Safer Healthcare Now!
Getting Started in Homecare

Sept. 11, 2008

Welcome to New Teams

Agenda

- What is Safer Healthcare Now (SHN)?
- Why medication reconciliation in homecare?
- What is the medication reconciliation homecare pilot?
  - Objectives
  - Expectations
  - Getting started

Safer Healthcare Now!

- Grassroots 2 yr+ pan Canadian Campaign
- National Steering Committee (CPSI Chairs)
- 3 National Working Groups
- Intended to help teams, systems develop skills/capacity to monitor their performance, improve quality
- The focus is on implementing proven patient safety best practices to improve outcomes for patients, residents, families and care givers.

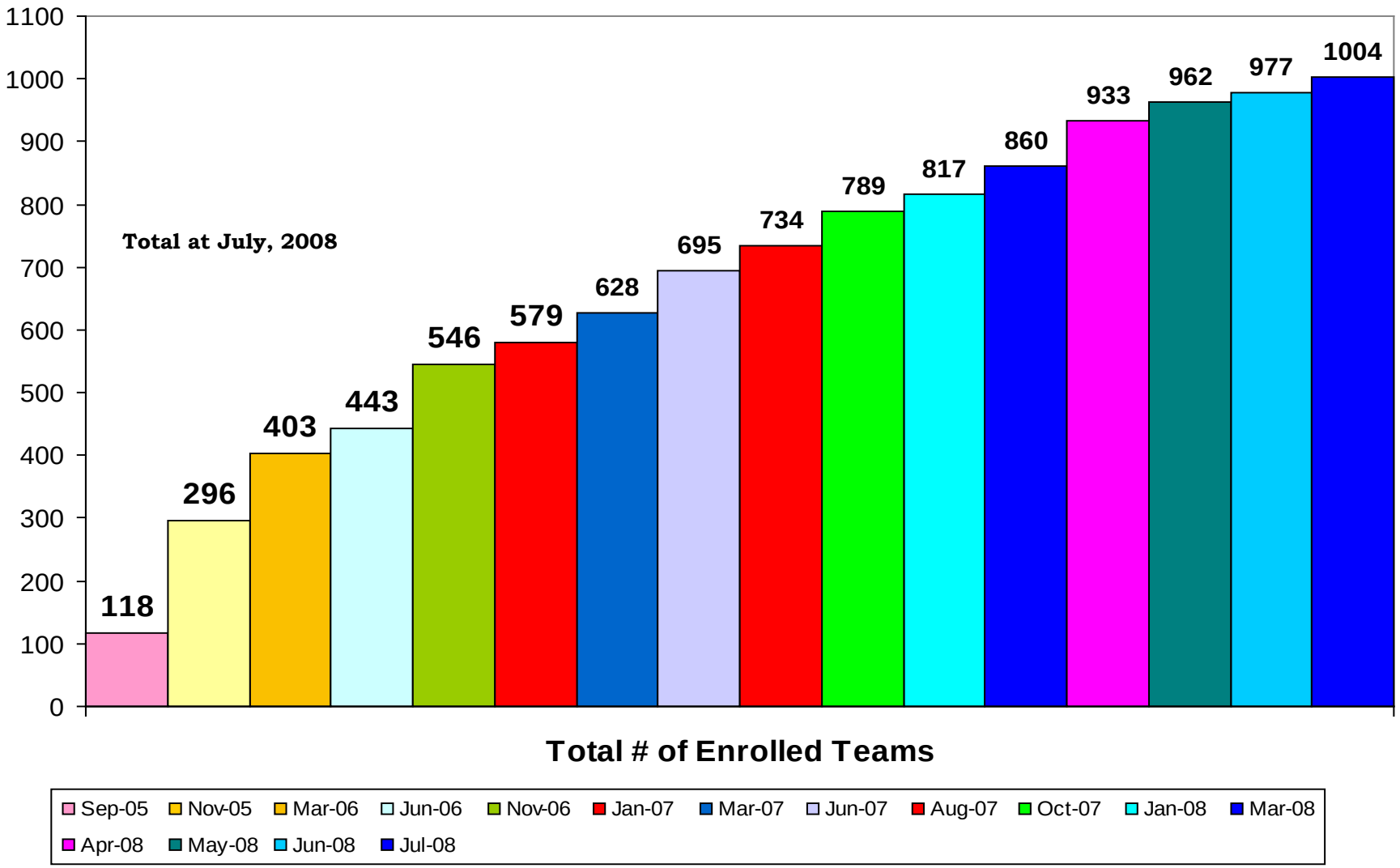
Safer Healthcare Now!

- The Key focus of SHN! is solving the implementation issues that stand between our knowledge of "what works" and our ability to reliably and sustainably provide this standard of care for all patients.
- Safer Healthcare Now! Nodes aim to provide quality improvement ideas, supports and resources to teams across the country with the goal of providing safer care.
- SHN! is about team based collaboration and capacity building

Resources and Team Support

- Getting Started Kits
- Getting Started Calls
- Communities of Practice Web sites
- Node Leaders (4)
- National Working Groups
- Safety Improvement Advisors
- Local level education
- Site visits / working with teams

Safer Healthcare Now! Overview Total # Enrolled Teams September 2005 to July 2008



Medication Reconciliation

- A process in which an accurate list of patient's home medications are compared at transitions of care
- Discrepancies are identified and reconciled with physician
- Intended to minimize potential patient harm from unintended discrepancies

The Goal of Medication Reconciliation in Homecare

- Clarify medications patient is actually taking (BPMH)
- Identify and resolve discrepancies between what providers perceive client is taking and BPMH
- Create and communicate clear and accurate medication lists to patients, families and homecare clinicians
- Reduce potential ADE's

Why Is Medication Reconciliation Important?

- **Most frequently cited** category of root cause for serious adverse drug events:

  Ineffective communication

- Most **vulnerable** parts of a process:

  Links between the steps ("hand-offs")

Medication reconciliation addresses these

Medication Reconciliation Teams

- Acute Care – 333
- Long Term Care – 49
- Homecare – 7 previously in western node
- Now ~ 20 in pilot

Why Medication Reconciliation ?

- The literature
- Accreditation Canada
- Experience in acute and long term care (LTC)

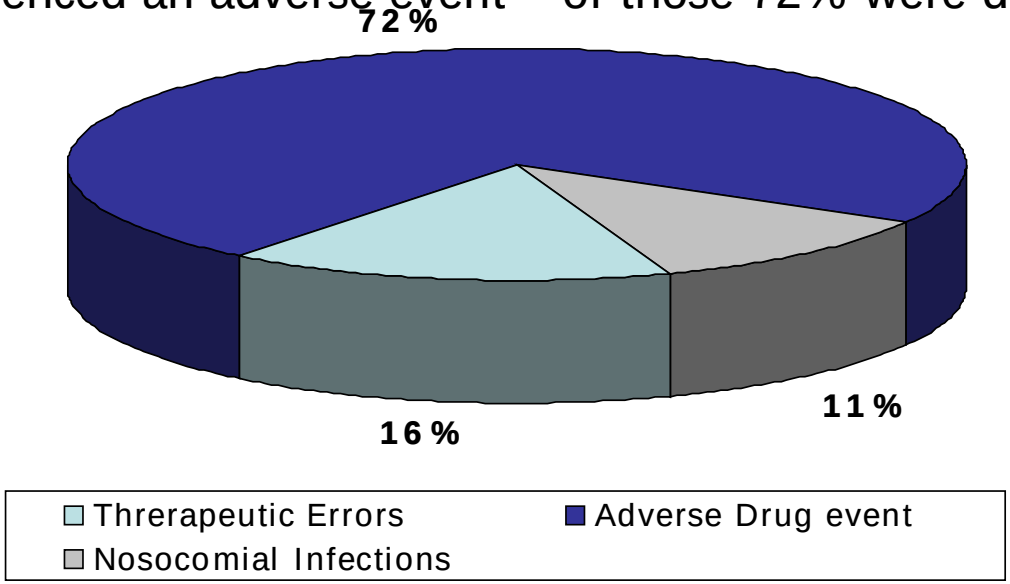
Literature: The Case for Medication Reconciliation

- Many patients (70%) not receiving medication instructions at discharge

(Alibhai SMH, Han RK, Naglie G. Medication Education of Acutely Hospitalized Older Patients. J Gen Intern Med 1999 Oct;14: 610-616)

Patient Medication Adverse Events Post Discharge

23% of Discharged Patients from a Canadian Hospital experienced an adverse event – of those 72% were drug related



328 patients who were discharged from a Canadian teaching hospital were studied prospectively in 2002 for 14 weeks. *(AJ Forster,et al., CMAJ 2004:170(3)345-349.)*

Real Patient Stories

Home Care Accreditation:

Expectation - Patient Safety Area: Communication

GOAL: Improve the effectiveness and coordination of communication among care/service providers and with the recipients of care/service across the continuum

ROP:

1. Reconcile the patient/client's medications upon admission to the organization and with the involvement of the patient/client
2. Reconcile medications with the patient/client at referral or transfer, and communicate the patient's/client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization

Homecare

- Practice Setting with Unique challenges
  - High risk population with complex medication issues and drug related problems
  - Not well defined or understood
- Best Practice
  - Medication reconciliation required by accreditation standards but best practices/ optimal sustainable models not well defined
- SHN Campaign
  - Not well known

Objectives of Pilot

- Introduce medication reconciliation to a broader ambulatory/ community based homecare audience
- Design and test strategies for implementation of medication reconciliation in homecare across Canada
- Validate the key steps of the process for front-line clinicians and teams in this unique setting
- Measure actual patient results
- Develop a structured and sustainable process for homecare

Principles

- Pilot Advisory Steering Committee
- Consider varied organizational structures across Canada
- Incorporate and build on learning from 2007 Western Node homecare pilot

Criteria for Team Selection

- Expressed interest
- Senior leadership support
- Must agree to guidelines set out by steering committee
- Basic understanding of quality improvement
- Commitment to timelines, data submission, conference calls etc
- Pan Canadian

Key Partners

- VON and ISMP Canada
- SHN Secretariat CPSI
- All nodes
- Western Node Collaborative medication reconciliation homecare teams

What has Been Done

- Briefing document “The Case for Medication Reconciliation in Homecare”
- Detailed workplan
- Conceptual framework
- Developed measures to test
- Teams recruited

How Will the Pilot Work?

- Teams meet virtually to learn about medication reconciliation
  - Why and how
  - Measures for pilot
  - Criteria for patients/clients
  - How to reconcile
- Teams develop and test reconciliation processes in their environment
- Learning is documented and shared for greater homecare implementation in Canada

Homecare Teams Support

- Enrollment package
- Monthly calls and/or Webex's
- Support and feedback from Central Measurement Team, Safety Improvement Advisors, Node Leaders VON Canada and ISMP Canada
- One face-to-face meeting
- Model for Improvement

Next Steps

- Ensure leadership commitment & active involvement
- Form team
- Read materials
- Call Sept. 22 to Get Started!!