Medication Reconciliation

ISMP Canada Annual Report to CPSI

Safer Healthcare Now! Medication Reconciliation Intervention

April 2007 to March 2008

ismp CANADA

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Safer Healthcare Now!

ISMP Canada Annual Report

Medication Reconciliation Intervention

Key Results for Period April 2007 to March 2008

The Institute for Safe Medication Practices (ISMP) Canada is committed to the advancement of medication safety in all healthcare settings. ISMP Canada is appreciative of the Canadian Patient Safety Institute's (CPSI) vision and commitment to patient safety across Canada. The combined effort of ISMP Canada and CPSI supports Canadian healthcare facilities to implement Medication Reconciliation in acute, long term and home care settings through the *Safer Healthcare Now!* campaign.

ISMP Canada, with support from CPSI and a *SHN!* National Medication Reconciliation Faculty created the Getting Started Kit for Medication Reconciliation in Acute Care during Phase I of the *Safer Healthcare Now!* campaign. In the second year of the *SHN!* campaign, ISMP Canada continued to support registered acute care teams, recruit new teams and created the Getting Started Kit for Medication Reconciliation in Long Term Care.

For 2007/2008, a number of key deliverables were established between ISMP Canada and CPSI related to the *Safer Healthcare Now!* Medication Reconciliation intervention (acute care and long-term care). ISMP Canada is pleased to present the following results for the contract deliverables.

Medication Reconciliation in Acute Care

Major Accomplishments

- ISMP Canada led the medication reconciliation (MedRec) intervention nationally in collaboration with the *SHN!* nodes, committees, working groups and partner organizations.

- ISMP Canada created, in collaboration with the National MedRec Faculty (Appendix 1), Version II of the Getting Started Kit (GSK) - Medication Reconciliation in Acute Care. This version included sections on implementing medication reconciliation at Transfer and Discharge. A French and English Version II GSK was released in May 2007.

- The terms 'Best Possible Medication History, (BPMH), 'undocumented intentional discrepancies', 'unintentional discrepancies' and 'Best Possible Medication Discharge Plan', (BPMDP) are becoming a common language in hospitals across the country and though new, have been quickly understood by practitioners. These terms are also be adapted by the High 5's – a WHO/ Joint Commission International initiative.

- The Canadian measures are working! Teams are measuring outcomes rather than just process. These measures will also be adapted by the High 5's – a WHO/ Joint Commission International initiative.

- Medication reconciliation is a Required Organizational Practice (ROP) for Accreditation Canada. ISMP Canada works closely with Accreditation Canada to develop and ensure the ROPs are attainable. ISMP Canada also assists teams with interpretation of the standards as they relate to medication reconciliation and to assist them in meeting these standards.

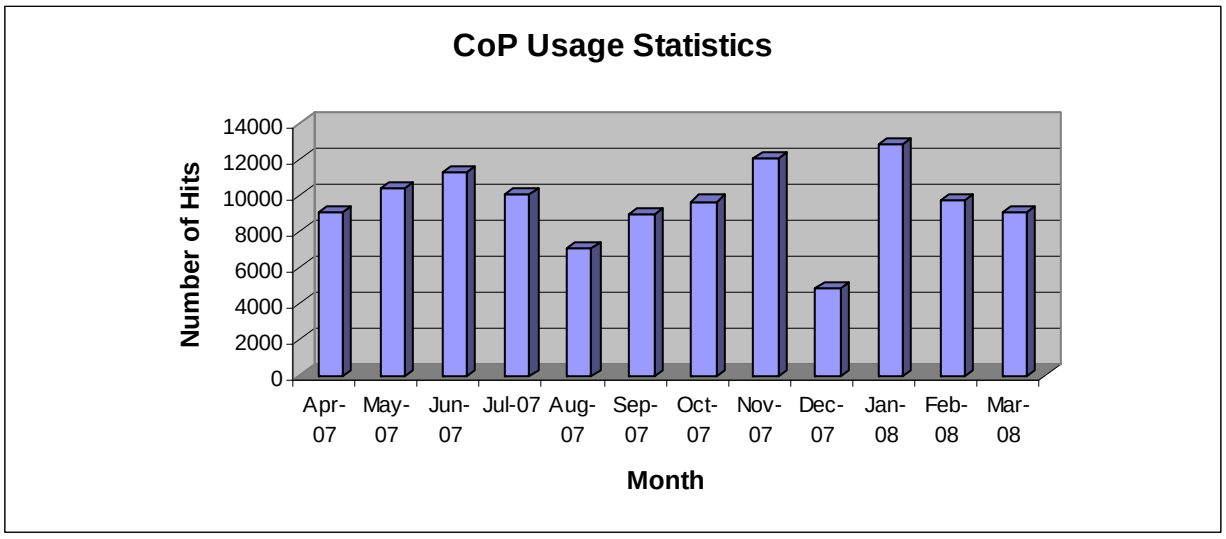
- The ISMP Canada team worked with the Canadian Society of Hospital Pharmacists (CSHP) to develop a position statement on medication reconciliation which will be approved by CSHP Council in August 2008.

- There were 9 national medication reconciliation calls for acute care hospitals between April 2007 and March 2008. These calls were very well attended with numbers of participants often reaching over 400 per call. The calls are listed in Appendix 2.

- Assistance in implementing the medication reconciliation process is required by teams across Canada. As a result, ISMP Canada team members have been involved in or invited to speak at numerous educational sessions and conferences across the country. All nodes were visited and supported during the course of the year. These include a 2-day Medbuy conference dedicated to MedRec, QHN conferences, Atlantic Node road-trips, Professional Practice Conference (PPC), the Western Node Collaborative meetings, etc. See Appendix 3 for a list of some these workshops and conferences.

- The ISMP Canada team identified topics, recruited and supported speakers for Learning Series 5 in Winnipeg, as well as developed and delivered plenary sessions and workshops (Clinical Significance of Medication Reconciliation and BPMH Training).

- The medication reconciliation Communities of Practice (CoP) is one of the most active in the campaign with 932 active members and between 7,000 and 12,803 hits per month. This CoP has seen teams across Canada begin to work together and help one another, sharing information, forms, and ideas and as a result has helped to strengthen the national campaign. ISMP Canada continues to monitor the MedRec CoP, continually populating it with new items related to medication reconciliation. Teams across Canada appear to value the CoP. ISMP Canada is also creating a bilingual CoP for some key materials.



- The ISMP Canada team identifies priority issues and responses, tools and approaches that work, resources and training, roles that are effective and common answers to questions for Canadian teams.

- ISMP Canada, along with the National MedRec Faculty created a one-page poster summarizing the steps involved in MedRec. This has assisted teams with an easy-to-read overview of the process involved for medication reconciliation at admission, transfer and discharge in an acute care facility (Appendix 4) and is available in both English and French.

- Development and support for medication reconciliation in homecare with VON was initiated in 2007 and 15-20 teams will begin in Sept. 2008.

- The number of teams enrolled in the *SHN!* MedRec in Acute Care intervention has increased from 210 – 374 over the period of April 2007 – March 2008. This total includes 333 Acute Care Teams and 16 Paediatric Teams.

National MedRec Acute Care Teams

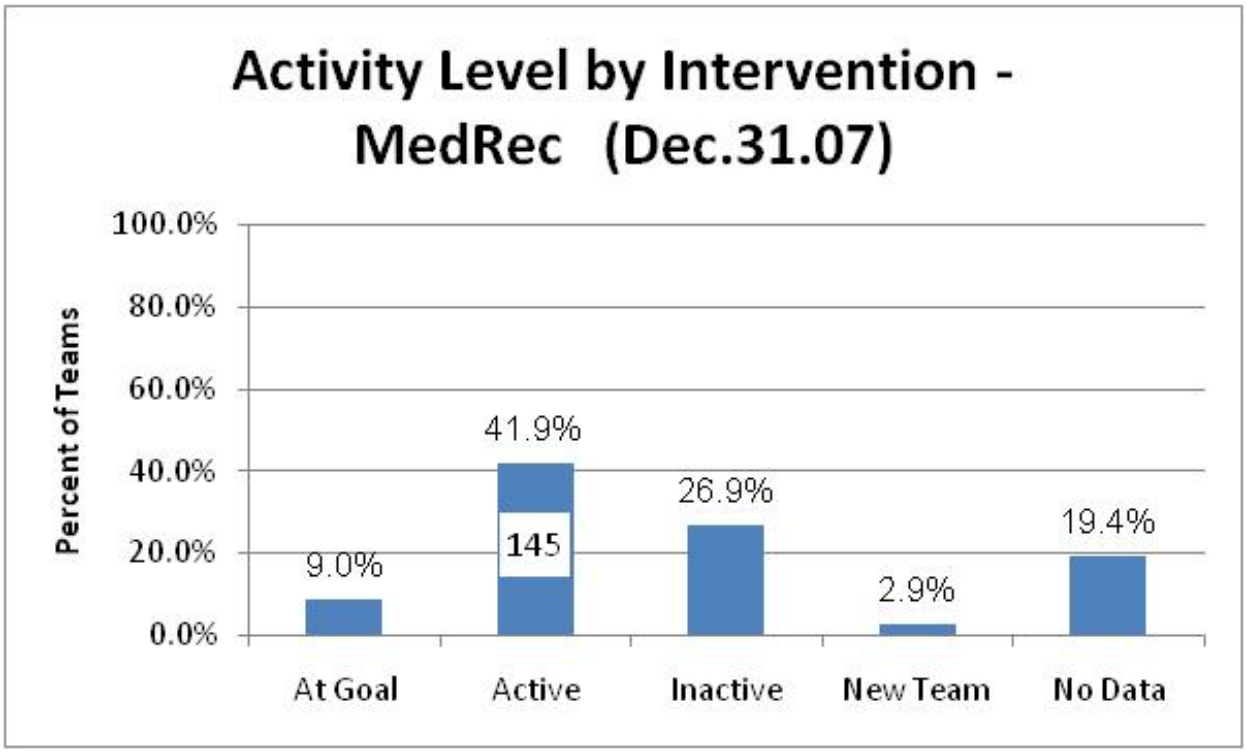
Node/Campaign	Regions	Healthcare Facilities	Teams	Reporting	% Reporting
Atlantic	23	34	46	43	93%
Quebec	5	9	9	1	11%
Ontario	14	95	170	131	77%
Western	45	110	131	103	79%
TOTAL	87	248	356	278	78%

- National MedRec teams reporting data to the Central Measurement Team, including paediatric teams has **increased from 39% in May 2006 to 77%** in May 2008

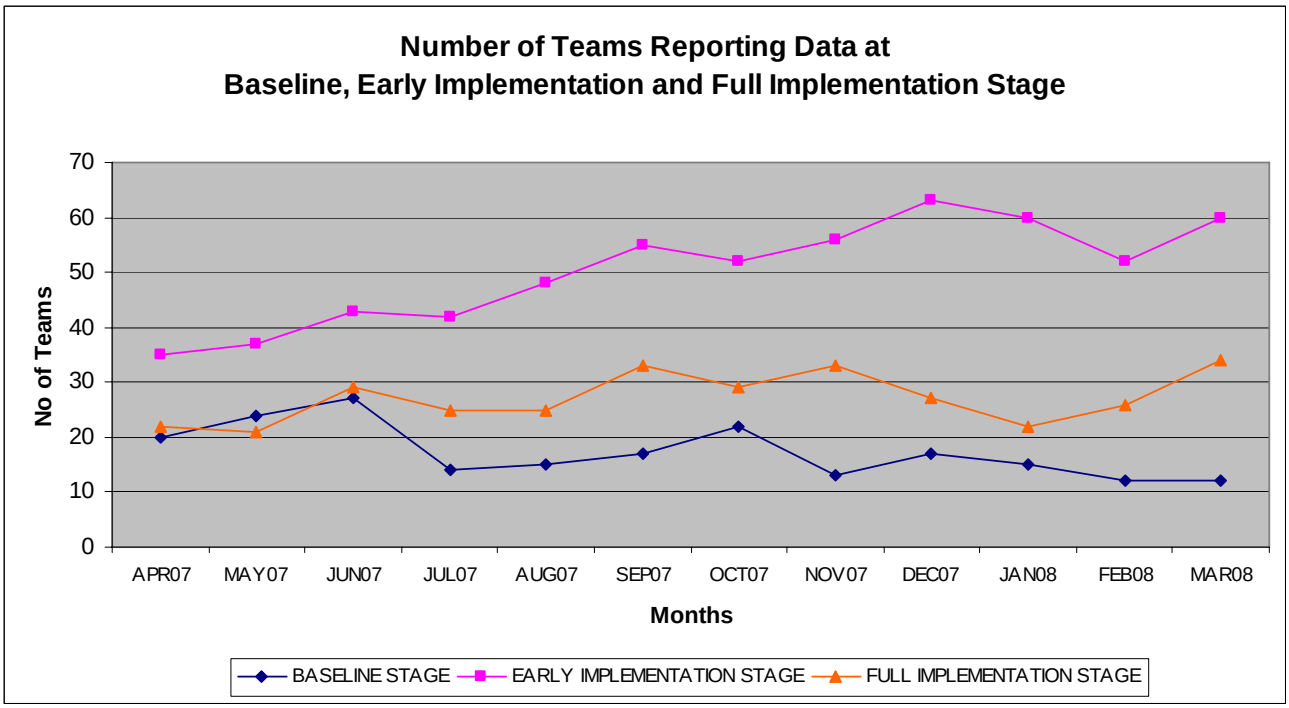
National MedRec Acute Care Teams reporting data vs. teams enrolled

Teams	May '06	May '07	May '08
Teams enrolled	118	225	374
Teams submitting	46	162	228
TOTAL	39%	72%	77%

- The activity level of teams submitting data shows that 41.9% of teams enrolled in MedRec are actively reporting data. The 26.9% of teams who have not submitted data in the last 6 months and are considered 'inactive'.



- A total of 278 (78%) of the acute care teams are reporting data to the central measurement team and 204 of the teams are submitting data for early to full implementation of the intervention. The remainder of the teams are at the baseline data collection stage or have not submitted data to date. As the months progress the trend for teams reporting baseline data will decrease as teams move into the early implementation stage. We expect to see this decrease occur in teams reporting in the early implementation stage as they progress to full implementation.

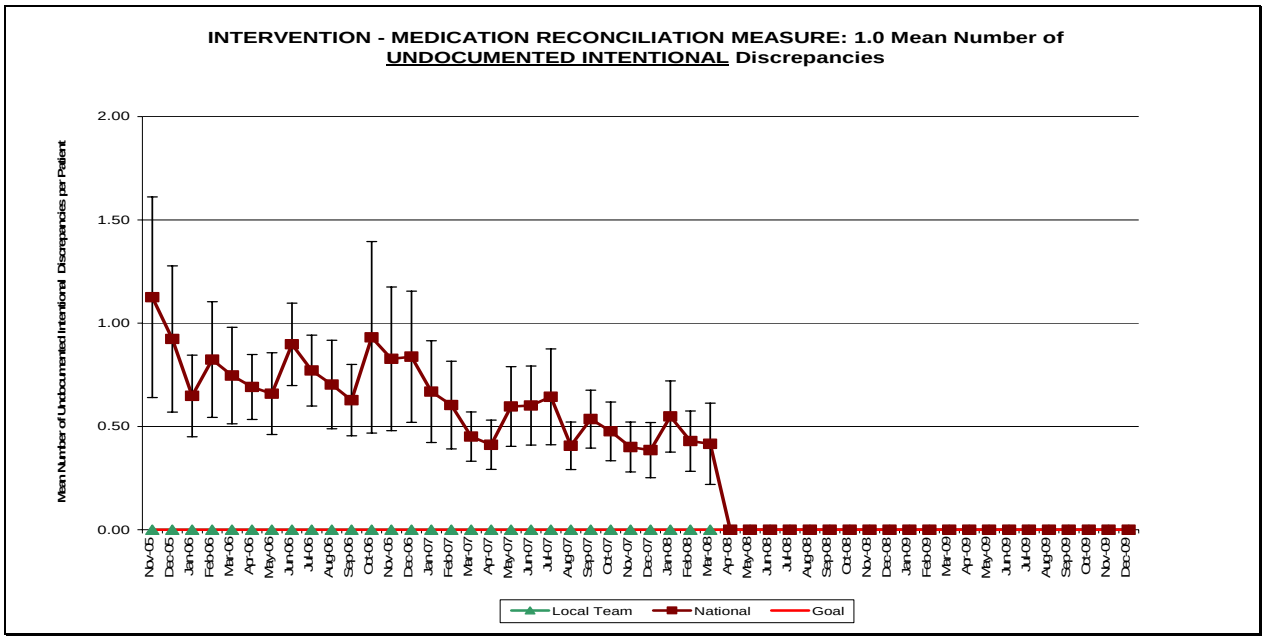


- The average number of team's continuously reporting data for the core measures is the highest of all measures in the *SHN!* campaign. We sense that this reflects that the measures are meaningful to teams and are understood. These measures have proven to be useful for teams to present to their management and senior administration teams to demonstrate value. It is understood of course, that the accreditation standard requirement greatly increases the reporting.

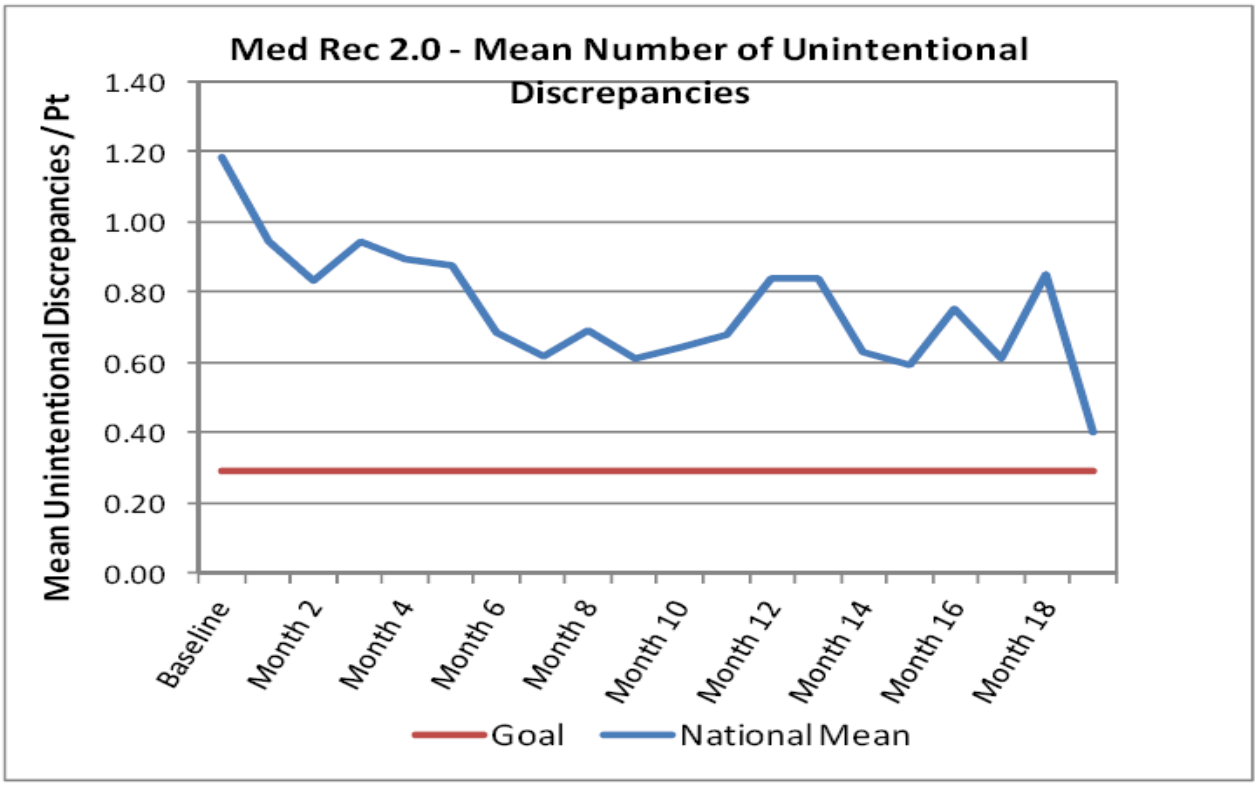
National MedRec Acute Care Teams continuously reporting the core measures to the Central Measurement Team

Measurement	Mean	Median	Range
1.0 Undocumented Intentional Discrepancies	67	69	28-97
2.0 Unintentional Discrepancies	67	69	28-94
3.0 Success Index	64	68	29-89

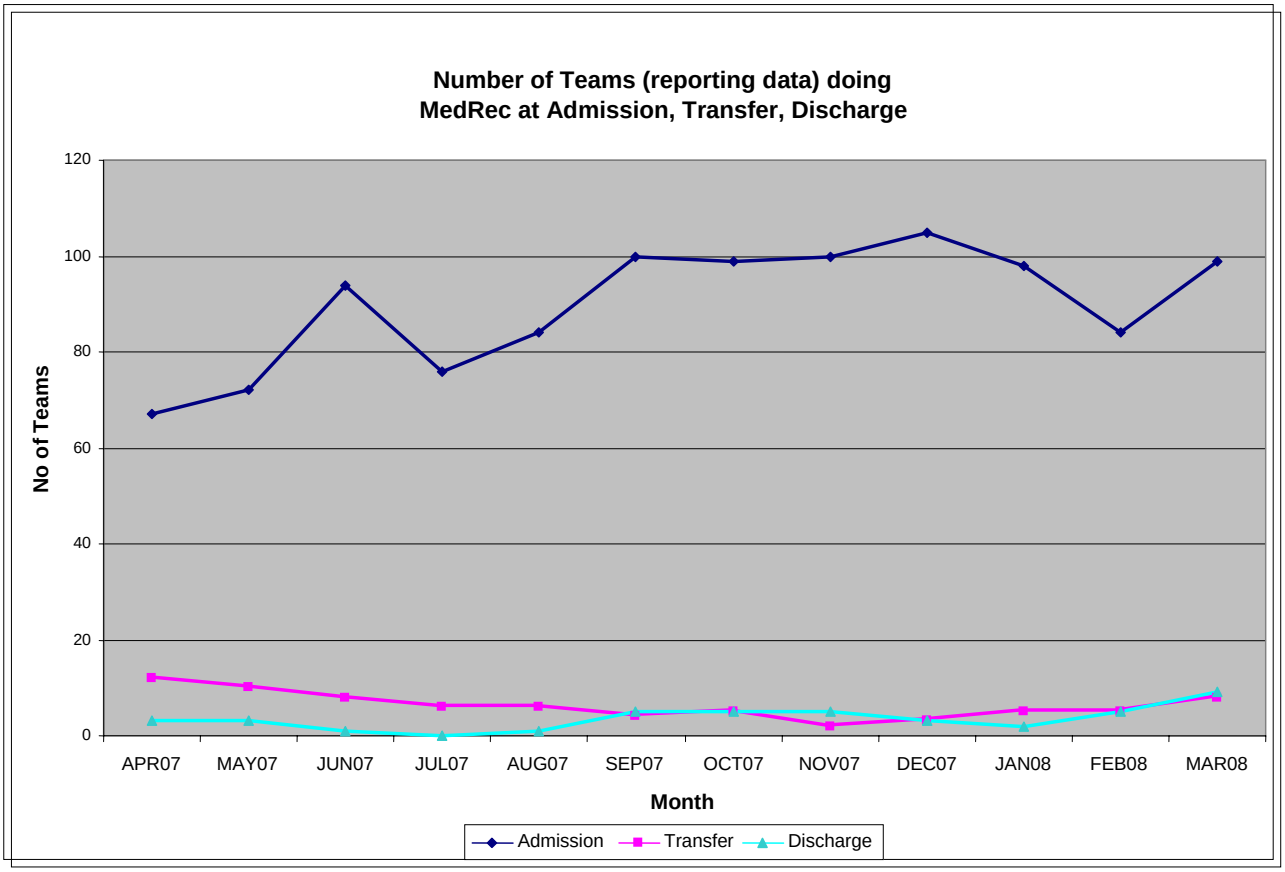
- *<u>Undocumented Intentional</u> Discrepancies* have decreased from 1.1 per patient to 0.34 per patient by the end of phase I of the campaign. This data is for teams in the early or full implementation stage and who are submitting data to the Central Measurement Team. Of the 209 teams reporting data, 67% have reached the national target goal of 0.25 undocumented intentional discrepancies per patient.



- *<u>Unintentional</u> Discrepancies* have decreased from 1.2 per patient to 0.42 per patient by the end of phase I of the campaign. Of the 209 teams reporting data, 54% have reached the national target goal of 0.25 unintentional discrepancies per patient.



- The number of teams who have implemented or started to implement MedRec at admission is close to 100 of those submitting data. Teams implementing MedRec at transfer and discharge is low due to teams wanting to have the MedRec process working well at admission and spread to all areas of their facility before starting on the next phase. Accreditation Canada is requiring hospitals to have medication reconciliation implemented at transfer points so we predict an increase.



"What Worked Well"

- GSK revisions were well received and made sense to teams regarding transfer and discharge.

- Teleconference calls were well attended and people seem to look forward to them. These national calls profiled teams and successes across the country.

- CoP became a main venue for communication and sharing amongst teams. The CoP includes hands-on experience, proven processes, procedures and forms; gets questions answered and has high usage statistics. Storage space is always an issue resulting in requests for more space on an almost monthly basis.

- National intervention leadership for medication reconciliation supporting nodes and connecting and sharing the work of teams builds national capacity for the intervention. The understanding that we have gained is now being utilized to develop processes to implement medication reconciliation across the continuum into LTC and homecare.

- The Medication Reconciliation National Faculty are quite engaged, are willing to participate in teleconference calls, present at conferences and answer questions on the CoP when requested. The

faculty appears to work better when there is a face-to-face meeting during the year. A face-to-face meeting helps to re-engage and reconnect members.

- A video was created for Learning Series 5 in which a patient's family member speaks about the significant impact of a medication reconciliation failure on a family. It has proven to be a valuable tool for teams.

- ISMP Canada assisted the Western Collaborative home care teams to create and test measures and is using the learning in the next project with VON Canada.

- Role playing skits were used in two nodes to demonstrate the medication reconciliation process and getting a BPMH.

Key Next Steps Planned

- Continue to educate teams by attending/speaking at conferences, workshops across Canada for acute care, long term care and home care sectors.

- Continue to hold national teleconference calls. The proposed schedule is to have one national call for Acute Care on the 3rd Wednesday of each month. Calls will not be scheduled in July and August. Topics for each call will be dependent on the needs of the teams. Suggested topics and schedule is in Appendix 2.

- Continue to educate teams that MedRec is not about creating and using a 'form'. It is about getting the Best Possible Medication History (BPMH) and reconciling the BPMH to physician orders at all interfaces of care in order to resolve them. Medication reconciliation is about communication.

- Continue to maintain and monitor the CoP to ensure all material within is organized, content is appropriate and questions are answered in a timely manner.

- Continue to review and revise the GSK for Acute Care to ensure information is up-to-date and correct. As this is a relatively new intervention, with limited data to support it, revisions and updates may be required. All revisions to the GSK will involved the MedRec National Faculty and teams as appropriate.

- Medication reconciliation in Acute Care GSK will be reviewed and revised to include the Accreditation Canada standards, potential revision of medication reconciliation definition, and measures. A faculty call will be planned for July/August to begin to address these issues.

- Including the 'Clinical appropriateness' of medications is a potential next step to be added to the MedRec process.
- Measurement of the impact of medication reconciliation at transfer and discharge will take place in 2008.
- Participation in medication reconciliation at High 5's – a WHO/ Joint Commission International effort.

- Explore the possibility of holding webinar's for certain training sessions. This could include training teams on how to get a BMPH, BPMDP, etc.

Medication Reconciliation in Long Term Care

ISMP Canada prepared the Getting Started Kit for Medication Reconciliation in Long-Term Care with input from the national faculty and clinical practitioners who work in the Long Term Care (LTC) sector across Canada. The kit was released to national teams at the Learning Series 5 in Winnipeg on April 2, 2008.

Although the kit uses the same concepts and terminology as the Acute Care GSK it was determined early on that these are two very different work environments. In general, long-term care facilities provide living accommodation for people who require on-site delivery of 24-hour, 7 days a week supervised care, including professional health services, high levels of personal care and services. They accommodate varying health needs with on-site supervision for personal safety.[1]

Long-term care facilities have a higher resident to nurse or RPN/LPN ratio and on-site pharmacist/physician services that vary from daily to weekly or monthly basis. The acuity of long-term care residents, while usually less than acute care patients has been increasing steadily, but long-term care residents are typically in more stable condition, except in specialized programs. Therefore, changes to a resident's care or medication regimen occur less frequently than in acute care. Residents in long-term care are often prescribed multiple medications and are usually serviced by a community or in-house pharmacy with multi-dose packaging.

Because of the above differences and needs in LTC, ISMP Canada recruited new members for the national medication reconciliation faculty to ensure clinical practitioners who work within the long term care sector were included. It was also very important to have the GSK reviewed by clinical experts working in the LTC sector. As a result, the kit was reviewed over a period of 6 months by 20 practitioners from across Canada.

Major Accomplishments

- Recruited clinical experts from the Long Term Care sector to join the medication reconciliation faculty (Appendix 1). This group now include experts from the Acute Care and Long Term Care sectors and continues to be a valuable resource to Canadian teams.

- Created a Getting Started Kit for Medication Reconciliation in Long-Term Care. This GSK includes LTC specific references and processes and was created with input from the national medication reconciliation faculty and nurses, doctors and pharmacists who currently work within the LTC sector across Canada.

- Launched the MedRec in LTC Getting Started Kit at the Learning Series 5 in Winnipeg MB on April 2, 2008. This kit is available in both French and English. More flow diagrams, PDSA cycles were translated in this kit than the Acute Care Kit.

- Revised the Measurements for medication reconciliation in long term care to include the 'Mean number of unintentional discrepancies', the 'Mean number of undocumented intentional discrepancies' and the 'Percentage of Residents Reconciled'. The acute care measure '% of patients reconciled at Discharge' was not applicable to LTC as most residents are not discharged from their facilities.

- Revised the One-Page-Poster to make it appropriate for the long term care environment. Patients generally are not discharged from LTC however when this happens teams are asked to communicate the Most Recent Medication List to the next care provider. This poster is available in English and French. Appendix 5 contains the LTC poster.

[1] Adapted from: Health Canada. What is Long-Term Facilities-Based Care? [cited 18Dec2007] Available from: http://www.hc-sc.gc.ca/hcs-sss/home-domicile/longdur/index_e.htm l.

- Contacted all provincial Long Term Care associations across Canada. These associations agreed to distribute the announcement about the LTC initiative and encourage teams to join the campaign. Appendix 5 contains the launch announcement.

- Created a 'Source of Information' reference as Long Term Care residents enter the facilities from/via a number of different locations/methods and the source of information required to complete the BPMH for each 'type' of admittance may differ.

- Revised the Communities of Practice to accommodate the Long Term Care initiative. This revision is ongoing and will continue as required. It was decided to use the existing medication reconciliation CoP for LTC as this will give them access to forms, tools, education packages already created and used by acute care facilities. This will help to decrease the LTC developmental workload.

- All national organizations for provincial and private funded long-term care homes were contacted and agreed to distribute to its membership the *SHN!* Announcement of this new initiative. To date 41 long-term care teams have joined the initiative. We anticipate this will increase in the next year.

National MedRec Long-Term Care Teams June 2008

Node/Campaign	Teams
Atlantic	8
Quebec	2
Ontario	9
Western	22
TOTAL	41

Key Next Steps Planned

- Teleconference calls for LTC will be planned and scheduled on the 2nd Wednesday of each month. At times some calls may be applicable to both LTC and Acute Care. The proposed schedule can be found in Appendix 2.
- Description of processes and development of measurement for medication reconciliation across the continuum of care – from acute care to homecare, nursing homes, community practice, etc. will be done.
- Increased support and resources for new teams.
- Increased sharing of team successes and processes that work across all sectors in the care continuum.
- Participation in LTC Collaborative in the Atlantic Node.
- Measurement of the impact of medication reconciliation at transfer and discharge will take place in 2008.
- Participation in medication reconciliation at High 5's – a WHO/ Joint Commission International effort.

Medication Reconciliation in Acute Care and Long Term Care

Summary of Major Accomplishments for both Initiatives

- Successful partnership and collaboration between ISMP Canada and CPSI and many other partners to support *SHN!*. Teams may not have known that some of the groups supporting them did not really work together until *SHN!*.
- Teams across Canada are now working together and helping one another – sharing information, forms, ideas, which strengthens the national campaign.
- ISMP Canada is working towards the creation of resources on the CoP for teams in both the English and French languages. National teleconference call presentations and agendas, announcements and selected posters are currently being posted in both languages.
- ISMP Canada, along with a national working group, created the framework for a *SHN!* mentorship program. This framework included documentation of all processes and procedures required to start a trial for the mentorship program.
- Continued and consistent involvement in *SHN!* committee/working group meetings and partnership in planning, problem-solving, sharing with the *SHN!* network of organizations has allowed ISMP Canada and the medication reconciliation initiative to maintain its alignment with the national and strategic direction of *SHN!*.
- The terms Best Possible Medication History, BPMH, Undocumented Intentional Discrepancies, Unintentional Discrepancies, Best Possible Medication Discharge Plan, and BPMDP are becoming a common language among healthcare practitioners and their meanings are understood.
- Workshops regarding medication reconciliation are being delivered as a partnership with Accreditation Canada across the country (both French and English) – this should result in more teams joining the *SHN!* Campaign and using the CoP.
- Education packages about 'why medication reconciliation', some of them very sophisticated, are posted on the CoP.
- The measures for medication reconciliation are working. Teams are reporting their data which is an indication that the measures are understood and useful. We have heard of teams using their data in monthly reports to their senior leaders and to request additional staff.
- The time to complete a BPMH is decreasing with experience. Teams collecting this optional measure have reported a decrease since the start of the intervention.
- Although not proven directly, we believe that medication reconciliation is decreasing the potential for Adverse Drug Events (ADEs) in Canadian healthcare facilities.

Key Next Steps for both Initiatives

- Continue to support Canadian medication reconciliation teams by planning, attending and speaking at conferences, workshops held by *SHN!* and other Canadian associations. To provide additional support for medication reconciliation for the next year, ISMP Canada has hired Dr. Olavo Fernandes from the University Health Network in Toronto. Dr. Fernandes will be joining ISMP Canada on a secondment beginning July 2008 and he will enhance our capacity to respond to requests for support and presentations, and strategically plan for medication reconciliation across Canada. He will also assist with the WHO High Fives project.
- Continue to reorganize the CoP to include sections for Acute Care, Long Term Care, Home Care, and Community Pharmacy. Having once central CoP for Medication Reconciliation will encourage sharing amongst teams regardless of their facility type.

- Medication reconciliation is the focus of Canadian Patient Safety Week this year. ISMP Canada is supporting and promoting CPSW and *SHN!* teams by supplying resources and tools to assist CPSW. This will also provide the opportunity to educate patients and encourage them to carry an accurate and up-to-date list of their medications.
- Administrators, leaders and team members must be well informed about the resource commitment for medication reconciliation – this continues to be a priority area.
- Leadership engagement – need more CEO's at the *SHN!* tables/conferences etc. The resource intensiveness of such a system change needs to be understood by leadership.
- More face-to-face meetings with teams.
- Communication strategy to reach patients – public education campaign.
- Faculty attendance at a yearly face-to-face meeting would increase their involvement in the campaign.
- Patient involvement is critical to the medication reconciliation process. The patient is the only constant participant across the system and is critical to the success of this major system change.
- Medication reconciliation is a system change which will contribute to seamless care across *all* healthcare settings. Collaboration with community pharmacists, long term care facilities and homecare is mandatory to ensure appropriate medication monitoring is present across all transition points.
- Electronic systems that simplify the medication reconciliation process are needed and ISMP Canada will have a leader in this regard in Olavo Fernandes.

Potential Risks for Future Phases Identified for both Initiatives

- Continued buy-in of physicians, nurses and pharmacists as the work becomes more mundane.
- Leadership buy-in in Long Term Care facilities.
- Time commitment for the medication reconciliation intervention across the system.
- Lack of understanding of the complexity of spreading across an organization.
- Difficulty implementing medication reconciliation at transfer and discharge – the definition of the best possible medication discharge plan is not yet well understood – we are asking for best practice and it is not an easy fix for acute care.
- Difficulty with sustaining measurement without increased leadership engagement**.**

Report prepared by Brenda Carthy, National Project Coordinator and Marg Colquhoun, National Intervention Lead. *Submitted July 2, 2008.*

Appendix

1

National Medication Reconciliation Faculty

Medication Reconciliation National Faculty

Name	Position	Facility
Hilary Adams	Quality Improvement Physician, Department of Family Medicine	Calgary Health Region, AB
Chaim Bell	Assistant Professor of Medicine and Health Policy, Management, & Evaluation Staff General Internist	University of Toronto, ON St. Michael's Hospital, ON
Patti Cornish	Pharmacist - Patient Safety Service	Sunnybrook Health Sciences Centre, ON
Margaret Colquhoun	Project Leader	Institute for Safe Medication Practices Canada (ISMP Canada), ON
Scott Edwards	Clinical Pharmacist	Newfoundland Cancer Treatment and Research Foundation, NFLD
Edward E. Etchells	Director, Patient Safety Service, Sunnybrook & Women's, Associate Professor of Medicine, Faculty of Medicine	Sunnybrook Health Sciences Centre, University of Toronto, ON
Kathy James Fairbairn	Consultant Pharmacist	Good Samaritan Society, AB
Olavo Fernandes	Pharmacy Practice Leader, Department of Pharmacy Services, Assistant Professor Faculty of Pharmacy Safety Specialist	Toronto General Hospital, University of Toronto, ON ISMP Canada, ON
Virginia Flintoft	Project Manager	Safer Healthcare Now! Central Measurement Team, University of Toronto, ON
Neil Honcharik	Regional Pharmacy Manager, Professional Practice Development Clinical Pharmacist	Winnipeg Regional Health Authority Pharmacy Department, Critical Care Health Sciences Centre, MB
James Lam	Director, Pharmacy Services	Providence Healthcare, ON
Neil J. MacKinnon	Associate Director for Research & Associate Professor, College of Pharmacy, Associate Professor, School of Health Services Administration and Department of Community Health and Epidemiology	Dalhousie University Halifax, NS
Peter Norton	Professor and Head of the Department of Family Medicine, Faculty of Medicine	University of Calgary, AB
Fruzsina Pataky	Medication Safety Coordinator	Providence Health Care, BC
Judy Schoen	Pharmacy Patient Care Manager	Foothills Medical Centre, Calgary Health Region, Calgary, AB
Kim Streitenberger	Team Leader, Quality Programs Pediatric Intensive Care Unit, Department of Critical Care Medicine	Hospital for Sick Children, Toronto, ON

Appendix

2

National Medication Reconciliation Teleconference Calls

National Medication Reconciliation Teleconference Calls

Thu, Apr 26, 2007 12:00 PM to 1:00 PM	**Hot off the Press! - MedRec Getting Started Kit, Version 2: The Keeping Going Kit!** Purpose of the call is to describe key changes to the Medication Reconciliation Getting Started Kit including new internal transfer and discharge processes and changes to the measurement strategy and share new information in the GSK to assist teams when implementing medication reconciliation across the continuum of care. Speaker: Marg Colquhoun, ISMP Canada
Thu, May 31, 2007 12:00 PM to 1:00 PM	**"Empowering clinicians to address the challenges of discharge medication reconciliation"** A teleconference for all medication reconciliation teams. The Purpose of the call is to identify strategies to successfully implement medication reconciliation at discharge including the provision of the Best Possible Medication Discharge Plan. Speaker: Dr. Olavo Fernandes, University Health Network, Toronto, ON.
Tue, Jul 17, 2007 2:00 PM to 3:00 PM	**"Trading Data for Dollars: Making the case for Medication Reconciliation"** The purpose of the call is to help teams identify strategies to successfully create a business plan for medication reconciliation. Speaker: Dr. Ed Etchells, Sunnybrook Health Sciences Centre, Toronto, ON.
Wed, Sep 12, 2007 12:00 PM to 1:00 PM	**“Med. Rec. - "Using a Tech” - Successful Experiences with Pharmacy Technicians in Implementing Medication Reconciliation** The purpose of the call is to identify strategies to successfully implement medication reconciliation using a pharmacy technician to obtain the Best Possible Medication History (BPMH). Speakers: Lauza Saulnier, Melissa White, Southeast Regional Health Authority, Moncton, NS and Susan Macdonald, Ross Memorial Hospital, Lindsay, ON
Wed, Oct 31, 2007 12:00 PM to 1:00 PM	**MedRec in Mental Health** The purpose of the call is to Identify strategies to successfully implement medication reconciliation in a mental health facility or patient care area. Speaker: Jamie Kellar, Whitby Mental Health Centre, Whitby, Ontario.
Tue, Nov 27, 2007 12:00 PM to 1:00 PM	**MedRec Strategies for Transfer** The purpose of this call is to share the experience of developing a process for the identification of medication discrepancies occurring upon transfer, assessing the prevalence and clinical significance of these discrepancies, and the challenges of medication reconciliation at this point of care. Speakers: Jennifer Harrison, Kori Leblanc and Dr. Dante Morra, University Health Network, Toronto ON.
Wed, Jan 16, 2008 12:00 PM to 1:00 PM	**MedRec in a Surgical pre-admission clinic** The purpose of the call is to talk about how Vancouver Island Health Authority was successful at implementing MedRec in a surgical pre-admission clinic. Presentation handouts to follow. Speaker: Cynthia Turner, Vancouver Island Health Authority, BC.

Note: All times = Eastern Standard Time

Medication Reconciliation Teleconferences by Node

Thu, Feb 22, 2007 12:00 PM to 2:00 PM	**CAPHC-SHN! Paediatric Medication Reconciliation Collaborative** The purpose of the call is: How are we doing? National Summary of Paediatric Early Implementation Data, review of the Safer Healthcare Now! Third Quarterly Report and sharing and learning from each other: Are we being family centred? Guest Speakers: Collaborative Members Virginia Flintoft, SHN! Central Measurement Team Margaret Colquhoun, ISMP Canada
Mon, Apr 23, 2007 12:00 PM to 1:00 PM	**Medication Reconciliation in Home Care** Getting Started For home care teams in the Western Node
Thu, Sep 06, 2007 1:00 PM to 2:30 PM	**CAPHC-*SHN!* Paediatric Medication Reconciliation Collaborative** Listen, Reflect and Move Forward Purpose of the call: Overview of PMRC progress to date to Sept 2007 Update on Baseline and Early Implementation Data The crossroads – moving from early implementation to sustainability
Mon, Oct 29, 2007 12:00 PM to 1:00 PM	**Ontario Node Open Line Call** The Ontario Node is launching its series of Ontario Node Open Line Calls which will run throughout the coming year. The first call in this new series will take place on Monday, October 29th, from 12:00-1:00 p.m. EDT ...
Wed, Nov 07, 2007 12:00 PM to 1:00 PM	**Medication Reconciliation- Atlantic Node Connection Call** The purpose of the MedRec Connection Call is to provide a forum for open dialogue, sharing of work, and building capacity to improve the safety of healthcare services.

National MedRec Calls - Proposed Schedule

Proposed National Teleconference Calls April 2008 – March 2009
MedRec in Long-Term Care

Proposed Date	Proposed Topic	Proposed Speaker
April 16, 2008	Getting Started with MedRec in LTC	Marg Colquhoun
May 14, 2008	Finding MIMO (Moving In Moving Out) Medication Orders in LTC	Fruzsina Pataky
June 18, 2008	How to Train Your Staff to get a BPMH	Linda Cawthorn
September 10, 2008	**Webinar:** Fraser Healthcare's module for MedRec at Emergency and Pre-admission clinic	Janice Munroe
October 8, 2008	Getting Started with the Quality Improvement Model	Dannie Currie
November 12, 2008	How our LTC Facility Implemented MedRec	Kathy James Fairburn – Western Node
December 10, 2008	How our LTC Facility Implemented MedRec	TBD – Ontario Node
January 14, 2009	How our LTC Facility Implemented MedRec	TBD – Atlantic Node
February 11, 2009	Accreditation Canada Expectations for MedRec in LTC	TBD – Accreditation Canada Representative
March 11, 2009	TBD	TDB

Note: TBD indicates topics and speakers are open dependent on needs of teams

Proposed National Teleconference Calls April 2008 – March 2009
MedRec in Acute Care

Proposed Date	Proposed Topic	Proposed Speaker
June 18, 2008	How to Train Your Staff to get a BPMH	Linda Cawthorn
September 17, 2008	Overcoming Barriers with MedRec	Doris Nessim, North York General Hospital
October 15, 2008	Our Experience with Spreading MedRec at Admission to all Sites within our Region	Don Kuntz
November 19, 2008	MedRec in the Emergency Department – Our Success Tips	Nancy Kay, Chatham-Kent, ON or TBD
December 17, 2008	MedRec at Discharge – Our Success Tips	Olavo Fernandes and other teams TBD
January 14, 2009	Accreditation Canada Expectations for MedRec in Acute Care	Accreditation Canada Representative
February 18, 2009	TBD	TBD
March 18, 2009	TBD	TBD

Note: TBD indicates topics and speakers are open dependent on needs of teams

Appendix

3

National Conference Speaking Engagements

National Conference Speaking Engagements

May 02, 2007	**Don't Feel Wrecked by Medication Reconciliation** – **Atlantic Node Road Show,** Halifax, NS
May 04, 2007	**Don't Feel Wrecked by Medication Reconciliation** – **Atlantic Node Road Show,** Cornerbrook, NL
May 08, 2007	**Don't Feel Wrecked by Medication Reconciliation** – **Atlantic Node Road Show,** - Fredericton NB
May 14 - May 15, 2007	**Learning Session 1: Western Node Breakthrough Series Collaborative Learning Session** - Saskatoon, SK
May 28 – May 30 2007	**EDMONTON II: Enhancing Safety in Home, Community and Long Term Care,** Edmonton, AB
June 4 – June 5, 2008	**Medbuy Medication Reconciliation Conference,** London, ON
June 14, 2008	**Lilly Seminar** - PEI
June 18, 2007	**Don't Feel Wrecked by Medication Reconciliation – Atlantic Node Road Show,** Cornwall, PEI
Sept 06, 2007	**CAPHC-*SHN!* Paediatric Medication Reconciliation Collaborative**
Sept 23 – 26, 2007	**Learning Series II: Western Node Breakthrough Series Collaborative Learning Session** – Victoria, BC
Jan 28 – Jan 30, 2008	**Professional Practice Conference**, Toronto, ON
Feb 3 – Feb 5. 2008	**Learning Series III: Western Node Breakthrough Series Collaborative Learning Session**, Edmonton, AB
Feb 25 - Feb 27, 2008	**Edmonton III: Enhancing Safety in Home, Community and Long Term Care Conference**, Edmonton, AB
Apr 01 - Apr 02, 2008	**Learning Series 5 - Building Momentum for the Future:** Winnipeg, MB

Note: All times = Eastern Standard Time

Appendix

4

INSTITUTE FOR SAFE MEDICATION PRACTICES CANADA

ISMP Canada Annual Report: Medication Reconciliation Intervention, April 2007 to March 2008

Medication Reconciliation Acute Care Posters

MEDICATION RECONCILIATION
From Admission to Discharge

ADMISSION

AT ADMISSION:

The goal of admission medication reconciliation is to ensure there is a conscious decision on the part of the patient's prescriber to continue, discontinue or modify the medication regime that a patient has been taking at home.

Compare:

Best Possible Medication History (BPMH)

vs.

Admission Medication Orders (AMO)

to identify and resolve discrepancies

TRANSFER

AT TRANSFER:

The goal of transfer medication reconciliation is to consider not only what the patient was receiving on the transferring unit but also any medications they were taking at home that may be appropriate to continue, restart, discontinue or modify.

Compare:

Best Possible Medication History (BPMH)

and the

Transferring Unit Medication Administration Record (MAR)

vs.

Transfer Orders

to identify and resolve discrepancies

DISCHARGE

AT DISCHARGE:

The goal of discharge medication reconciliation is to reconcile the medications the patient is taking prior to admission and those initiated in hospital, with the medications they should be taking post-discharge to ensure all changes are intentional and that discrepancies are resolved prior to discharge.

Compare:

Best Possible Medication History (BPMH)

and the

Last 24 hour Medication Administration Record (MAR)

plus

New medications started upon discharge

to identify and resolve discrepancies and prepare the Best Possible Medication Discharge Plan (BPMDP)

Adapted from Gurwitz, J. H. (2005). Medication Reconciliation. American Journal of Nursing, 105(6), 51-54.

BILAN COMPARATIF DES MÉDICAMENTS
de l'admission au congé

ADMISSION

LORS DE L'ADMISSION :

Le but du bilan comparatif des médicaments lors de l'admission est de s'assurer que le médecin prescripteur décide de manière éclairée de poursuivre, d'interrompre ou de modifier les médicaments que le patient prenait à la maison.

Comparer :

le meilleur schéma thérapeutique possible (MSTP)

avec les

ordonnances émises à l'admission (OÉA)

pour identifier et résoudre les divergences

TRANSFERT

LORS D'UN TRANSFERT :

Le but d'un bilan comparatif des médicaments lors d'un transfert est de prendre en considération, non seulement les médicaments que le patient reçoit lors du transfert, mais aussi tous les médicaments qu'il prenait à la maison et qui doivent être maintenus, interrompus ou modifiés.

Comparer :

le meilleur schéma thérapeutique possible (MSTP)

et le

Registre d'administration des médicaments dans l'unité de transfert

avec les

ordonnances émises lors du transfert

pour identifier et résoudre les divergences

CONGÉ

LORS D'UN CONGÉ :

Le but du bilan comparatif des médicaments lors d'un congé est de comparer les médicaments pris par le patient avant l'admission (MSTP) et ceux pris à l'hôpital avec les médicaments qui doivent être pris après le départ du patient de l'hôpital, pour s'assurer que tous les changements sont intentionnels et que les divergences sont résolues avant le congé.

Comparer :

le meilleur schéma thérapeutique possible (MSTP)

et le

Registre d'administration des médicaments dans les 24 dernières heures,

ainsi que les

nouveaux médicaments prescrits lors du congé

pour identifier et résoudre les divergences et élaborer le meilleur plan médicamenteux possible lors d'un congé (MPMPC)

Adapted from Gunnarsson, J. H. (2012). Medication Reconciliation. American Journal of Nursing, 112(10), 61-64.

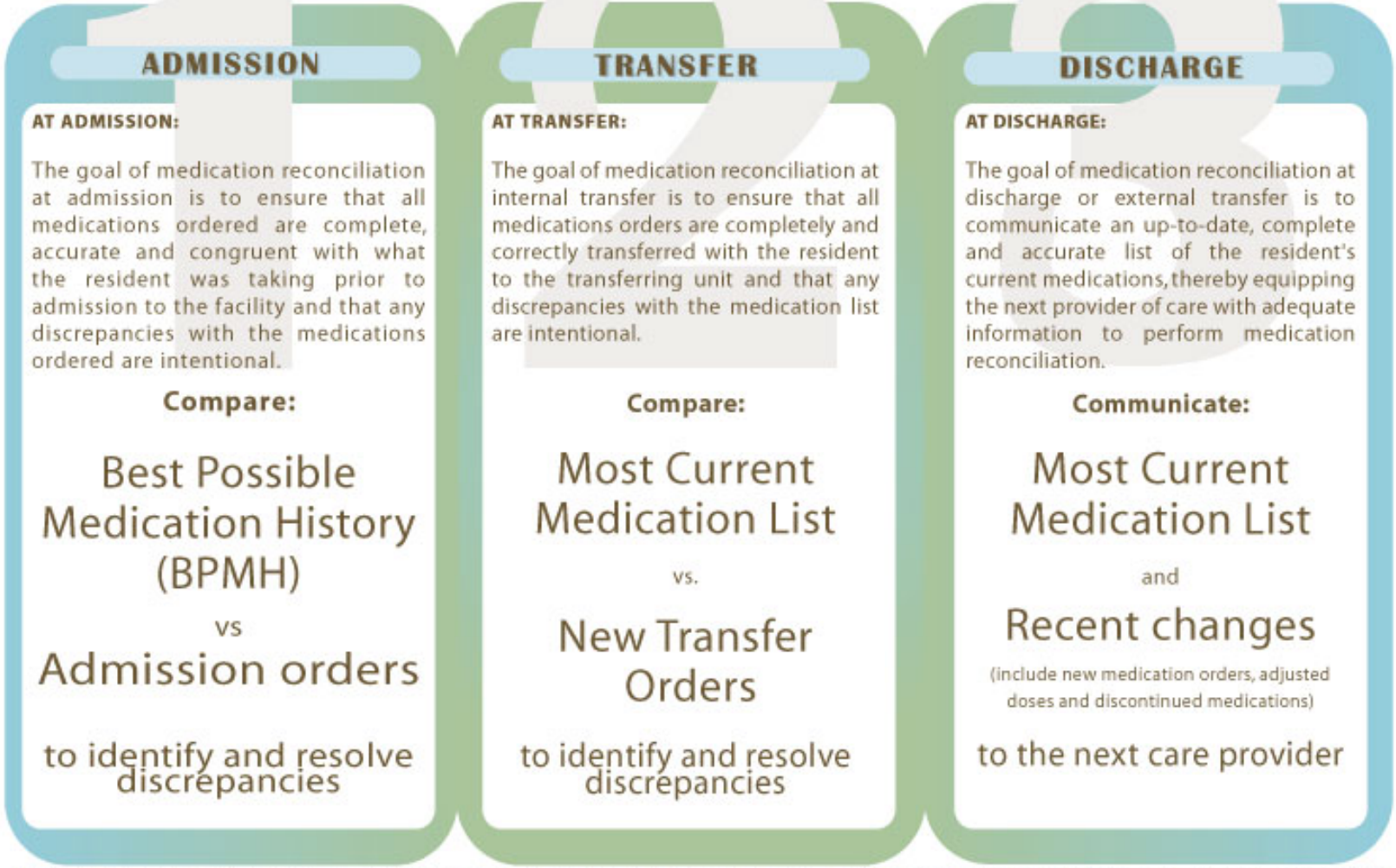
Appendix

5

Medication Reconciliation Long-Term Care Posters

MEDICATION RECONCILIATION

From Admission to Discharge in Long-Term Care



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.

LE BILAN COMPARATIF DES MÉDICAMENTS

De l'admission au congé en soins de longue durée

ADMISSION

À L'ADMISSION :

Le but du bilan comparatif des médicaments au moment de l'admission est d'assurer que tous les médicaments prescrits soient complets, adéquats et congruents avec ce que le résident prenait avant l'admission à l'établissement et que toute divergence en lien avec les médicaments prescrits est intentionnelle.

Comparez :

Le meilleur schéma thérapeutique possible (MSTP)

avec

Les ordonnances émises à l'admission (OÉA)

afin de pouvoir identifier et résoudre les divergences

TRANSFERT

AU TRANSFERT :

Le but du bilan comparatif des médicaments au moment du transfert interne est d'assurer que toutes les ordonnances de médicaments soient entièrement et correctement transférées avec le résident à l'unité de transfert et que toute divergence avec la liste de médicaments est intentionnelle.

Comparez :

La liste de médicaments la plus récente (LMPR)

avec

Les nouvelles ordonnances émises lors du transfert

afin de pouvoir identifier et résoudre les divergences

CONGÉ

AU MOMENT DU CONGÉ :

Le but du bilan comparatif des médicaments lors d'un congé ou d'un transfert externe est de communiquer une liste complète, précise et à jour des médicaments du résident, procurant ainsi au prochain professionnel de la santé l'information adéquate qui lui permettra d'établir le bilan comparatif des médicaments.

Communiquez :

La liste de médicaments la plus récente (LMPR)

et

les derniers changements
(incluant les nouvelles ordonnances de médicaments, les ajustements de doses et les médicaments discontinués)

au prochain professionnel de la santé

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.

Appendix

6

Medication Reconciliation in Long-Term Care Announcement

New *Safer Healthcare Now!* Intervention

Medication Reconcililation in Long-Term Care

Getting Started Kit to be released April 2, 2008

The *Safer Healthcare Now!* (SHN) campaign is expanding!

One of four new interventions is Reducing Adverse Drug Events in Long-term Care (LTC) by implementing Medication Reconciliation (MedRec)

Canadian Long Term Care facilities are invited to join the *Safer Healthcare Now!* medication reconciliation intervention. The goal is to decrease medication discrepancies upon admission to LTC by 75% in the next year.

What is Medication Reconciliation?

Medication reconciliation is process intended to reduce potential adverse drug events (ADEs) and potential harm associated with changes in or the loss of medication information, as patients/clients/residents transfer among healthcare settings. Medication reconciliation should occur upon admission to long -term care facilities.

A 2006 review of the transfer of information from an acute care hospital to a long term care facility identified that major errors of omissions and commissions occur frequently.[1]

Enrolment in the Campaign is a simple two stage process:

(1) Complete the online form

(2) Print your enrolment form, obtain a signature from your CEO/Designate, and fax to the number provided.

If you are already enrolled in Phase I of the *Safer Healthcare Now!* campaign, it is not necessary for you to re-enroll for the new interventions, but you must advise us that you are adding this intervention.

Join now! You can help to reduce adverse drug events and ensure Canadian long term care facilities are safe for our residents.

[1] Lee V, Westley CJ, Fletcher K. If at first you don't succeed: Efforts to improve collaboration between nursing homes and a health system. Top Adv Pract Nurse J. Available at: http://www.medscape.com/viewarticle/487323 November 1, 2006

Upcoming National LTC Medication Reconciliation Calls:

April 2, 2008
MedRec in LTC Getting Started Kit Launch

April 16, 2009
Getting Started with MedRec in LTC

May 14, 2008
Finding MIMO (Moving In Medication Orders) to LTC

safer healthcare now!

For more information on the *Safer Healthcare Now!* campaign visit our webiste at: www.saferhealthcarenow.ca

Safer Healthcare Now! Enrolment in Long-Term Care Medication Reconciliation

Safer Healthcare Now! (*SHN!*) is excited to launch Phase II of the medication reconciliation intervention which is implementation of **medication reconciliation in long-term care** (LTC) settings. This is intended to eliminate confusion, inadvertent changes and/or errors in medication information at care transitions such as home to LTC or acute care to LTC.

The goal of medication reconciliation is to prevent adverse drug events ADE's) at interfaces of care. This is done by identifying and resolving discrepancies and improving documentation.

In acute care, in the first phase of *SHN!,* medication reconciliation was shown to be an effective process in reducing unintentional discrepancies and potential patient harm. By the end of the second year of data submission to the *SHN!* campaign; acute care medication reconciliation teams were able to reduce the rate of *undocumented intentional* discrepancies by 55% and the rate of *unintentional* discrepancies by 30%.

Based on the learning from Phase I, *SHN!* has developed resources, processes, tools and infrastructure to support teams to expand medication reconciliation into long-term care settings.

Long-Term Care Facilities are invited to join the medication reconciliation intervention *of Safer Healthcare Now!*. Our goal is to reduce the number of discrepancies by 75% and conduct reconciliation on 100% of admissions in the next year.

By joining the *SHN!* campaign you will become a member of the Medication Reconciliation Communities of Practice. This on-line resource website allows teams across the country to share information, tools, resources, and discuss successful strategies. Canadian acute care medication reconciliation teams are very willing to share their experience and as a result these resources will be available to all teams.

Enrollment in the campaign is a simple two step process:

1. Complete the enrollment form (click 'enrollment form')
2. Print your completed enrollment form, obtain a signature from your CEO/Designate, and fax to the number provided.

If you are already enrolled in Phase I of the *SHN!* campaign, it is not necessary to re-enroll for the new intervention, but you must advise us that you are adding Long Term Care.

Join Now! You can help to reduce adverse drug events in your long-term care facility.

The Institute for Safe Medication Practices (ISMP) Canada will lead this intervention, expanding on the process developed for medication reconciliation in acute care.

Nouvelle stratégie pour la campagne québécoise Ensemble, améliorons la prestation sécuritaire des soins de santé! (EAPSS)

Bilan comparatif des médicaments en soins de longue durée

La trousse En avant! sera lancée le 2 avril 2008

La campagne québécoise EAPSS est en expansion!

Une des quatre nouvelles stratégies est de réduire le nombre d'événements indésirables liés à l'utilisation des médicaments dans le milieu des soins de longue durée (SLD) en mettant en œuvre le bilan comparatif des médicaments (BCM)

Les établissements de soins de longue durée sont invités à participer à la stratégie du BCM de la campagne québécoise EAPSS. L'objectif est de réduire de 75% le nombre de divergences liées à la médication lors de l'admission dans un établissement de SLD, d'ici la prochaine année.

En quoi consiste le bilan comparatif des médicaments?

Le BCM est un processus qui permet de réduire le nombre d'événements indésirables liés à l'utilisation des médicaments tout en diminuant le préjudice potentiel associé à un changement ou à une lacune au niveau de l'information liée à la médication, alors que les patients/clients/résidents sont transférés dans un autre établissement de santé. Le BCM devrait être effectué lors de l'admission dans un établissement de SLD.

En 2006, une revue de la littérature portant sur le transfert de l'information d'un centre hospitalier de soins de courte durée vers un établissement de soins de longue durée a permis d'identifier une fréquence élevée d'omissions.[1]

L'inscription à la campagne québécoise EAPSS se fait en deux étapes :

1. Compléter le formulaire disponible en ligne sur : http://www.chumtl.qc.ca (lien de la campagne québécoise)
2. Imprimer le formulaire d'inscription, le faire signer par le directeur général de l'établissement et l'envoyer par télécopieur au numéro indiqué.

Si vous êtes déjà inscrit à la Phase I de la campagne québécoise EAPSS, vous n'avez pas besoin de vous réinscrire pour la phase II, mais vous devez nous aviser que désirez ajouter une nouvelle stratégie.

Venez vous joindre à nous! Vous pouvez aider à réduire le nombre d'événements indésirables liés à l'utilisation des médicaments dans le milieu des soins de longue durée.

[1] Lee V, Westley CJ, Fletcher K. *If at first you don't succeed: Efforts to improve collaboration between nursing homes and a health system.* Top Adv Pract Nurse J. Disponible sur le site : http://www.medscape.com/viewarticle/487323 1er novembre, 2006

Conférences téléphoniques nationales à venir sur le BCM en soins de longue durée:

Le 2 avril, 2008
Lancement de la trousse En avant!

Le 16 avril, 2008 – Conférence téléphonique
En avant avec le BCM en soins de longue durée

Le 14 mai, 2008 – Conférence téléphonique
Trouver MIMO (Moving In Medication Orders) en SLD

Campagne québécoise
Ensemble, améliorons la prestation sécuritaire des soins de santé!

Pour plus d'informations sur la campagne québécoise EAPSS, visitez notre site internet au : www.chumtl.
(lien de la campagne québécoise).

des soins de santé plus sécuritaires Maintenant!

Campagne québécoise
Ensemble, améliorons la prestation sécuritaire des soins de santé!

des soins de santé plus sécuritaires maintenant!

Inscription au bilan comparatif des médicaments en soins de longue durée

La campagne québécoise Ensemble, améliorons la prestation sécuritaire des soins de santé (EAPSS), en collaboration avec la campagne canadienne Des soins de santé plus sécuritaires maintenant!, est heureuse de faire le lancement de la deuxième phase de la stratégie du bilan comparatif des médicaments qui se fait cette fois-ci dans le milieu des soins de longue durée (SLD). Ceci a pour but d'éliminer la confusion, les changements par inadvertance et/ou des accidents liés à de ***l'information inappropriée*** *sur le médicaments lors des transferts p.ex. du domicile aux SLD ou des soins de courte durée aux SLD.*

L'objectif du bilan comparatif des médicaments est de prévenir les événements indésirables lies à l'utilisation de la médication à toutes les étapes de soins en identifiant et en résolvant les divergences et en améliorant la documentation.

Lors de la première phase de la campagne québécoise EAPSS, qui était effectuée dans un contexte de soins de courte durée, il a été démontré que le bilan comparatif des médicaments est un processus efficace pour réduire les divergences non-intentionnelles de même que les préjudices potentiels envers le patient. À la fin de la deuxième année de transmission des données à la campagne canadienne Des soins de santé plus sécuritaires maintenant!, les équipes inscrites au BCM en soins de courte durée ont pu réduire le taux de divergences intentionnelles non documentées de 55% et le taux de divergences non intentionnelles de 30%.

Suite aux apprentissages de la Phase I, la campagne québécoise EAPSS en collaboration avec la campagne canadienne Des soins de santé plus sécuritaires maintenant!, ont tous les deux développé des ressources, des processus, des outils ainsi qu'une infrastructure pour apporter du soutien aux équipes et étendre le BCM dans le milieu des soins de longue durée.

Les établissements de soins de longue durée sont invités à s'inscrire à la stratégie du bilan comparatif des médicaments de la campagne québécoise EAPSS. Notre objectif est de réduire le nombre de divergences de 75% et d'effectuer un BCM sur 100% des admissions d'ici la prochaine année.

En s'inscrivant à la campagne québécoise EAPSS vous allez être membre de la communauté de pratique du BCM. Cette ressource disponible en ligne, permet aux différentes équipes de partager de l'information, des outils, des ressources et avoir un forum pour discuter des stratégies gagnantes, et ce, à travers le Canada. Les équipes de BCM en soins de courte durée sont prêts à partager leur expérience et elles seront disponibles à tous les membres.

L'inscription à la campagne québécoise se fait en deux étapes:

1. Compléter le formulaire d'inscription (aller sur le site www.chumtl.qc.ca, cliquer sur le lien de la campagne québécoise et cliquer de nouveau sur l'onglet comment s'inscrire)
2. Imprimer le formulaire, le faire signer par le directeur général de votre établissement et l'envoyer par télécopieur au numéro qui est affiché sur le formulaire.

Si vous êtes déjà inscrit à la Phase I de la campagne québécoise EAPSS, vous n'avez pas besoin de vous réinscrire pour la phase II, mais vous devez nous aviser que vous désirez ajouter la stratégie du BCM en soins de longue durée.

Venez vous joindre à nous! Vous pouvez aider à réduire le nombre d'événements indésirables liés à l'utilisation des médicaments dans votre établissement de soins de longue durée.

APPENDIX

7

Medication Reconciliation in Long-Term Care Information Summary Sheet

Medication Reconciliation (Long-Term Care)

The 10 SHN interventions

- **AMI** – Acute Myocardial Infarction
- **CLI** – Central-line associated Bloodstream Infections
- **Falls** – Falls Collaborative in Long-term care
- **MedRec** – Medication Reconciliation (Acute-care)
- **MedRec** – Medication Reconciliation (Long-term care)
- **MRSA** - Antibiotic-resistant organisms (AROs)/Methicillan-resistant *Staphococcus aureus*
- **RRT** - Rapid Response Teams
- **SSI** - Surgical Site Infections
- **VAP** - Ventilator-associated Pneumonia
- **VTE** – Venous thromboembolism

Goal

The goal of medication reconciliation in Long Term Care (LTC) is to reduce the potential for adverse drugs events (ADEs) and patient harm by identifying and resolving discrepancies and improving documentation in drug regimens at care transitions such as admission to LTC.

Background

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.[1]

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. Their recommendation was to implement medication reconciliation, at the time of admission back to the long-term care facility.[1]

A 2006 study by Boockvar, found that the possibility of having a discrepancy related adverse drug event was less likely in the group of residents who had medication reconciliation performed by a pharmacist with physician communication upon transfer from acute care to long-term care compared with the group that did not.[1]

In Phase 1 of the *Safer Healthcare Now!* campaign acute care medication reconciliation teams made significant improvements in reducing discrepancies and preventing potential errors. Expanding implementation of medication reconciliation to long-term care and community care organizations in Phase 2 will further help to close communication gaps in medication information transfer thus improving resident safety across the continuum of care.

Intervention

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

1. At admission, obtaining a complete and accurate list of each resident's current and pre-admission medications – including name, dosage, frequency and route (BPMH).
2. 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.
3. Any resulting changes in orders are documented and communicated to the relevant providers of care and resident or family member wherever possible.

Intervention Measures

The Core Measures are:

1. **Mean number of UNDOCUMENTED INTENTIONAL Discrepancies** (Documentation Accuracy)
   Target: Reduce baseline in area of focus by 75%.
2. **Mean number of UNINTENTIONAL Discrepancies** (Medication Error)
   Target: Reduce baseline in area of focus by 75%.
3. **Percentage of Residents Reconciled upon admission**
   Target: 100% of residents reconciled upon admission.

[1] Earnshaw, K et. al. Perspectives of Alberta Nurses and Pharmacists on Medication Information Received. July 29, 2007
[2] 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
[3] Boockvar K et. Al. Medication Reconciliation for Reducing Drug-Discrepancy Adverse events *Am J Geriatr Pharmacother*. 2006;4:236-243

SSPSM 10 stratégies :

- **BCM** - Bilan comparatif des médicaments (sons de courte durée)
- **BCM** - Bilan comparatif des médicaments (sons de longue durée)
- **CHUTES** - Collectif sur les chutes en milieu de soins de longue durée
- **CIC** – Prévention des infections reliées aux cathéters intravasculaires centraux
- **EIR** – Déployer des équipes d'intervention rapide
- **IAM** – Soins améliorés en cas d'infarctus aigu du myocarde
- **ISO** – Prévention des infections du site opératoire
- **ORA** - Organismes résistant aux antibiotiques / staphylocoque aureus résistant à la methicilline (SARM)
- **PVA** – Prévention de la pneumonie sous ventilation assistée
- **TEV** – Thromboembolie veineuse

But

L'objectif du bilan comparatif des médicaments en soins de longue durée (SLD) est de réduire le nombre d'événements iatrogènes médicamenteux et de préjudices envers les patients en identifiant et en résolvant les divergences et en améliorant la documentation sur les schémas posologiques lors des transferts tels que l'admission aux SLD.

Campagne québécoise
Ensemble, améliorons la prestation sécuritaire des soins de santé!

des soins de santé plus sécuritaires maintenant!

Contexte

Une information sur la médication qui est fausse ou incomplète représente une problématique importante dans plusieurs études portant sur les SLD. Voici les résultats issus d'un sondage albertain effectué en 2007 auprès de pharmaciens et d'infirmières en soins prolongés portant sur la qualité de l'information relative aux médicaments lors de l'admission de patients transférés d'un centre hospitalier de soins de courte durée à un établissement de SLD :

- Dans 75% du temps, l'information sur la médication n'était PAS lisible et complète
- Dans 90% du temps, l'information n'était PAS suffisante pour déterminer si les ordonnances étaient appropriées compte tenu des diagnostics du résident
- Dans 40% du temps l'information relative aux médicaments des résidents n'était PAS transmise le jour même de son admission. [1]

Dans une étude réalisée par Broockvar en 2004, l'incidence des événements iatrogènes médicamenteux causés par des modifications aux ordonnances des résidents lors d'un transfert entre établissements s'élevait à 20 %. Ces événements se produisaient plus souvent lors du transfert d'un résident du centre hospitalier vers un établissement de SLD. Les auteurs de l'étude recommandent la mise en œuvre d'une intervention, comme le bilan comparatif des médicaments, lors de la réadmission du résident à un établissement de SLD.[1]

Dans une autre étude réalisée par Broockvar en 2006, la possibilité qu'un événement iatrogène médicamenteux survienne était moins élevée chez les résidents dont le bilan comparatif des médicaments était établi par un pharmacien (en communication avec le médecin) lors de leur transfert du centre hospitalier à un établissement de SLD que chez les résidents dont le bilan n'était pas établi par un pharmacien.[1]

Lors de la phase 1 de la campagne Des soins de santé plus sécuritaires maintenant! en collaboration avec la campagne québécoise Ensemble, améliorons la prestation sécuritaire des soins de santé!, les équipes de bilan comparatif des médicaments en soins de courte durée a permis de réaliser des améliorations significatives en réduisant le nombre de divergences et en évitant des accidents potentiels. L'expansion de la mise en œuvre du bilan comparatif en SLD et dans des organismes de soins de proximité dans le cadre de la phase 2 aidera à colmater davantage les écarts de transfert d'information améliorant alors la sécurité des résidents à travers le continuum de soins.

Stratégie

Le bilan comparatif des médicaments en soins de longue durée est un processus formel qui nécessite:

1. D'obtenir à l'admission la liste complète et précise des médicaments pris par le résident actuellement et avant l'admission- incluant le nom, la dose, la fréquence et la voie d'administration. Ceci correspond au meilleur schéma thérapeutique possible (MSTP).
2. D'utiliser le MSTP pour générer les ordonnances émises à l'admission (OÉA) ou bien en comparant le MSTP aux OÉA pour le résident tout en identifiant les divergences à l'attention du prescripteur afin de les résoudre.
3. De documenter et de communiquer toute modification liée à l'ordonnance aux professionnels de la santé concernés de même que le résident et sa famille, si cela s'avère possible.

Mesures d'intervention

Les mesures de base sont les suivantes :

1. **Le nombre moyen de divergences INTENTIONNELLES NON-DOCUMENTÉES** (absence de documentation)
   Objectif : Réduire de 75% les valeurs obtenues lors de la phase préliminaire.
2. **Le nombre moyen de divergences NON INTENTIONNELLES** (accident lié à la médication)
   Objectif : Réduire de 75% les valeurs obtenues lors de la phase préliminaire.
3. **Pourcentage de résidents dont le bilan comparatif des médicaments a été établi lors de l'admission**
   Objectif : 100% des résidents aient un bilan comparatif des médicaments à l'admission.

[1] Earnshaw, K et al. Perspectives of Alberta nurses and pharmacists on medication information received. Le 29 juillet 2007.
[2] Broockvar 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.
[3] Broockvar K et al. Medication reconciliation for reducing drug discrepancy adverse events. *Am J Geriat Pharmacother*. 2006; 4: 236-243.

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