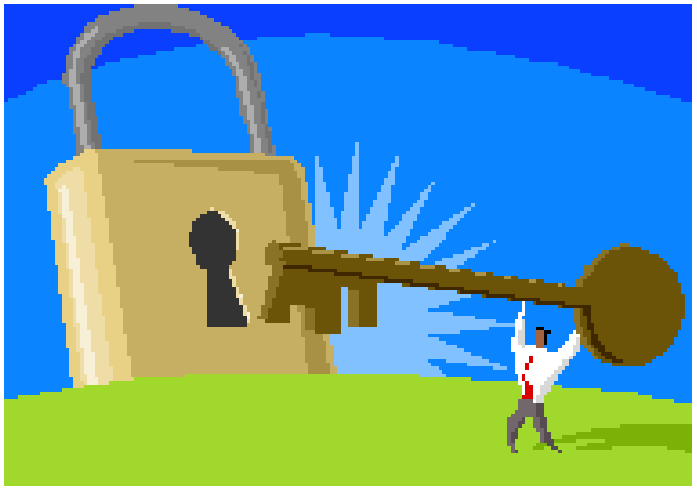


http://www.saferhealthcarenow.ca/EN/enroll/Pages/ParticipantSignup.aspx

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.

Purpose

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.

Brief History

- 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.

Brief History

- 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.

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.

Needs Identified

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.

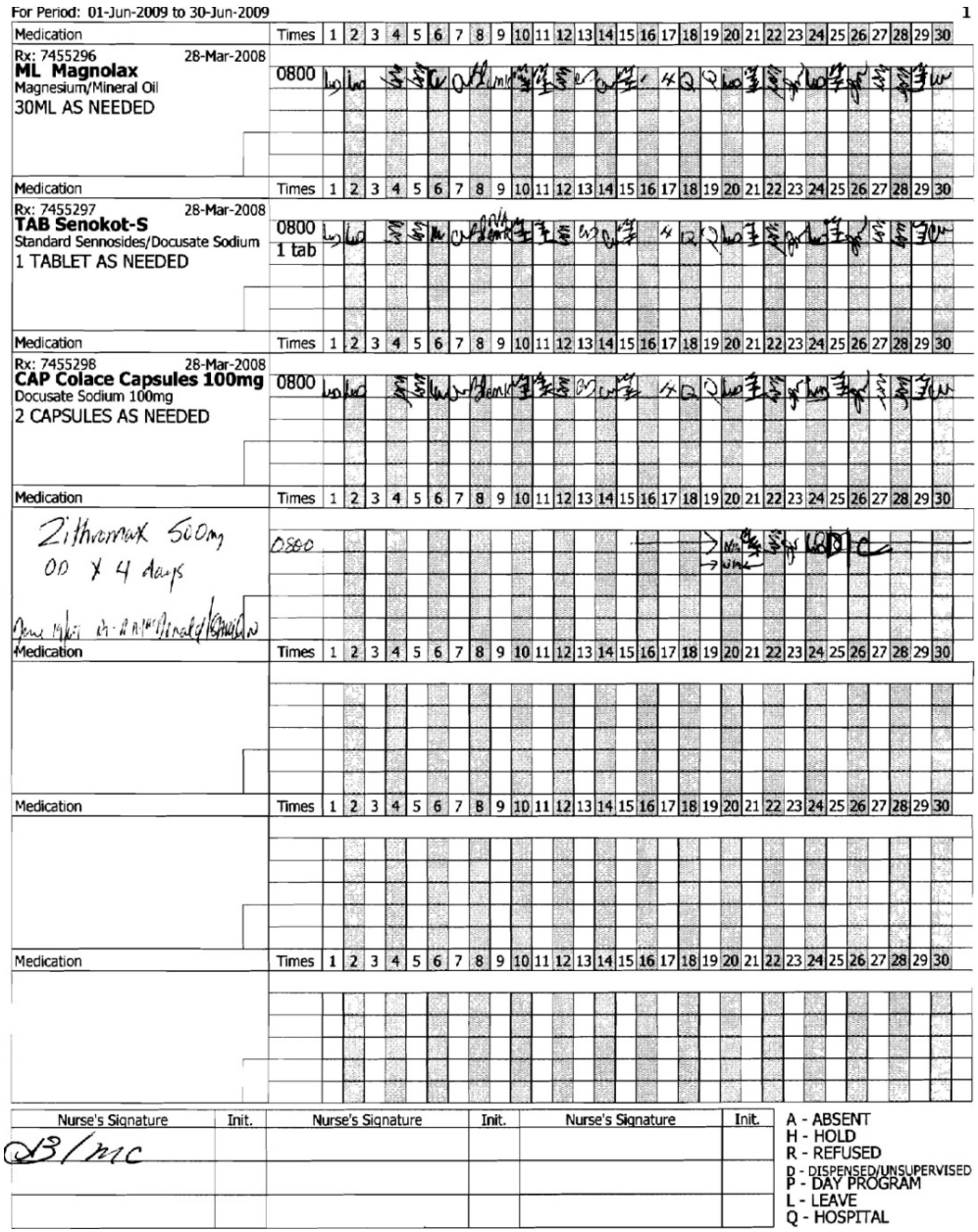
- There was wonderful discussion, sharing of ideas and understanding of each others point of view which lead to the development of this new tool.

- Little did we know it was so new and innovative!!

Out with the old, In with the new

- 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!

Old Format

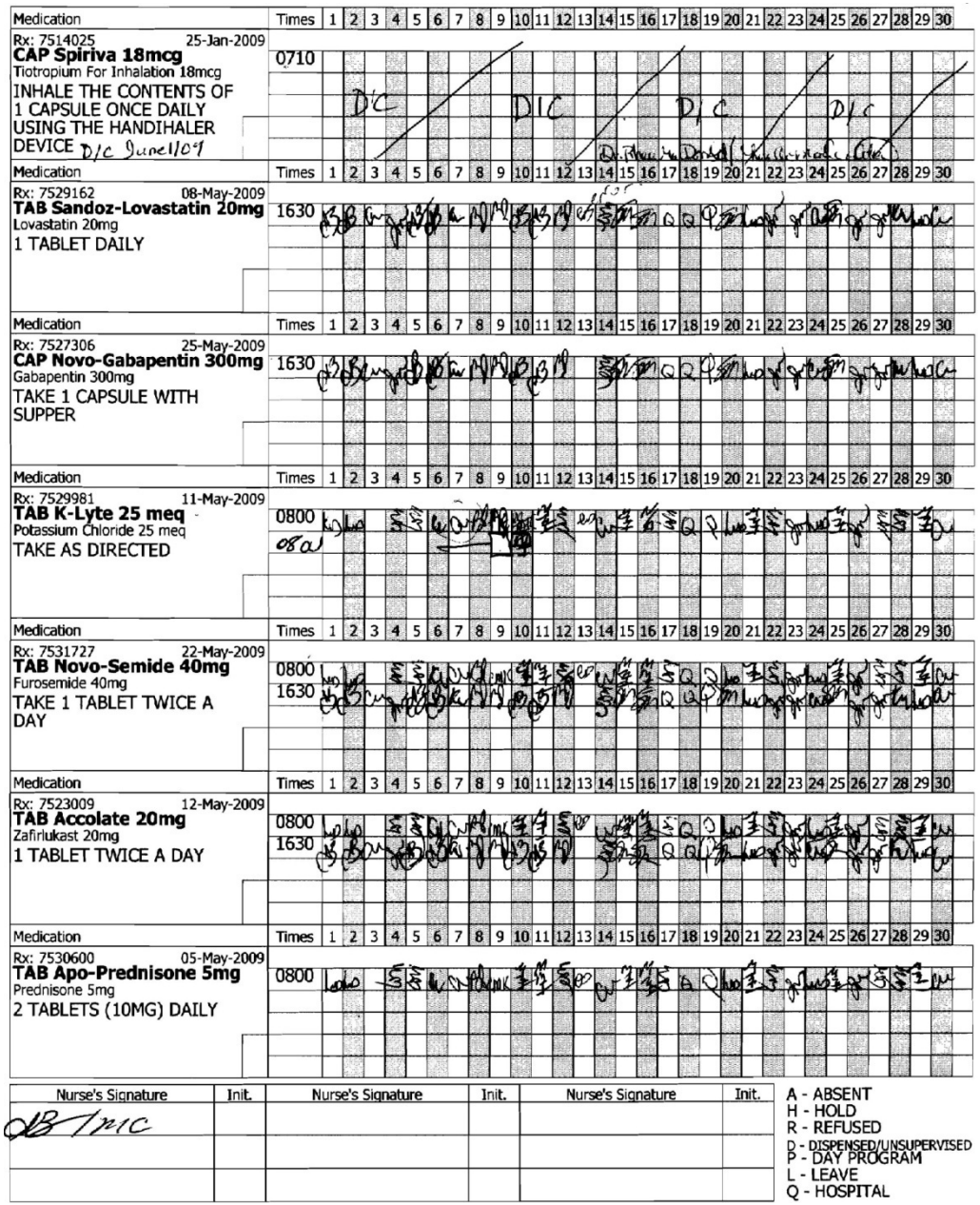


For Period: 01-Jun-2009 to 30-Jun-2009 — 1

Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Rx: 7455296 28-Mar-2008 **ML Magnolax** Magnesium/Mineral Oil 30ML AS NEEDED	0800																														
Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Rx: 7455297 28-Mar-2008 **TAB Senokot-S** Standard Sennosides/Docusate Sodium 1 TABLET AS NEEDED	0800 1 tab																														
Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Rx: 7455298 28-Mar-2008 **CAP Colace Capsules 100mg** Docusate Sodium 100mg 2 CAPSULES AS NEEDED	0800																														
Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Zithromax 500mg OD X 4 days	0800																														
Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Nurse's Signature	Init.	Nurse's Signature	Init.	Nurse's Signature	Init.
JB/mc					

A - ABSENT
H - HOLD
R - REFUSED
D - DISPENSED/UNSUPERVISED
P - DAY PROGRAM
L - LEAVE
Q - HOSPITAL



Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Rx: 7514025 25-Jan-2009 **CAP Spiriva 18mcg** Tiotropium For Inhalation 18mcg INHALE THE CONTENTS OF 1 CAPSULE ONCE DAILY USING THE HANDIHALER DEVICE D/C June1/09	0710			D/C							D/C							D/C						D/C							
Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Rx: 7529162 08-May-2009 **TAB Sandoz-Lovastatin 20mg** Lovastatin 20mg 1 TABLET DAILY	1630																														
Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Rx: 7527306 25-May-2009 **CAP Novo-Gabapentin 300mg** Gabapentin 300mg TAKE 1 CAPSULE WITH SUPPER	1630																														
Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Rx: 7529981 11-May-2009 **TAB K-Lyte 25 meq** Potassium Chloride 25 meq TAKE AS DIRECTED	0800 08a																														
Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Rx: 7531727 22-May-2009 **TAB Novo-Semide 40mg** Furosemide 40mg TAKE 1 TABLET TWICE A DAY	0800 1630																														
Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Rx: 7523009 12-May-2009 **TAB Accolate 20mg** Zafirlukast 20mg 1 TABLET TWICE A DAY	0800 1630																														
Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Rx: 7530600 05-May-2009 **TAB Apo-Prednisone 5mg** Prednisone 5mg 2 TABLETS (10MG) DAILY	0800																														

Nurse's Signature	Init.	Nurse's Signature	Init.	Nurse's Signature	Init.
MIC					

A - ABSENT
H - HOLD
R - REFUSED
D - DISPENSED/UNSUPERVISED
P - DAY PROGRAM
L - LEAVE
Q - HOSPITAL

NOVA SCOTIA
Department of Health

Form D

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 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, and behaviour, necessitating a reclassification, and
c) the applicant is returning to the same Home for Special Care from which he/she was hospitalized.

If these conditions do not apply, then a Form A Medical must be completed and submitted to the local Placement Worker. If there are any disputes regarding this patient, then 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 [redacted] Init.

Date of Birth [redacted] Number

Health Card [redacted] Number

Type of Care [redacted]

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

Name of Hospital ICMH

Date of Admission (YYYYMMDD) 20080823

Describe person's present condition

Describe treatment person received in hospital I.V. + oral steroids & antibiotic

What further treatment, if any, should person receive? Prednisone, Actonel 35 weekly, Calcium 500mg TID, Cozaar 25mg p.o. O.D., Keflex 500mg po. QID x 5days, Lasix 20mg O.D. Phenobarbital 15mg TID, Senokot 5 ii tabs prn, Vit. D 800 I.U. O.D., Tylenol 325 ii po prn, Colace ii po daily, Losec 20mg daily, Crestor 10mg daily, ASA 81mg O.D., Lorazepam 0.5mg T.i.d. prn

Medications Required Prednisone 50 O.D. x 7 day then 15, 12.5, 10 ... 10 O.D. Dilantin 300mg daily, Dilantin ... 50mg O.D.

COMPLETE IF AND WHEREVER APPLICABLE: Bricanyl turbohaler t qid; Atrovent HFA 20 mcg II puffs qid

Date of Surgery (YYYYMMDD) ______ Type of Surgery ______

Date Sutures to be Removed (YYYYMMDD) ______ Type of Dressing and how often to be changed ______

Is Intake adequate? FLUID ☐ Yes ☐ No CALORIC ☐ Yes ☐ No SPECIAL DIET ☐ Yes ☐ No

Date (YYYYMMDD) ______ [signature] To be Signed and Dated by Attending Medical Staff Member

SECTION 3 — To be completed by the Hospital Staff making the re-admission arrangements and sent immediately (within 3 working days) to the appropriate Classifications and Assessment Section.

Movement Code 13

Date Re-admitted to Home (YYYYMMDD) 20080829

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

[signature] Signature of Hospital Staff making the re-admission arrangements

SINCE THIS IS A COMBINED APPROVAL AND RE-ADMISSION FORM NO FURTHER RE-ADMISSION INFORMATION IS TO BE SUBMITTED BY THE HOME.

COPY DISTRIBUTION: WHITE - Nursing Home/Home for the Aged; PINK - Classification; BLUE - Placement Worker

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

Completed by Sending Facility

Completed by Receiving Facility

Inverary Manor

Most Current Medication List and Transfer/Discharge Orders

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

Addressograph

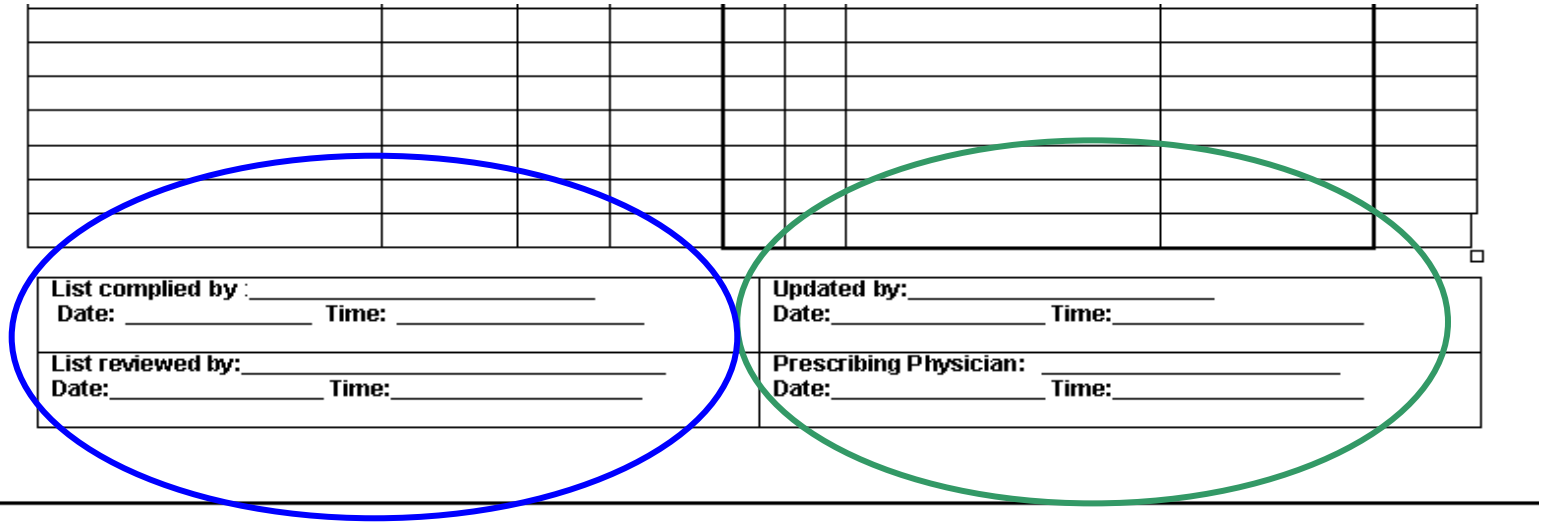
Weight:_____

Allergies:

Adverse Reactions:

Most Current Medication List				Physician Orders: To complete upon discharge from Hospital				Time of Last Dose
Medication: Including topicals, treatments, inhalations, patches, OTC, drops, injections, herbals, alcohol	Dose/Frequency	Route	Time of Last Dose	Continue	Discontinue	New Order *Include duration*	Reason	

How it Works



List complied by :_____ **Date:** _____ **Time:** _____	**Updated by:**_____ **Date:**_____ **Time:**_____
List reviewed 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 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 other 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 (now physician orders) will be returned to the nursing home.
6. A new 'most current' list will be generated using the information on the form.

AUG-04-2009 10:46 ACTIVE CARE ICMH

Most Current Medication List and Transfer/Discharge Orders

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

Weight: ________

Allergies: None Known.

Adverse Reactions:

Most Current Medication List				Physician Orders: To complete upon discharge from Hospital				Time of Last Dose
Medication: Including topicals, treatments, inhalations, patches, OTC, drops, injections, herbals, alcohol, calcium supplement	Dose/Frequency	Route	Time of Last Dose	Continue	Discontinue	**New Order** *Include duration*	**Reason**	
Metreprolol 25mg	25mg OD	PO			✓	Cardizem CD 240		o.D
Avapro 300mg	300mg OD	PO		✓		Cipro 500	BID	
Aspirin EC	81mg OD	po		✓		~~[illegible]~~		
Tylenol 325mg x 2 tabs	650mg TID	po		✓				
Quetiapine	25mg BID	po		✓				
Lorazepam	0.5mg BID	po		✓				
Senokot-S	2tabs BID	po		✓				
Colace Capsules x 2 caps	200mg BID	po		✓				
Omeprazole	20mg OD	po		✓				
Domperidone Meleate	10mg TID	po		✓				
Synthroid	0.1mg OD	po		✓				
Sandoz-Pramoxine(?)	Hemorrhoids BID PRN			✓				
Vitamin D	800IU OD	po		✓				
Pennsaid topical to knees	HS			✓				
Gravol 25mg - 50mg	25-50mg (PRN)	po		✓				

List Compiled: [signature]
Date: July 28, 2009 Time: 0745hr.

List reviewed by: ________
Date: ________ Time: ________

Updated by: ________
Date: Aug 4/09 Time: ________

Prescribing Physician: [signature]
Date: Aug 4/09 Time: ________

TOTAL P.08

Challenges

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 seperate 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

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Debbie LeLievre RN,BScN

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lelievred@cbdha.nshealth.ca

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

MEDICATION RECONCILIATION

Jo-Anne Thompson RN
Patient Safety Officer
South Eastman Health

South Eastman Health
Santé Sud-Est

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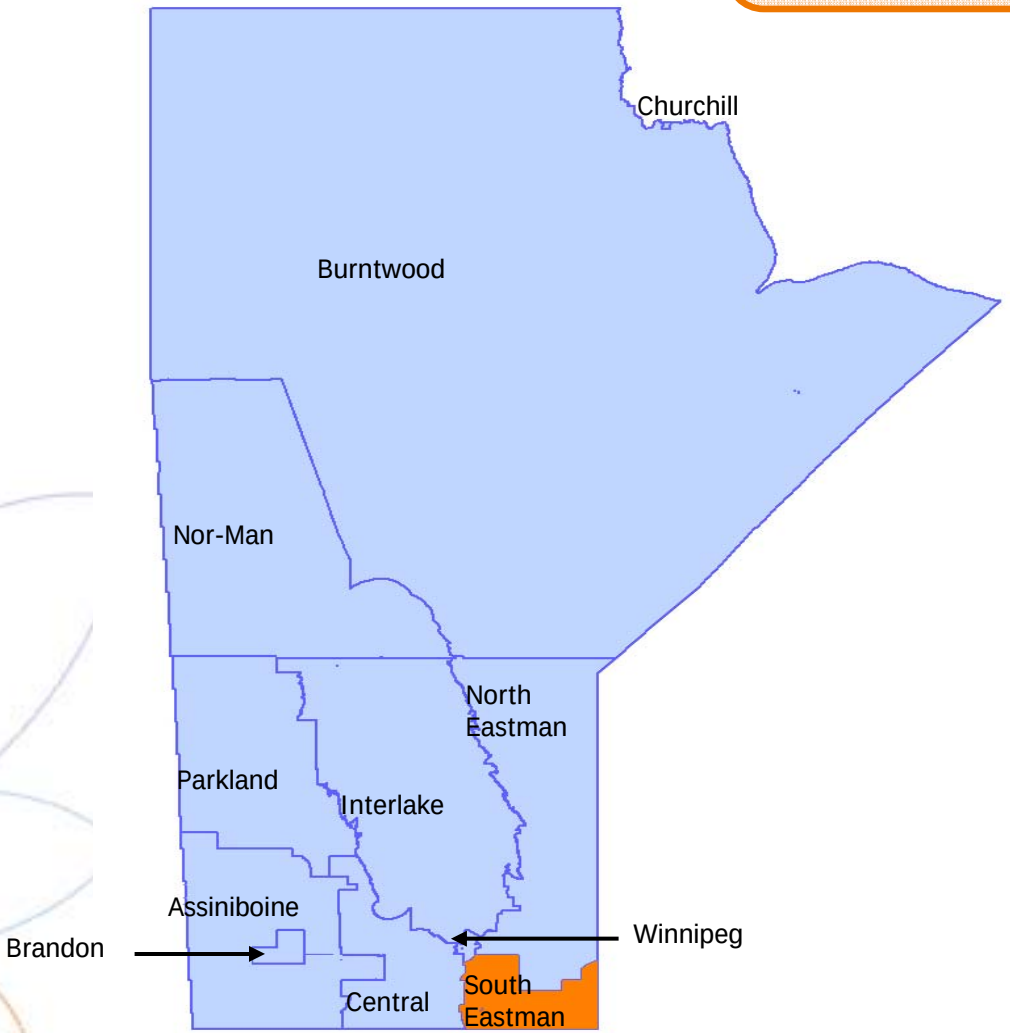
En partenariat avec vous

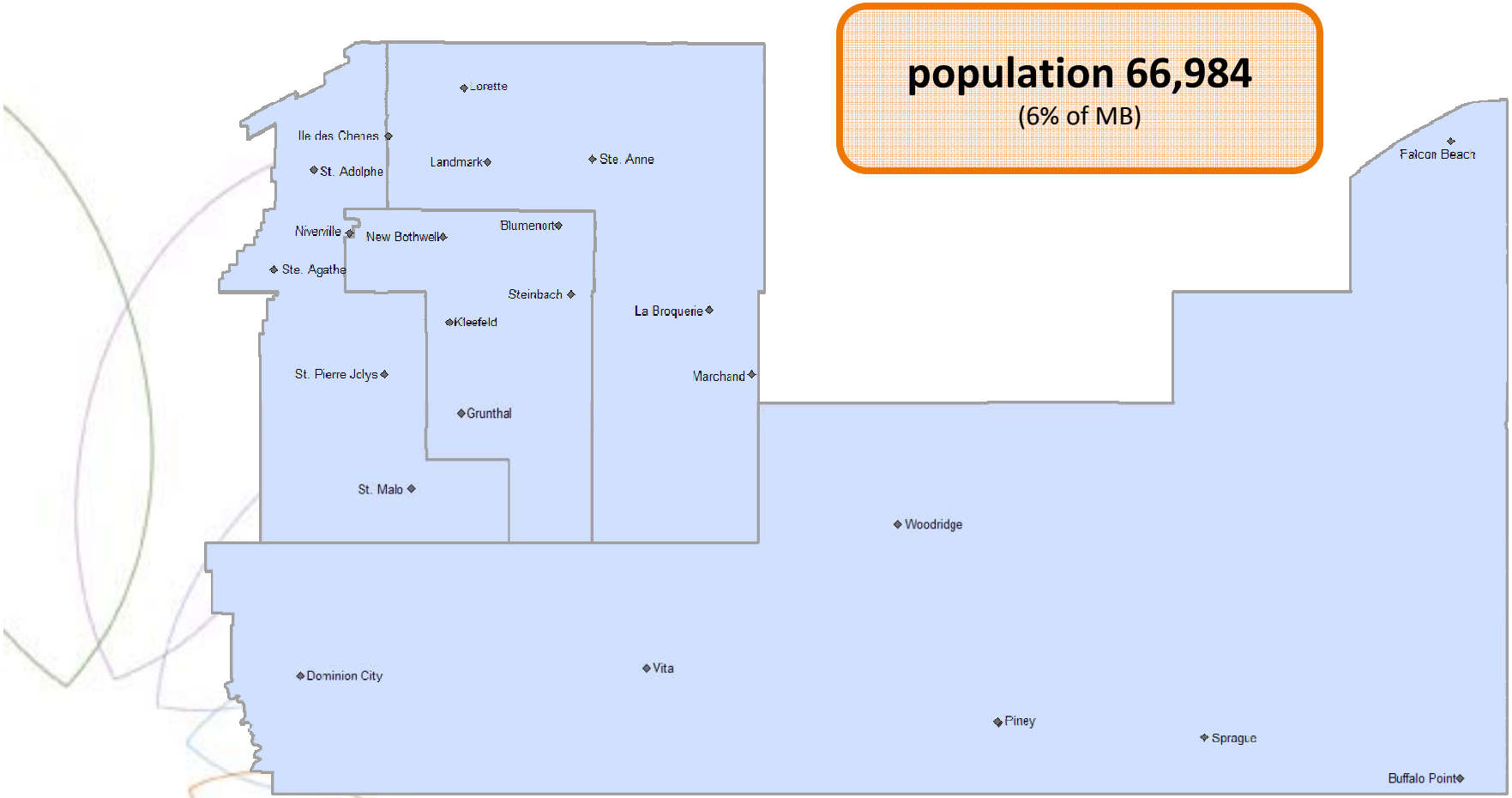
WHO ARE WE?

There are 11 regional health authorities in Manitoba.



SOUTH EASTMAN RHA

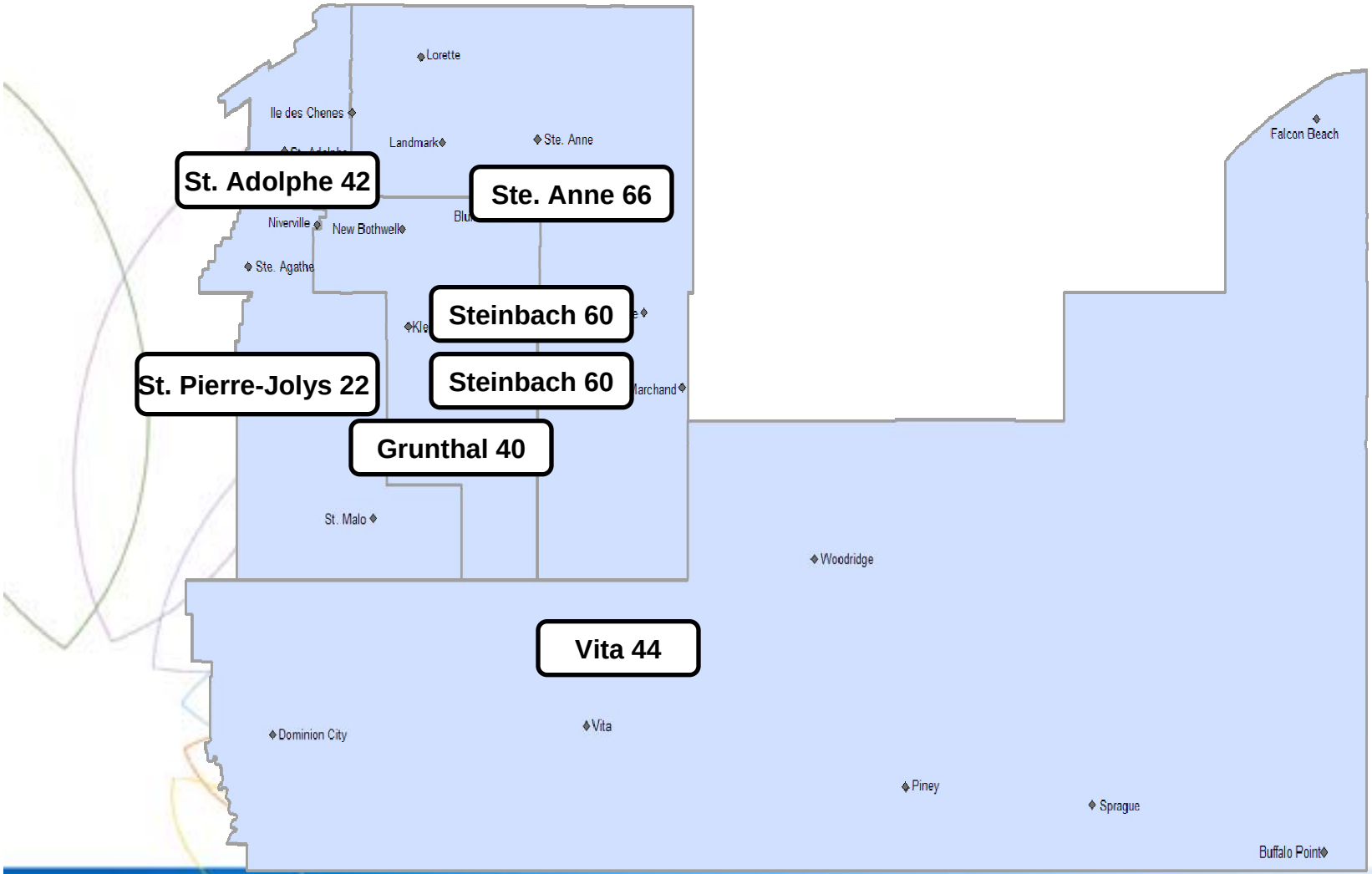
population 66,984
(6% of MB)



Source: Manitoba Health (June 2009)

PERSONAL CARE HOME BEDS

N = 334



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.

HOW WILL WE KNOW WE ARE MAKING A DIFFERENCE ?

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

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

<u>Undocumented Intentional</u> 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*

<u>Unintentional</u> 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.

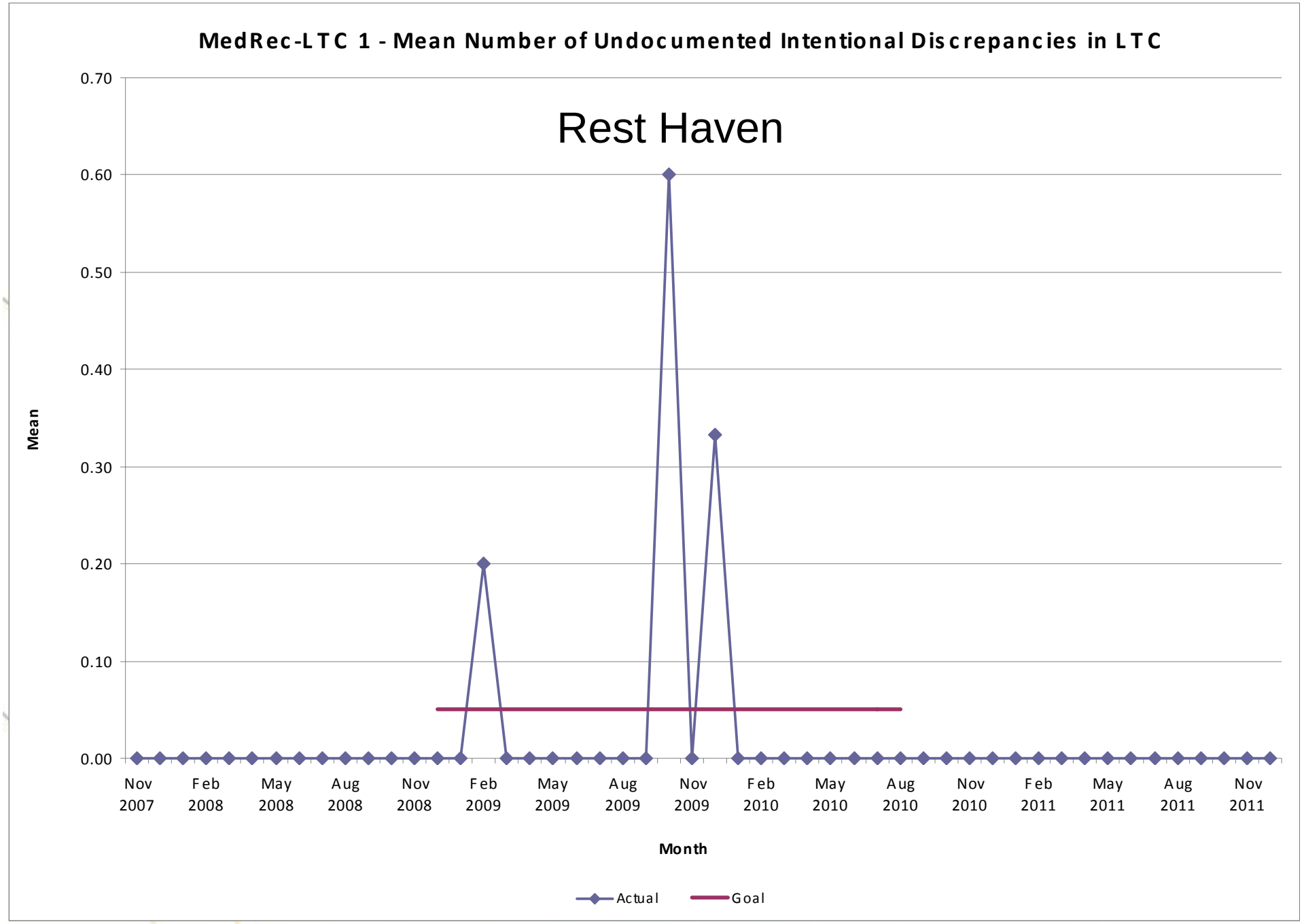
GOAL

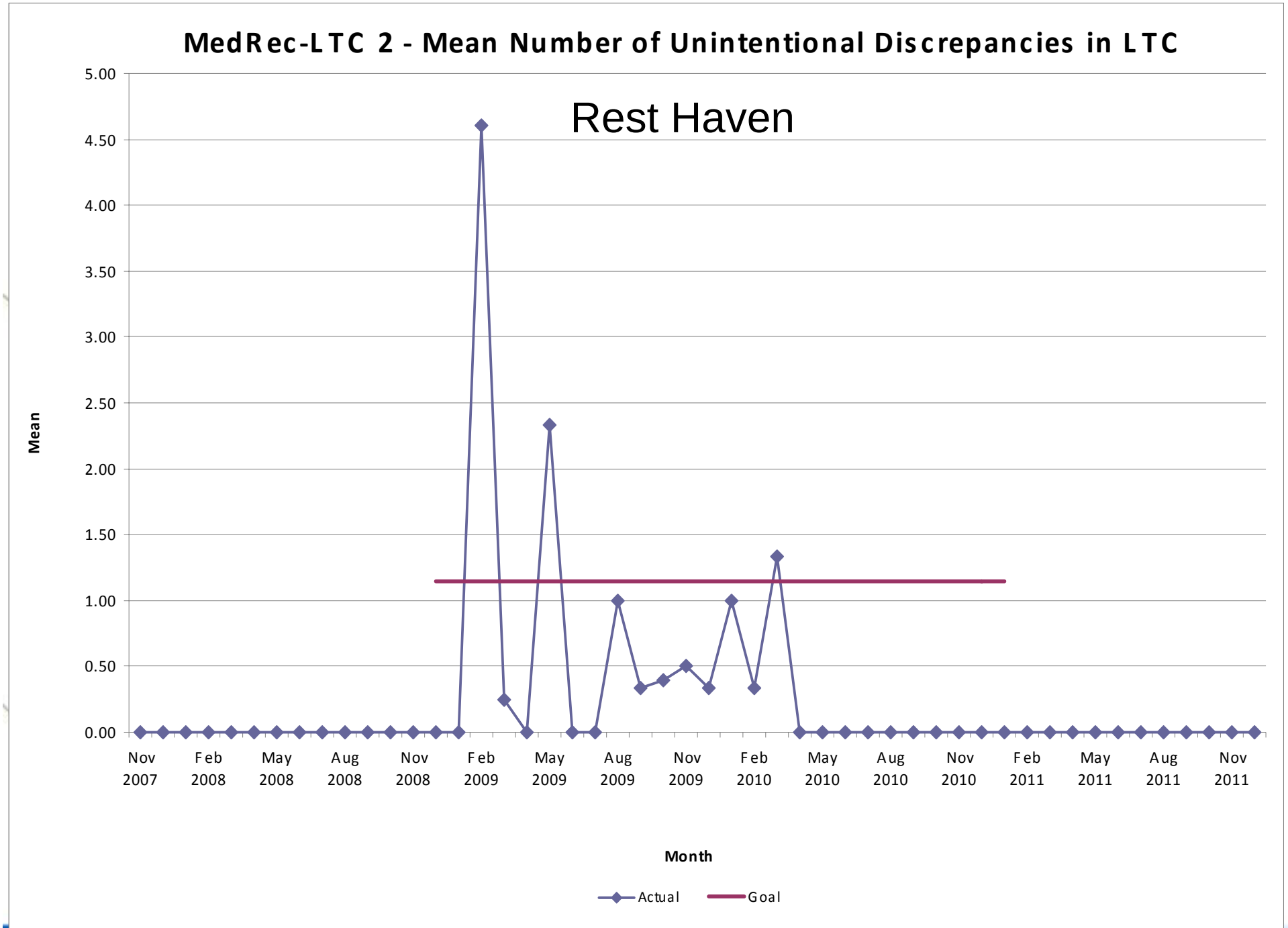
The area of focus will be to decrease the mean # of undocumented intentional discrepancies on patients admitted to the hospital & LTC facilities by 75%, as well as the unintentional discrepancies by 75%.

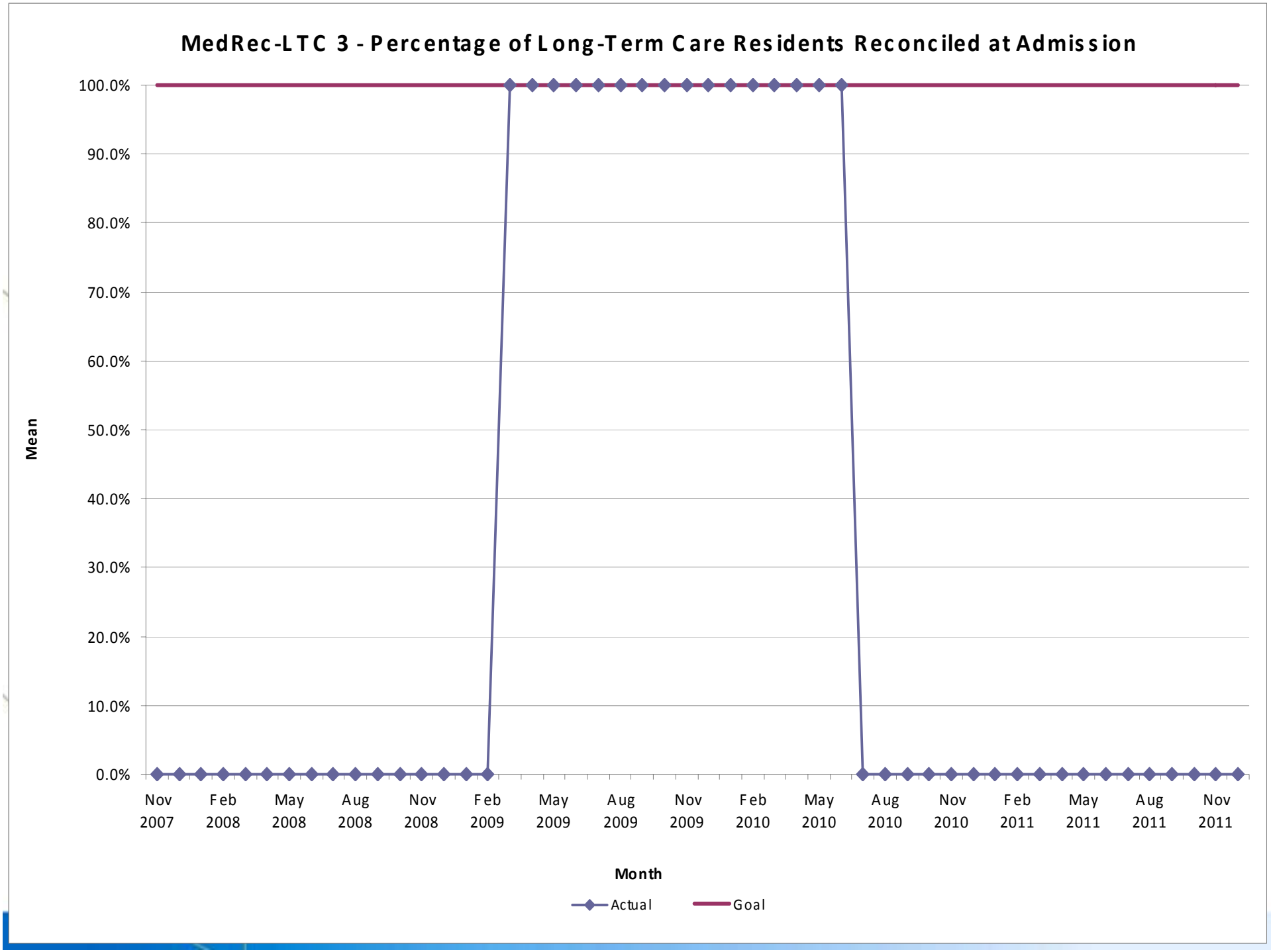
SO HOW DO WE KNOW THAT WE ARE SUCCEEDING?

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
Mean
0.70
0.60
0.50
0.40
0.30
0.20
0.10
0.00
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
Month
Actual
Goal


MedRec-LTC 2 - Mean Number of Unintentional Discrepancies in LTC
Rest Haven
Mean
5.00
4.50
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
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
Month
Actual
Goal


MedRec-LTC 3 - Percentage of Long-Term Care Residents Reconciled at Admission
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
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
Month
Actual
Goal

Medication Reconciliation Baseline Audit
February 2008

Vita & St.Pierre

Chart #	MedRec Process Implemented			
	No Discrepancy	Intentional Discrepancy	Unintentional Intentional Discrepancy	Unintentional discrepancy
1	8	1		
2	4			
3	Med process not used, no nursing Hx and M.D. orders?			
4	Med process used but no reconciliation done. No discharge process completed.			
5	7	1		
6	Med Rec not completed, patient transferred out.			
7				1
8	7		1	
9	13	1	1	
10	10			
11	6			
12	10			
13	4		3	
14	15	4		
15	2			
16	7			
17	7		1	
18	Patient not on meds.			
19	1			
20	Med Rec not done.			

Bethesda & Ste.Annes

MedRec Process NOT Implemented			
No Discrepancy	Intentional Discrepancy	Unintentional Intentional Discrepancy	Unintentional discrepancy
6	2	2	
			2
Med Hx not properly completed.			
7		8	2
7	1		1
		1	4
Patient not on meds.			
1			
9			
2		1	2
2		7	3
4		1	1
4			1
No admission Hx (ER triage list) M.D. orders done on ward, missing 5/14 meds.			
5	1	3	5
1			1
		4	
No meds documented at all.			
Reported on Hx, no meds.			
5			

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 it self. The steering committee team will work on resolving issues on a ongoing basis.

Continuous Education for **all** new employee’s hired

SOUTH EASTMAN HEALTH

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!

South Eastman Health
Santé Sud-Est

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En partenariat avec vous

www.sehealth.mb.ca

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Centre affilié universitaire

Health and Social Services
Centre Jeanne-Mance

MEDICATION RECONCILIATION

LONG-TERM CARE

Renée Claire Fox, B.A., M.Sc. Inf.

Sept 14 2010

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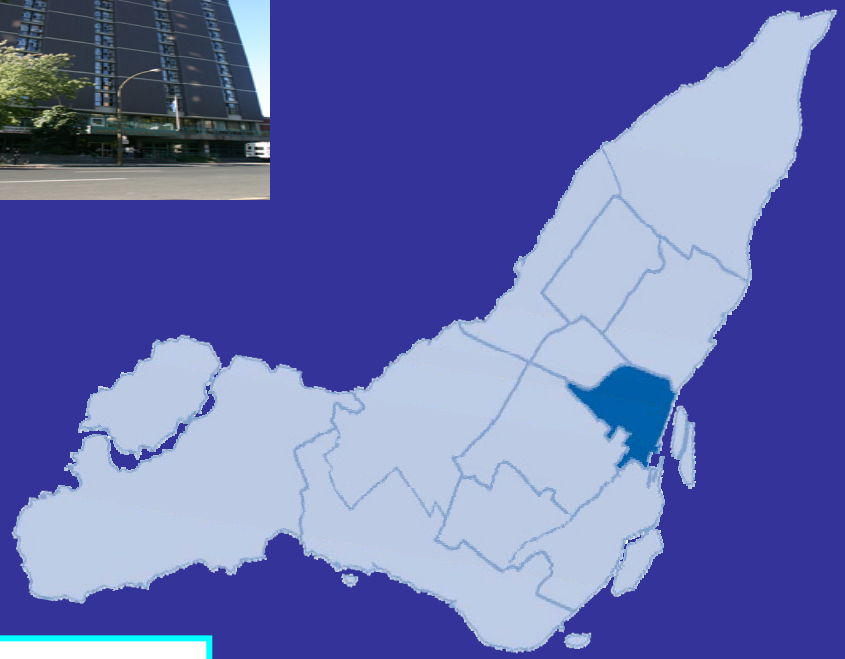
Health and Social Services

Centre Jeanne-Mance

7 LONG-TERM CARE FACILITIES
1200 beds

3 CLSC
population 138000

Affiliated with the U of Mtl teaching and research



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Objective

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

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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

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Fundamental question

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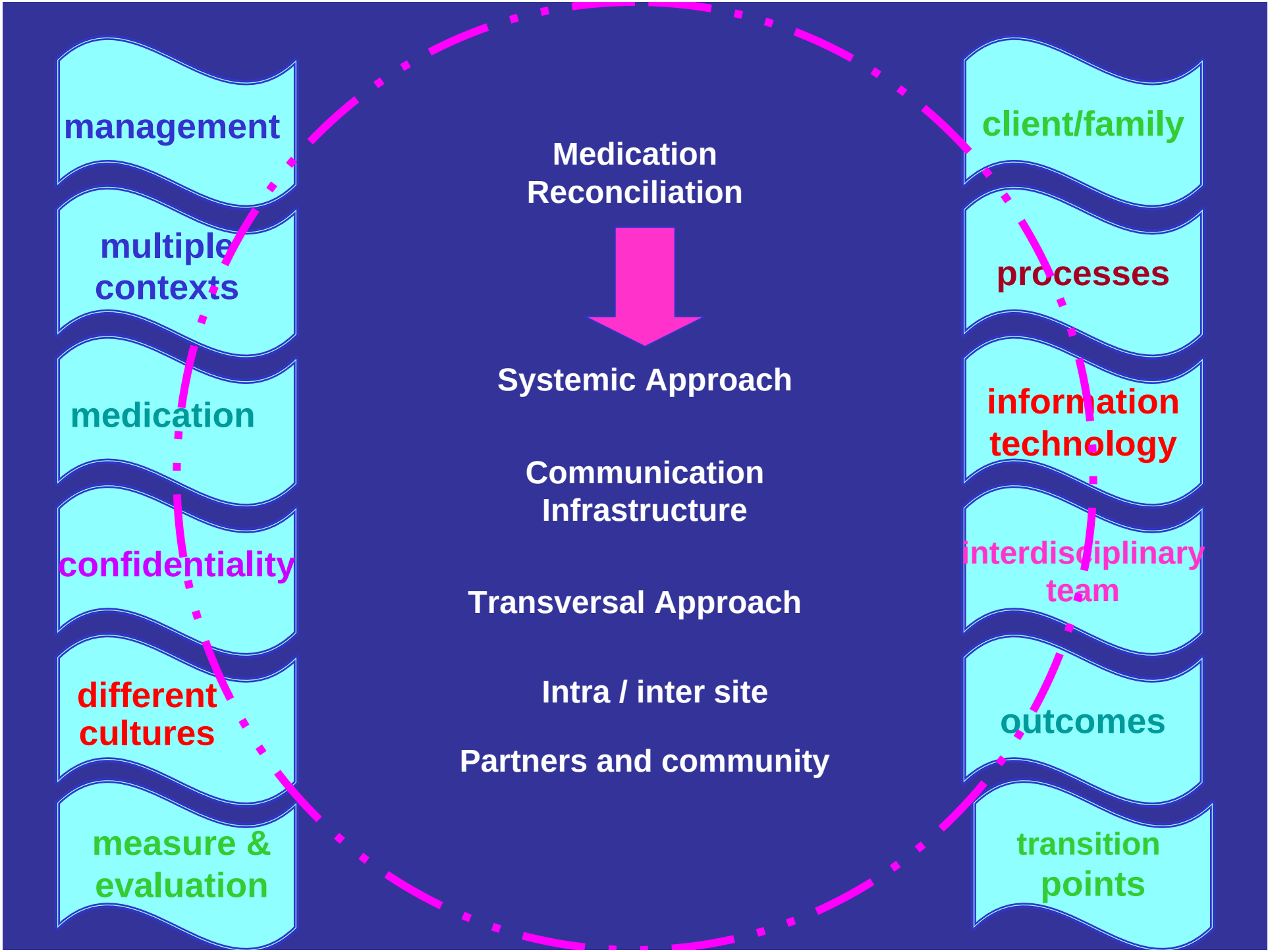
Med Rec Steering Committee

- 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

consensus


management
multiple contexts
medication
confidentiality
different cultures
measure & evaluation
Medication Reconciliation
Systemic Approach
Communication Infrastructure
Transversal Approach
Intra / inter site
Partners and community
client/family
processes
information technology
interdisciplinary team
outcomes
transition points

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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

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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

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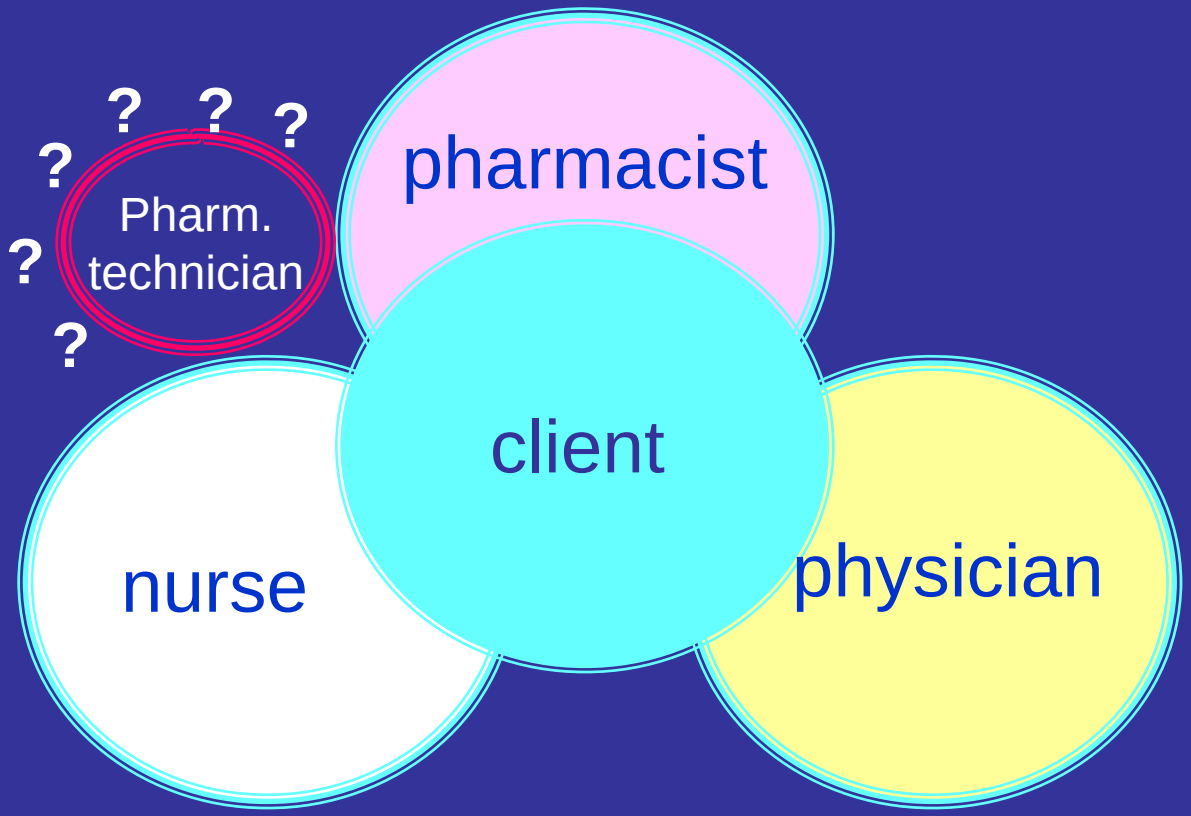
Team members



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Med Rec Model

All admissions

Proactive process

Long-term care

Transfers/discharge
- to home care
- to other long-term care facility

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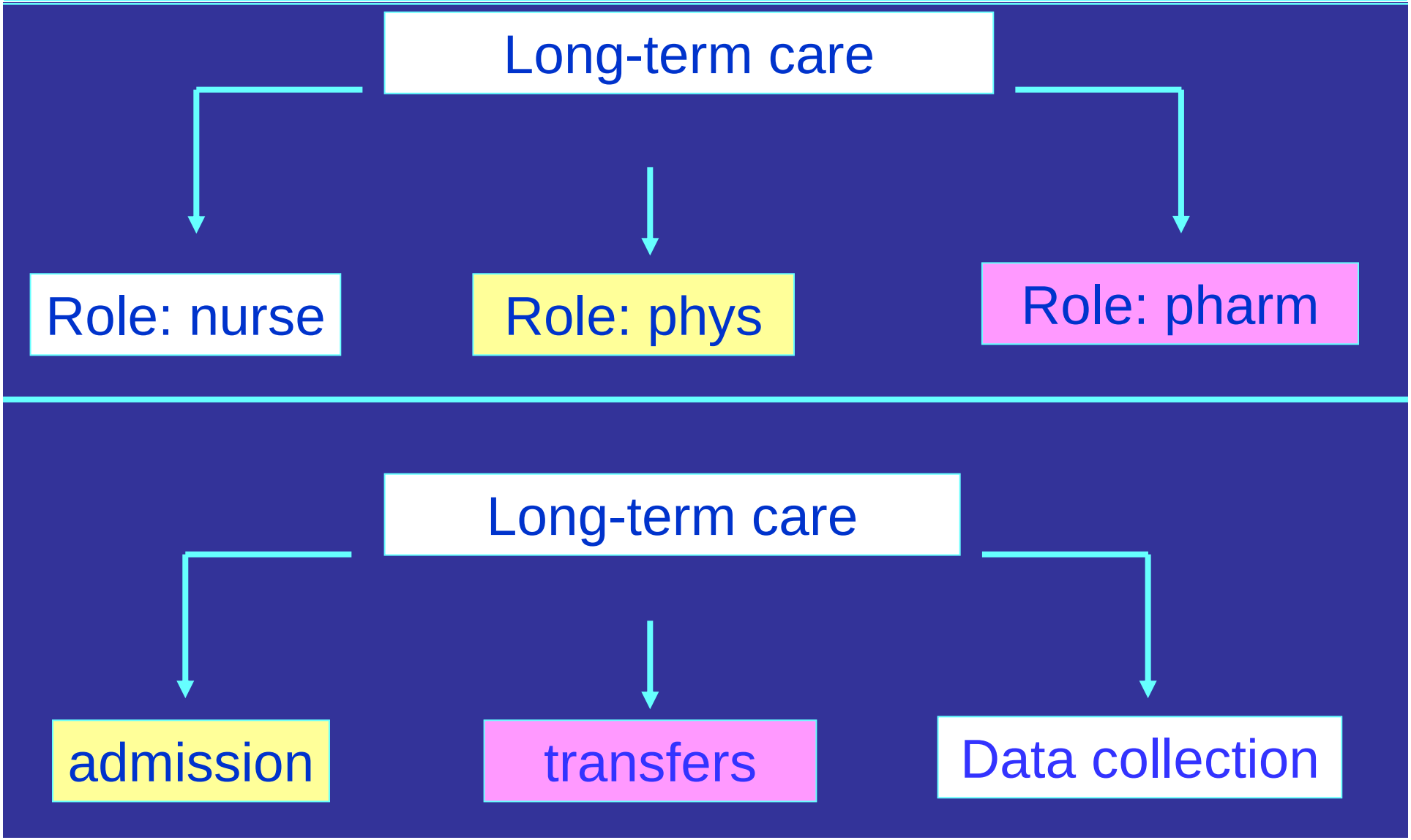
Med Rec Processes



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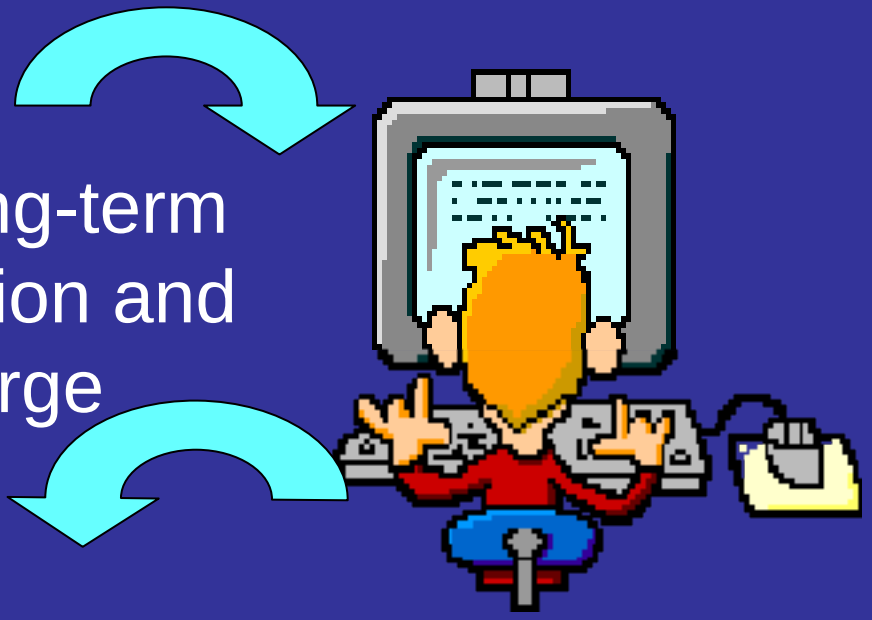
Indicators

CLINIBASE

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



Data for Board members and management

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And the discrepancies?

ACCESS

- Analyse data
- Make recommendations

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Measure and evaluation

- Audit tools for :
  - BPMH
  - Reconciliation

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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

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Tools

- Tool for Admission Med Rec
- Tool for clinical information

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BILAN COMPARATIF DES MÉDICAMENTS À L'ADMISSION

Nom : _____

Prénom : _____

No dossier : _____

Date de naissance : ____/____/____
aaaa mm jj

Site :	☐ Faubourgs Papineau	☐ Plateau Mont-Royal
	☐ Faubourgs Parthenais	☐ Saint-Louis-du-Parc
	☐ Faubourgs Sanguinet	☐ Hébergement
	☐ Faubourgs Visitation	
	☐ Autre site :	

Cette ordonnance est une ordonnance originale, elle ne s'adresse qu'au pharmacien identifié. L'original ne sera pas réutilisé et sera consigné au dossier

Sources d'information S.I. (#)				
a. INFO DU RÉSIDENT	e. LISTE RX ANTÉRIEURES	I. PHARM. COMMUNAUTAIRE	NOM :	TEL :
b. INFO DE LA FAMILLE	f. FEUILLE D'ENREG. RX	j. PHARM. COMMUNAUTAIRE	NOM :	TEL :
c. FIOLE DE MÉDICAMENTS	g. RX DE DÉPART	k. MÉDECIN	NOM :	TEL :
d. DOSETTE	h. AUTRE _____	L. MÉDECIN	NOM :	TEL :

MEILLEURE HISTOIRE MÉDICAMENTEUSE POSSIBLE (**MHMP**)				ORDONNANCES DU MÉDECIN À L'ADMISSION						BCM				
			Compliance							Divergences				
S.I. (#)	**Médication prescrite ou en vente libre et produits naturels** précisez dose, voie, fréquence	Dernière dose	U	N	continuer	cesser	modifier	ajouter	**Ordonnances** précisez dose, voie, fréquence	**Répéter**	N.I.	N.I. résolue	I.N.D.	I.N.D. résolue	**Interrogations**

Médication cessée	Note complémentaire	
_____ Signature de l'infirmière ____/____/____ an mois jour _____ heure	_____ Signature du médecin _____ matricule ____/____/____ an mois jour _____ heure	_____ Pharmacien ____/____/____ an mois jour

Site _____ Équipe _____

N. B. Écrire lisiblement, utilisez les symboles et abréviations d'usage courant recommandés par ISMP Canada

☐ Le client consent à l'échange d'information entre le pharmacien communautaire et les intervenants du CSSS Jeanne-Mance

Nombre de pages ____/____

BILAN COMPARATIF DES MÉDICAMENTS À L'ADMISSION

l'usage du service des archives	

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Site :	☐ Faubourg Papineau	☐ Plateau Mont-Royal
	☐ Faubourg Berthelais	☐ Saint-Louis-du-Parc
	☐ Faubourg Sanguinet	☐ Hébergement
	☐ Faubourg Visitation	
	☐ Autre site :	

Nom : _____

Prénom : _____

No dossier : _____

Date de naissance : ____/____/____

aaaa mm jj

Informations complémentaires à la MHMP à l'admission

(Meilleure Histoire Médicamenteuse Possible)

SAD ☐ Hébergement permanent ☐

URFI ☐ Hébergement temporaire ☐ Date de départ:_____

Poids: Taille: ☐ amputation _____ (précisez les membres) ☐ fonte musculaire	
Cl créatinine _____ ou créatinine _____ ____/___/___ (Année mois jour)	(si pas de créatinine de – de 3 mois) créatinine RX oui ☐ non ☐
Diagnostics principaux: Source: CTMSP ☐ feuille sommaire ☐ DEMC ☐	
Compliance: 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	☐	Écraser médication	☐
	Donner avec du jus	☐	Épaissir liquides	☐
	Donner avec confiture	☐	Donner via gastrostomie	☐
	Donner avec compote	☐	Auto-administration	☐

____/___/___ (Année mois jour) _____ Signature de l'infirmière	J'ai pris connaissance des informations sur ce formulaire Médecin ____ (initiales) Pharmacien ____ (initiales)

INFORMATIONS COMPLÉMENTAIRES À LA MHMP À L'ADMISSION

À l'usage du service des archives	

Questions?