Medication Reconciliation

ISMP Canada Annual Report to CPSI

Safer Healthcare Now! Medication Reconciliation Intervention

April 2010 to March 2011

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Safer Healthcare Now!

ISMP Canada Annual Report

Medication Reconciliation Intervention

Key Results for Period April 2010 to March 2011

Medication Reconciliation in Acute Care, Long-Term Care and Home Care

The Institute for Safe Medication Practices Canada (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 (MedRec) in acute, long term and home care settings through Safer *Healthcare Now!*

Between April 2010 and March 2011, a number of key deliverables were accomplished in all sectors. ISMP Canada is pleased to present the following results for the contract deliverables.

Summary of Major Accomplishments

ISMP Canada and its partners are proud of their accomplishments from this fiscal year. These include:

1. Completion and launch of the new Medication Reconciliation in Home Care Getting Started Kit' for the home care sector based on successfully tested processes and learnings from the 2009 pilot study. The MedRec in Home Care Webpage was also developed for this kit.
2. Organized and delivered with VON Canada a successful virtual action series for the home care sector entitled: 'Medication Reconciliation in Home Care: *Home is where the heart is!*' This series which took place between September and November 2010 to coincide with the release of the MedRec in Home Care Getting Started Kit.
3. Organized and began delivery of a virtual action series 'MedRec To Go!: A Reliable Discharge Process' which concentrates on MedRec at discharge for acute care hospitals and is scheduled to begin in March 2011.
4. Reviewed and revised the Medication Reconciliation in Acute Care Getting Started Kit based on experience gained from teams within Canada and internationally. This new getting started kit incorporates both the pro-active and retro-active processes at admission used by teams worldwide, a new clearer step-by-step definition of the MedRec process at admission, transfer and discharge, and new tools for MedRec at discharge based on an ISMP Canada trial in Ontario. Recent discussions with some teams have about inclusion of medication management principles to assess the appropriateness of each medication may also added to the kit. Careful consideration of this addition by faculty during the review process will ensure the kit does not become too pharmacy focused. (pharmacists encouraged the addition of assessment)
5. ISMP Canada continues to support MedRec in each node by assisting in the organization and delivery of local events for teams, collaboratives, national calls and the sharing of new tools and systems. Teams continued to ask questions, online and by telephone; request site visits and attend

national calls in substantial numbers. There were 3 local events in the western node, three in the Ontario node, support to a conference in Quebec, and telephone support and webinars with specific teams in the Atlantic node in 2010.

6. ISMP Canada actively supported Accreditation Canada to revise the MedRec ROPs in acute care, home care, long-term care and ambulatory care for 2011. This included many calls, and review of documents with faculty.
7. ISMP Canada, CPSI and Canada Health Infoway organized a national invitational summit which included over 70 healthcare leaders from across Canada. The result is greater awareness and potential buy-in from national organizations such as the Canadian Medical Association, Canadian Association of Chain Drug Stores and Canadian Nurses Association of the expectations of MedRec across the system. The summit also resulted in the announcement of a national challenge to be launched November 2, 2011 during a full-day virtual conference dedicated to MedRec.

Key Deliverables

1. **Continued leadership and support to the Medication Reconciliation Intervention.**

   ISMP Canada staff continues to provide intervention leadership and are knowledgeable of and address the needs of SHN teams by:

   - conducting national webinars on identified barriers and facilitators including speakers with hands-on working knowledge of the relevant issue(s);
   - developing, revising and disseminating new tools, resources and strategies to assist with barriers to implementation;
   - reviewing and revising medication reconciliation getting started kits for acute care and long-term care as required. See Appendix 7 for the new MedRec Acute Care Getting Started Kit – draft version;
   - supporting SHN teams via on-site visits or phone conversations to discuss and resolve identified issues and concerns;
   - supporting SHN nodes; and
   - maintaining working relationships with healthcare related associations including Accreditation Canada.

2. **Lead the development of a paper on the Canadian SHN medication reconciliation experience and results**

   ISMP Canada has started the process to create a paper about the Canadian experience and results in medication reconciliation in February 2011. This article will be written with the assistance of the medication reconciliation faculty and hopefully published in 2011.

3. **Collaborate with Provincial and National Voluntary Associations and regulatory Authorities for Healthcare Professionals.**

   - ISMP Canada continues to **work with Accreditation Canada and key medication reconciliation faculty members to** develop and update the Required Organizational Practices (ROPs) for MedRec. The most recent revisions this year have been for MedRec in Home Care, Acute Care (April 2010) and Ambulatory care (January 2011). See Appendix 5 for a list of the New ROPs for Medication Reconciliation.

- The **Acute Care** ROPS were revised to include both the proactive and retroactive process of MedRec. The Tests for Compliance were also revised to include both processes. Teams had traditionally been rated as non-compliant, because they used the proactive model. Now, teams using the proactive or retroactive model will both be compliant with the revised ROP.
- Performance Measures were also included to help ease the burden of measurement by allowing a sample for measurement and providing a sampling strategy for teams. Teams will take a sample of 20 patients and measure the percentage of patients reconciled instead of being required to record the percentage of patients reconciled for all patients. As well, teams are allowed to target the population they wish to start implementing MedRec on and start measurement on that target population.
- The MedRec thresholds have been revised as per faculty input as of January 1, 2011, and the values are as follows:
  - Green: > 75%
  - Yellow: ≥ 50 and ≤ 75%
  - Red: < 50%
- The **Home Care** ROPs for MedRec were revised with the guidance of VON Canada and ISMP Canada to allow teams to reconcile clients only if medication management is a component of care. The Home Care performance measures are aligned with the SHN Homecare core measures. Home Care teams are also able to sample 10 clients monthly which will ease the measurement burden for teams.
- The Ambulatory ROPs for MedRec were revised with the help of a working group of ambulatory teams across the country, co-ordinated and led by ISMP Canada. This working group made revisions to the frequency of the ROP to start at the beginning of service when medication therapy is a significant component of care. Reconciliation should be repeated periodically as appropriate for the client or population receiving services. Due to the wide range of service offerings and client populations receiving care in ambulatory clinics, teams are encouraged to establish appropriate target populations to receive formal medication reconciliation. Medication reconciliation should focus on clients for whom medication therapy is a significant component of care. A screening or risk assessment approach may be adopted, and should consider: i) the client's needs, ii) the type of clinic, and iii) the service offerings of the clinic.
- NOTE: Documented rationale for the selection of target clients or populations, as well as the appropriate interval of reconciliation for these clients or populations, must be provided for the ROP.
- **Next Steps** include working with Accreditation Canada on revising MedRec at referral or transfer for the September 2011 revision. Teams on the frontlines are finding that the transfer language is not clear and that the surveyors are expecting admission MedRec on every unit in the emergency department and again when transferred on the unit. MedRec should only be required for patients transferred who have their medications re-written as per hospital policy and for admission to the hospital, not necessarily to the unit.

- **ISMP Canada** supports Accreditation Canada by answering questions from the field and co-presenting with them at conferences. **ISMP Canada** also presented about MedRec at Accreditation Canada pre-survey workshops.
- ISMP Canada continues to **work closely with Canadian professional associations** including the Canadian Nursing Association (CNA), Canadian Society of Hospital Pharmacists (CSHP). Recently, ISMP Canada, CPSI and Canada Health Infoway held a national invitational summit of top healthcare leaders from across Canada to identify MedRec barriers and facilitators. At the conclusion of the summit the Canadian Medical Association (CMA), Registered Nurses Association (RNA), Canadian Nurses Association (CNA), Canadian Society of Hospital Pharmacists (CSHP), the Canadian Pharmacist Association (CPA), and the Canadian Association of Chain Drug Stores (CACDS) agreed to work together to define roles and responsibilities for their membership with respect to MedRec and to support front-line practitioners. See Appendix 8 for the agenda, list of attendees and the executive summary of the report.

4. **Co-Lead Home Care implementation, supporting teams in Canada with VON Canada and four nodes.**

   ISMP Canada partnered with VON Canada to assist home care teams to implement MedRec in the home. This involved:

   - Creating **a** *Medication Reconciliation in Home Care Getting Started Kit* based on tested processes, tools and learnings from the 2009 Home Care Pilot Project. The kit took on a new look which included a shortened main section and links within an executable PDF document to various tools, forms, posters, etc. The goal was to ensure the process of doing MedRec in home care was defined in a concise, easy to understand way allowing teams to access additional information as required. Response from home care teams has been very positive about the readability and usefulness of the GSK.
   - Working collaborative between ISMP Canada, VON Canada and Accreditation Canada resulted in a new **Required Organizational Practice (ROP) for MedRec home care**. The goal was to ensure the ROP was directly aligned with the SHN measures. See Appendix 5.
   - **Creating measures** applicable to the home care environment to ensure relevant information was captured and was in-line with the new Accreditation Canada ROP for MedRec in home care.
   - Designing and developing new **posters and tools** specifically for the home care environment – see appendix 4.
     - Developing and delivering the *Medication Reconciliation in Home Care; Home is where the heart is! Virtual Action Series* for home care teams across Canada. The series was delivered in a virtual environment over a 3-month period. It was designed to generate awareness of MedRec in the home care sector, introduce the new MedRec in Home Care Getting Started Kit, and provide support to teams starting to implement MedRec in the home care sector.
       - A total of 35 teams from across the country enrolled in the virtual action series and attendance was consistent throughout the series. Feedback from the MedRec in Home Care Virtual Action Series indicated that series was:

- A wonderful way to be part of a national experience; to share and learn from a variety of experts with experience in the home care sector; and interact with others from across the country.
- Should be used in professional education programs including nursing schools and medical schools.

- Improvement comments included: session mostly delivered in English which made it difficult for French speaking participants to follow. Also indicated that the English persons found it distracting when French was spoken at times during the session.

  Teams are requesting a second session to begin soon. Tentative date would be fall 2011 with national teleconference calls used to assist teams.

5. **Refine and optimize communications (CoP, national calls, meetings) to support medication reconciliation across the continuum of care.**
   - The **Communities of Practice** (CoP) usage is starting to increase. We are now receiving more questions via the discussion forum however; we have not seen an increase in sharing tools and resources. ISMP Canada has worked hard to revitalize the site by uploading new articles, tools/forms, educational packages and presentations, etc. This process seems to be working, albeit slowly. ISMP Canada continues to:
     - Monitor the MedRec CoP, continually populating it with new items related to MedRec including new studies in Canada and around the world;
     - Monitor the discussion boards in the MedRec CoP and makes every attempt to ensure questions are answered within 24 hours. Many questions are still being submitted via email and ISMP Canada has been posting the questions and response on the CoP. This process increases the ISMP Canada workload substantially and has delayed the timely sharing of information to teams;
     - modify the Frequently Asked Questions document to assist teams in finding answers to their questions quickly;
     - Work towards creating resources on the CoP for teams in both the English and French languages. This includes the translation of pan-Canadian teleconference call presentations and agendas, announcements and selected posters;
     - Determine ways to encourage users to use the CoP with hopes of regaining the traffic previously experienced by posting all as much on the CoP as possible. By posting content specific items including upcoming events and national webinars, new tools and resources, articles, etc. on the CoP users are required to access the CoP to obtain the information**.**
   - **The Mentor Network** continues to be a valuable and helpful means for teams to connect with other mentor hospitals/sites. Currently we have 6 mentor hospitals in acute care and one mentor organization in home care. The success of the virtual action series has resulted in the recruitment of mentors in homecare. We continue to recruit mentors and the mentor program during teleconferences and conferences we attend and hope to expand our program to long-term care in the future. Current mentee partnerships include:
     - The University Health Network
     - The Moncton Hospital, Regional Health Authority B

- Markham Stouffville Hospital
- The Hospital for Sick Children (SickKids)
- Dryden Regional Health Centre
- Regina Qu-Appelle Health Region
- Saskatchewan Health Region Home Care

- **National MedRec Webinars** continue to be well attended by healthcare practitioners across Canada. Four (4) national webinars, one per quarter, were conducted during the time period of April 1 2010 and March 31, 2011 with attendance ranging from 76 teams to 300 teams. The low of 76 focused on teams just starting to implement MedRec within the acute care environment. National webinars were scheduled around the Virtual Action Series for Home Care and the upcoming MedRec To Go! Virtual Action Series for MedRec at Discharge. See Appendix 2 for a list of webinars – past and future and MedRec To Go! Virtual Action Series promotional material and schedule.
- ISMP Canada staff continues to **attend and play an active role all SHN working group meetings including** the Education and Resources Committee (EdRes), Node and Intervention Implementation Committee (NIIC), CPSI/SHN strategic planning meetings, web-based data system, CoP review and others as required.

6. Provide a team of clinicians with medication reconciliation expertise to provide ongoing support to the national medication reconciliation faculty and the SHN nodes and teams.

ISMP Canada staff includes clinicians with medication reconciliation experience and expertise including pharmacists, nurses. These staff members provide assistance and guidance to SHN teams on an ongoing basis through virtual and live education sessions, personal on-site visits, emails and phone calls. On-site visits often deal with specific questions or concerns related to implementation issues, spread, processes or form evaluations.

ISMP Canada staff members keep update on new trends, studies, resources by reviewing all new publications, trials, etc. on a daily basis. Discussions with the authors often occur to learn more about their work and determine if it can be incorporated into the Canadian MedRec processes.

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7. Refine tools for medication reconciliation in the Canadian Environment.

One of the great prides we take in this campaign is the sharing of tools and resources amongst teams across the country and world-wide. Because of ISMP Canada's involvement in the High-5s project, tools created by Canadian teams are helping others around the world and visa-versa. For example, The Independent Observer document created by ISMP Canada with input from High 5s teams has been shared with Canadian teams. National Webinar topics and learning's are shared with High 5s teams.

Procedures and tools developed in some successful projects in the US including BOOST (Better Outcomes for Older adults through Safer Transitions) and STAAR (State Based Strategy) and have been incorporated into the new GSK for Acute Care and the MedRec to Go Virtual Action Series.

Electronic medication reconciliation tools are slowly being incorporated into healthcare facilities IT systems. A number of presentations during national webinars and node conferences have discussed MedRec IT implementation barriers and facilitators. These are often presented by experience team members who have hand-on experience with the goal to help address any issues teams may be experiencing while in

8. **Develop and participate in workshops and learning sessions hosted by Safer Healthcare Now! and the Quebec Campaign**

   ISMP Canada clinical staff continues to be involved in the planning and delivery of many workshops and conferences hosted by SHN and the Quebec Campaign. See Appendix 3 for a complete list of these sessions.

9. **Communication Plan**

   During this fiscal year, the branding for SHN changed which required all new posters, GSKs, one-pagers, PDSA cycle graphics, etc. to be revised with the new colours. The template ISMP Canada created for the home care GSK was adapted for all new kits. ISMP Canada staff also ensures that all presentations given on behalf of SHN and the medication reconciliation intervention use the SHN templates.

10. **National Medication Reconciliation Faculty**

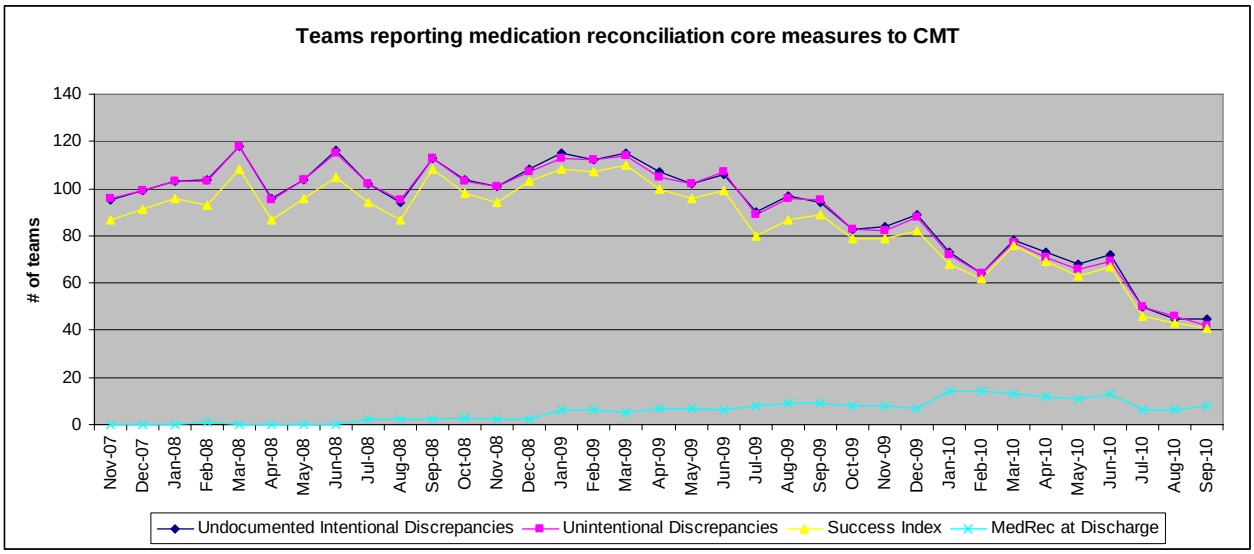
    As medication reconciliation evolves across the continuum of care, new members are added to the **National MedRec Faculty** to ensure each sector has representation. Some members have resigned due to new roles and responsibilities and new members are added to ensure all healthcare sectors involved in the MedRec intervention for SHN are adequately represented. The national MedRec faculty continues to play a key role in MedRec including reviewing kits, notices, speaking at conferences and national calls, responding to questions posted on the CoP in their areas of expertise, working with ISMP Canada and Accreditation Canada to ensure the ROPs are correct and obtainable. ISMP Canada attempts to involve them whenever and wherever possible. The current MedRec Faculty is listed in Appendix 1.

Additional Accomplishments

1. An **ambulatory clinic working group** was created in July 2010 to help support ambulatory clinics in MedRec. This group was first started to meet a need from ambulatory clinics who were implementing MedRec and wanted to collaborate with other clinics to share ideas and tools/resources. We posted all the resources and tools and the model for ambulatory clinics in MedRec on the COP. After our meeting in July, we decided our next steps would be to continue the discussion on how and who to do MedRec on in ambulatory and to work with Accreditation Canada to revise the ROPs for ambulatory clinics for 2011. The group met in September and December to work and revise the ROPs for Accreditation Canada. In January 2011, Accreditation Canada accepted our revisions and incorporated them into the revised ROPS for 2011.
2. ISMP Canada continues to be a subject matter expert in the **Electronic Health Record (EHR) on MedRec Processes** and have been involved in a national meeting.
3. ISMP Canada is a member of the advisory group of the **Ontario Drug Profile Viewer (DPV) Evaluation Working Group** to assess the impact of community pharmacy DPV profile on BPMH in acute care. The results were presented at the 2011 CPSI forum on Patient Safety and Quality Improvement.
4. **The terms** Best Possible Medication History (BPMH), *Undocumented Intentional Discrepancies*, *Unintentional Discrepancies*, Best Possible Medication Discharge Plan, and BPMDP have become common language not only in Canada but around the world. At the recent national invitational summit, Dr. Jeffery Schnipper's (USA), presentation included a number of Canadian terms such as BPMH, unintentional discrepancies and undocumented intentional discrepancies. He indicated that our measures and terminology are in tune with what he is trying to accomplish and make real sense to him. He also continues to work closely with members of our National MedRec Faculty.
5. The stories teams share demonstrates that MedRec is a factor and necessity to reducing the potential for patient harm. See section '**Canadian Success Stories'** for details.
6. ISMP Canada has developed tools to assist with discharge medication reconciliation for the acute care sector, which includes a Best Possible Medication Discharge Plan (BPMDP) template, Steps for Creating the BPMDP, BPMDP Patient Interview Guide and a BMPDP Checklist. The tools are currently in the process of being tested in a variety of acute care settings where ISMP Canada is assisting with implementing a standardized discharge medication reconciliation process. These tools and the learning's from implementation have been and will continue to be shared with SHN.
7. **ISMP Canada staff continues to promote the *Safer Healthcare Now!* Campaign and the MedRec intervention** at all conferences, presentations and booths in which they are involved across the country.

8. Measurement Results to December 2010

Teams are looking forward to using the new web-based PS metrics system this year. There has been a general overall decline in data reporting, due to teams either reaching goal and stopping measurement, or being overwhelmed by data collection burden. One way to alleviate this will be to align our SHN measures with Accreditation Canada measures and have data sharing and interoperability between the Accreditation Canada portal and the SHN web-based tool. As well, we hope to re-engage teams with data collection, once the web-based tool is operational and with our upcoming virtual action series on MedRec at discharge.

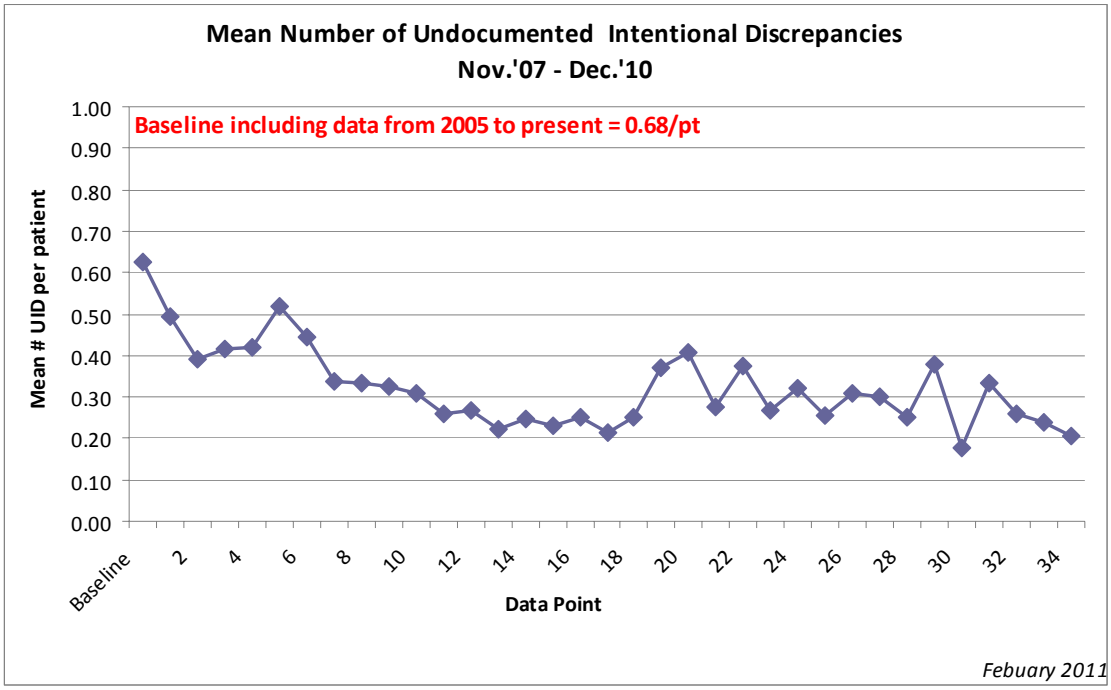


Acute Care

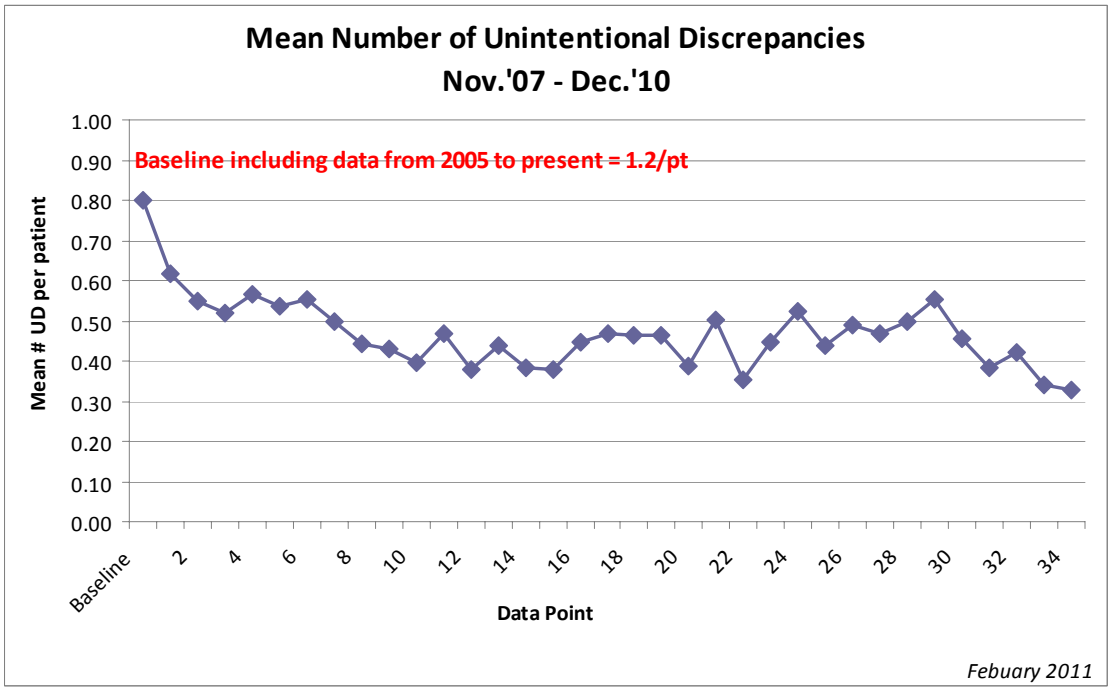
There has been a decrease in the number of teams reporting data in the last year from over 100 teams per month in March 2010 to about 60 teams a month in December 2011. The reporting numbers for discharge and transfer MedRec are low but are expected to rise with a new "blitz" and webinar series, new data reporting system and alignment and a single measuring system with Accreditation Canada. The measures in the new acute care getting started kit are the same as Accreditation Canada except for the quality measures which belong to SHN only. Reporting teams have improved significantly in all measures, especially unintentional discrepancies, which can lead to errors. A small number of teams are now reporting for MedRec at Discharge and have sustained improvement above ~80%. Teams joining the virtual action series in MedRec at Discharge in March 2011 are expected to report MedRec at Discharge in order for us to show the impact of our support.

Unintentional and undocumented intentional discrepancies are declining. The goal for teams is to aim for less than 0.3 unintentional discrepancies per patient, which is close to being reached nationally, for teams that are reporting.. We will continue our efforts to educate teams on when to measure, which has still been a struggle for some teams to understand.

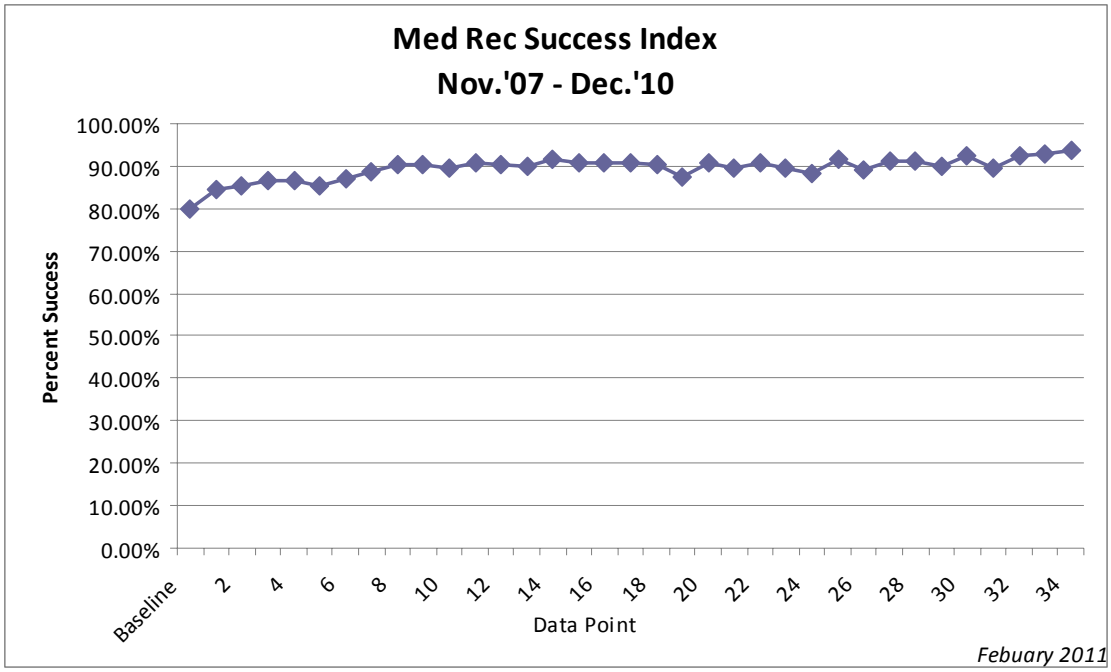
Acute Care –Mean Number of Undocumented Intentional Discrepancies per patient



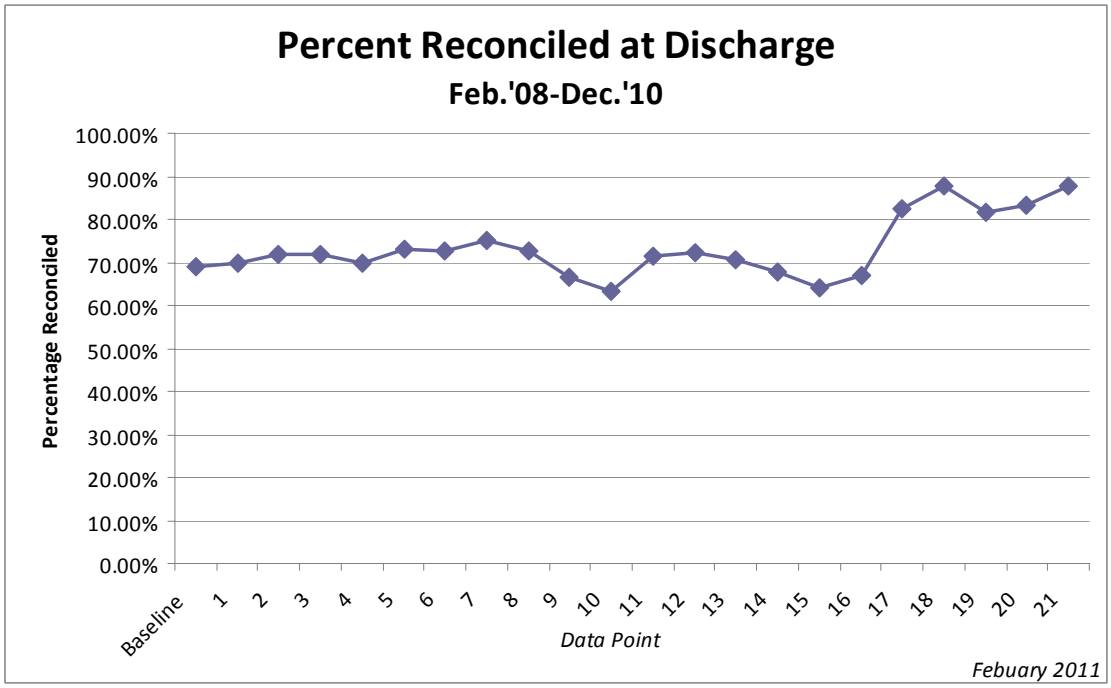
Acute Care - Mean number Unintentional discrepancies per patient



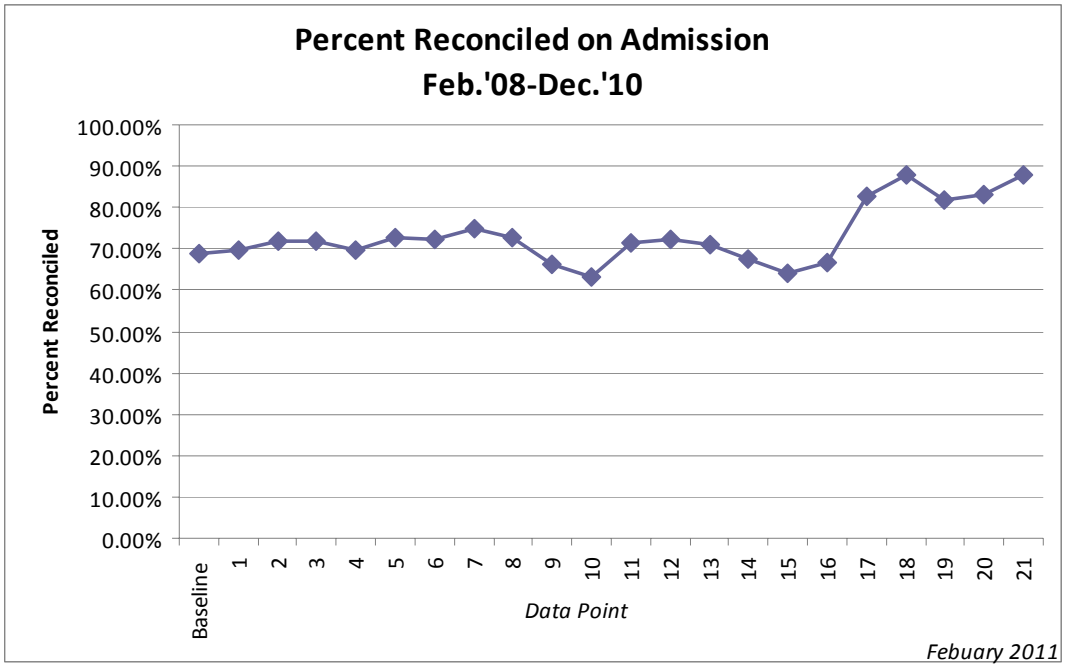
Acute Care - Success Index (Optional Measure)



Acute Care - MedRec at Discharge



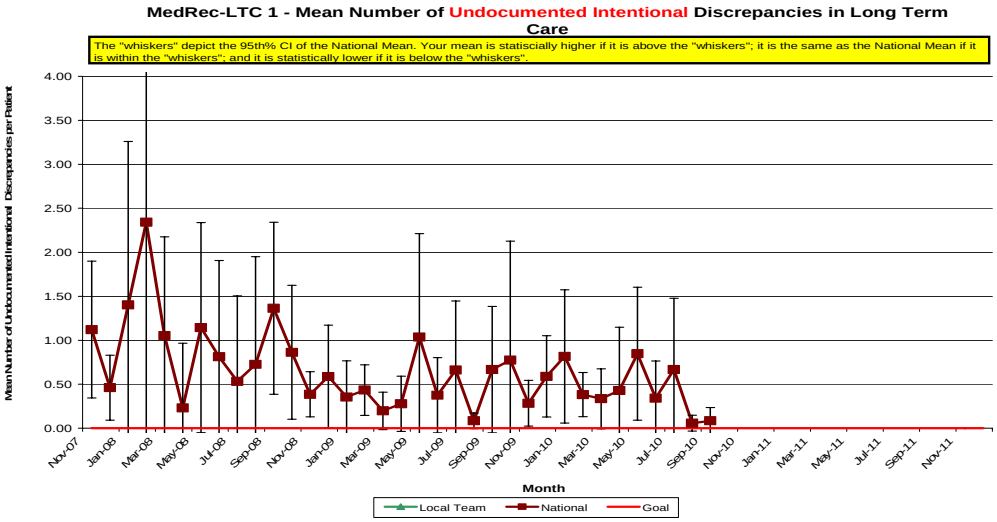
Acute Care - Percent Reconciled at Admission



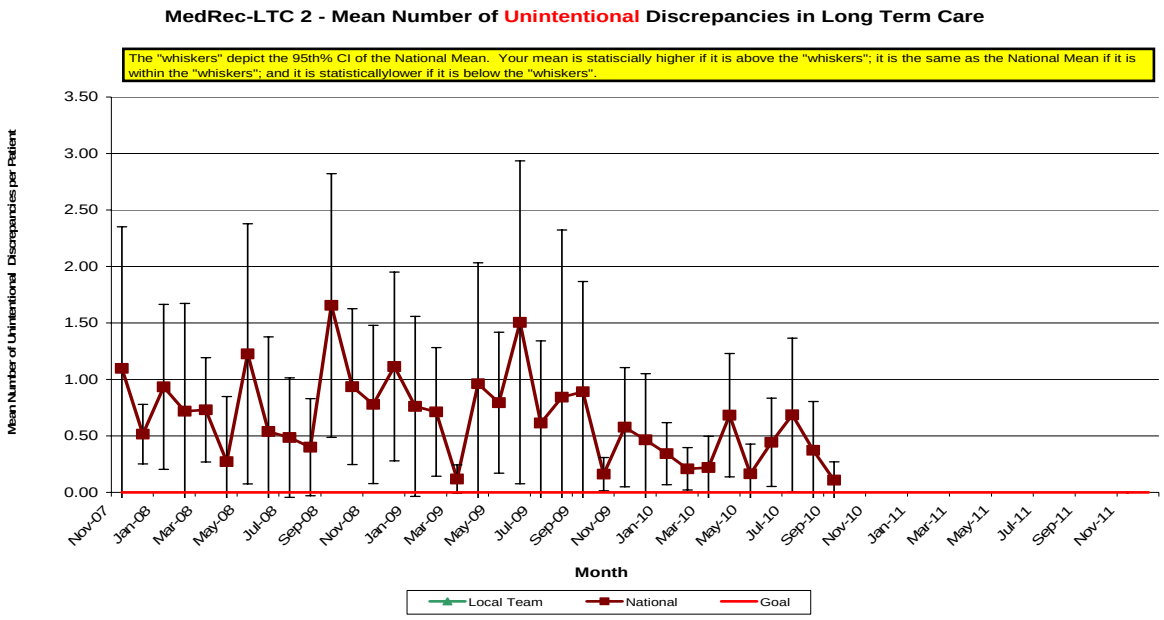
Long-Term Care

Long-term care data is available until September 2010. Long-term care teams who are reporting data for MedRec LTC 1, 2, 3 decreased from 23 to 14 teams reporting from April to September 2010. Again, data collection burden is an issue and we will try to address this by aligning with Accreditation Canada's ROPs and allow for sampling. Quality of MedRec as measured by the mean number of discrepancies (both unintentional and undocumented intentional) has improved dramatically this year and teams who do report have, nationally, met and sustained a goal of less than 0.3 unintentional discrepancies per patient. We plan a LTC blitz in 2011.

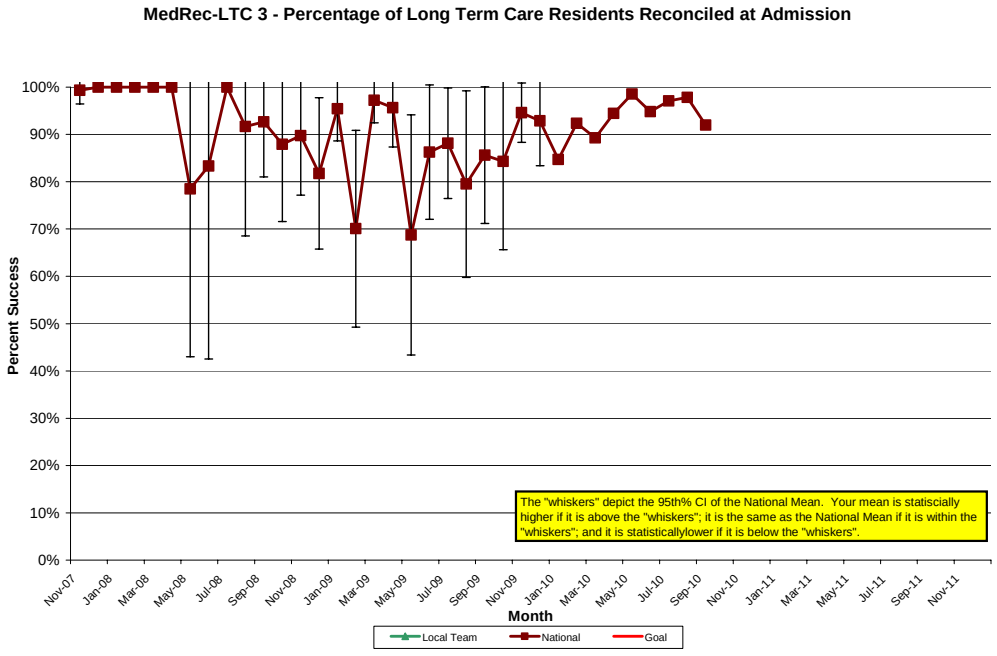
Mean Number of Undocumented Intentional Discrepancies in Long-Term Care



Mean Number of Unintentional Discrepancies in Long-Term Care



Percentage of Long-Term Care Residents Reconciled at Admission in Long-Term Care



Home Care

Data not available at this time.

- The MedRec Getting Started Kit for Acute Care Version 2 was downloaded a total of 4,133 times from the ISMP Canada website (www.ismp-canada.org) between April 1, 2010 and January31, 2011.

Month	Downloads
April 2010	748
May 2010	405
June 2010	528
July 2010	602
August 2010	528
September 2010	418
October 2010	79
November 2010	265
December 2010	306
January 2011	254
Total	**4133**

What Worked Well

- Creating and maintaining partnerships between ISMP Canada and Canadian organizations contributes to the success of the MedRec implementation across Canada.

CPSI

ISMP Canada's continued and consistent involvement in *SHN* committee/working group meetings and partnership in planning, problem-solving, sharing with the *SHN* network of organizations aligns the MedRec intervention with the strategic direction of *SHN*.

Accreditation Canada

ISMP Canada partnered with Accreditation Canada influencing changes in the Required Organization Practice (ROP) for MedRec and Evidence of Compliance to meet the needs of SHN teams. To assist SHN teams with interpretation of the standards and in meeting these standards ISMP Canada organized meetings with MedRec faculty and Accreditation Canada; held national webinars with Accreditation Canada representative speaking to discuss the 2010 ROPs and evidence of compliance See Appendix 5 for the 2010 revised ROPs for MedRec.

Victorian Order of Nurses

ISMP Canada & VON Canada jointly created a new Medication Reconciliation in Home Care Getting Started Kit based on the learning's from the national home care pilot. The core measure was developed in conjunction with Accreditation Canada and tailored for the unique and often complex home care patient population. The process diagram for home care MedRec will be published in 2011 with VPON Canada

Community Care Access Centre

ISMP Canada continues to collaborate with Ontario CCAC's to promote the SHN MedRec initiative to its membership.

Canadian Nursing Association

ISMP Canada is working with the CNA to educate members about medication reconciliation and the role of the nurse. CNA will also meet with other governing bodies to define the nurses' role in medication reconciliation

Ontario Medical Association

ISMP Canada initiated discussions with the Ontario Medical Association to create a position statement for Ontario physicians with respect to MedRec.

Canadian Medical Association

The CMA has agreed to work with ISMP Canada, CPSI and other national associations to define the physician's role in MedRec.

Ontario Hospital Association

ISMP Canada presented at the Ontario Hospital Association annual conference Health Achieve where we addressed the key topic of linking MedRec in hospitals and *MedsCheck* in community.

Canadian Society of Hospital Pharmacists

ISMP Canada was given the opportunity to present at the 2011 Professional Practice Conference in Toronto. All presentations for MedRec were at or over capacity. The interest was huge. ISMP Canada has partnered with Ontario Branch CSHP in an effort to increase the link between hospital MedRec and community *MedsCheck*.

Canadian Health Infoway

The ISMP Canada MedRec lead sits on the working group for pan-Canadian Drug Information benefits evaluation. ISMP Canada and CPSI partnered with Canada Health Infoway to conduct the national invitational summit on MedRec held on February 10, 2011.

Key Next Steps Planned

Engagement Strategy for Spread across the Continuum

- Work with CPSI and national partners to create a National Challenge for Medication Reconciliation. This will involve publications, creating public awareness campaigns, using social media, organizing a virtual conference to be held on November 2, 2011 during National Patient Safety Week.

Lead and Support of MedRec Implementation

- Organize and execute virtual actions series (VAS) for MedRec. The MedRec To Go! VAS begins in March 2011 and will conclude in June 2011. A repeat performance may be required in the fall based on feedback from teams attending the information session. Another VAS for MedRec in Home Care has also been requested by home care sector. Plans may involve repeating the Home is where the heart is VAS again and/or a part 2 to the session.
- We expect a series of calls should also be designed for LTC in conjunctions with experienced LTC teams and national organizations
- Overall coordination and alignment of the MedRec intervention - Acute Care, Long-term Care and Home Care.

- The MedRec Acute Care GSK has undergone extensive revisions however will not be final until a consensus has been made to add clinical appropriateness to the kit. This will require discussion among the national organizations and faculty to ensure it does not become a 'pharmacy' based process rather than a 'team' process. Inclusion of the MedRec in Ambulatory Care is also under consideration. This new kit will be final, translated and available to teams in early 2011 pending decisions as stated above.
- The MedRec GSK for long-term care is currently being reviewed my members of the MedRec Faculty who work in the long-term care sector to determine updates/modifications required. All revisions to the GSK will involved the MedRec faculty and teams as appropriate.
- Continued focus on a comprehensive strategy to address the many needs of MedRec teams in Canada (acute, long term care and home care).
- Keeping the momentum - National MedRec Faculty.
    - ISMP Canada plays a key role in the recruitment, coaching, and coordination of the national MedRec faculty to support MedRec.
    - ISMP Canada will strive to find creative ways to ensure the national MedRec faculty continues to feel motivated and engaged in the campaign.
- Work with MedRec Faculty to provide input on :
    - Accreditation Canada 2010 Required Organizational Practices;
    - MedRec in ambulatory care/community; and
    - Enhancing / optimizing MedRec processes and development of quality measures in collaboration with the Central Measurement team.
- Continue to support Canadian MedRec teams by planning, attending and speaking at conferences, workshops held by *SHN* and the Quebec campaign and other Canadian associations.
- Continue to revitalize the Communities of Practice to ensure members can locate items in a timely fashion. The new CoP will be analyzed and adjustments made based on feedback from our users. Also, ISMP Canada will continue to monitor the CoP to ensure all new material added is organized, content is appropriate and questions are answered in a timely manner.
- Provide a team of clinicians with MedRec expertise to provide ongoing support to the national MedRec faculty and the SHN Nodes and teams.

Support Innovation and Best Practice

- Incorporate the learning's from existing teams into best practice, new tools and strategies for continuing development, spread and addressing barriers and issues in all environments.
- Profiling the work and innovation of MedRec teams in the monthly SHN Newsletter.
- Continue to expand the MedRec Mentor Network in acute care, long-term care and home care as required.
- Continue to hold national webinars profiling the work of innovative teams and research in MedRec both in acute, long-term care and home care.

Research

- Lead the development of a paper on the Canadian SHN MedRec experience and results.
- Ensure that a comprehensive communications strategy is implemented, in conjunction with the Communications Advisory Group and the communications team from the CPSI Secretariat, including publications for international learning.

Engagement Strategy for Spread across the Continuum

- Follow-up on the enthusiasm of the national summit by joining the National Steering Committee and planning regional projects for system-wide implementation
- Work with national organizations to act upon ideas generated at the summit and enhance interdisciplinary expectation and processes for MedRec in collaboration with Provincial and National Voluntary Associations and Regulatory Authorities for Healthcare Professionals (specifically pharmacy, nursing and medicine)
  - Facilitate transition of the MedRec requirements and 'best practices' in acute care facilities, from the *Safer Healthcare Now!* Campaign to standards and guidance across the system.
  - Collaborate with existing provincial and national professional and regulatory organizations to more fully utilize provincial levers that link to community pharmacists and their payment for clinical service e.g. MedsCheck and new program in B.C..
  - With the national Steering Committee, target Leadership engagement - such a system change needs to be understood by senior management. Administrators, leaders and team members must be well informed about the resource commitment for MedRec and the value proposition – this continues to be a priority area. We need to create a group of physician speakers for the country.

Financial Report

ISMP CANADA

CPSI – *Safer Healthcare Now!* Medication Reconciliation – April 1, 2011 to March 31, 2011

Actual costs for period April 1 to January 31, 2011

	Hours	Rate/Hour	Costs	
MedRec Lead	507	66.25	33,589	
MedRec Specialist	515	67.43	34,726	
MedRec Associate	16	57.12	910	
Project Coordinator	634	43.89	27,851	
Admin support	314	44.20	13,881	
Total direct personnel costs	1,986		110,958	
Bilingual Support			12,290	
Communications			397	
Travel Expense			0	
				123,644

Projected Costs for period February 1 - March 31, 2011

MedRec Lead	100	66.25	6,625	
MedRec Specialist	170	67.43	11,463	
MedRec Associate	5	57.12	286	
Project Coordinator	210	43.89	9,242	
Admin support	80	44.20	3,547	
Total direct personnel costs	565		31,163	
Bilingual Support			2,400	
Communications			75	
Travel Expense			0	
				33,638

Total Actual and Projected costs for period April 1, 2010 to March 31, 2011 **157,282**

Report prepared by Brenda Carthy, Canadian Medication Reconciliation Intervention Coordinator, Marg Colquhoun, Canadian Medication Reconciliation Intervention Lead, and Alice Watt, Safety Specialist, ISMP Canada. Submitted February 2011.

Appendix

1

INSTITUTE FOR SAFE MEDICATION PRACTICES CANADA

ISMP Canada Annual Report: Medication Reconciliation Intervention, April 2010 to March 2011

National Medication Reconciliation Faculty

Medication Reconciliation Pan-Canadian Faculty

Province	Name	Facility	Position	Area of Expertise
AB	Hilary Adams		Quality Improvement Physician, Department of Family Medicine	Quality & Risk, Physician
ON	Chaim Bell	University of Toronto, St Michaels Hospital	Assistant Professor of Medicine and Health Policy, Management, & Evaluation, Staff General Internist	LTC & Physician
ON	Margaret Colquhoun	ISMP Canada	ISMP Canada Project Leader, Medication Reconciliation Pan-Canadian Lead	SHN Intervention Lead
NS	Paula Creighton	Nova Scotia Health	Geriatric Physician	LTC & Physician
NFLD	Scott Edwards	Eastern Health	Clinical Pharmacotherapy Specialist	Pharmacy & Research
ON	Edward E. Etchells	Sunnybrook Health Sciences Centre	Director, Patient Safety Service	Physician, Quality, Research
ON	Olavo Fernandes	University Health Network, ISMP Canada	Pharmacy Practice Leader	Pharmacy, Research
ON	Virginia Flintoft	*Safer Healthcare Now!* Central Measurement Team	Project Manager	measurement
MB	Nick Honcharik	Winnipeg Regional Health Authority	Regional Pharmacy Manager, Professional Practice Development, Clinical Pharmacist	Pharmacy
AB	Kathy James-Fairbairn	Good Samaritan Society	Consultant Pharmacist	LTC & Pharmacy
ON	James Lam	Providence Healthcare	Director, Pharmacy Services	LTC & Pharmacy
AB	Peter Norton	University of Calgary Medical Centre	Professor and Head of the Department of Family Medicine, Faculty of Medicine	Quality, physician, family practice
BC	Fruzsina Pataky	VCH-PHC Regional Pharmacy Services	Medication Safety Coordinator	Pharmacy
AB	Judy Schoen	Foothills Medical Centre, Calgary Health Region,	Pharmacy Patient Care Manager	Pharmacy
ON	Kim Streitenberger	The Hospital for Sick Children	Quality Analyst, Quality & Risk Management	Nursing, Quality, Paediatrics

Appendix

2

INSTITUTE FOR SAFE MEDICATION PRACTICES CANADA

ISMP Canada Annual Report: Medication Reconciliation Intervention, April 2010 to March 2011

MedRec National Webinars

MedRec To Go! Virtual Action Series

Medication Reconciliation National Webinars

MedRec Webinars April 2010 – March 2011				
Date	**Title**	Purpose of Call	Speakers	Attendance
18/05/2010	**MedRec Ideas That Spread**	Panellists discussed which area(s) would be appropriate for spread from the original pilot site (staged spread versus full scale "go live" spread); talked about creative ideas for wide spread engagement of staff and physicians and if and when it is appropriate to implement a policy supporting medication reconciliation upon admission to acute care sites.	Julie Johnson, Director QI Unit, Regina Qu'Appelle Health Region Christine Foote - Safer Healthcare Now Coordinator, Central Health, Newfoundland	165
14/09/2010	**Getting Started With Medication Reconciliation in Long Term Care**	The call was geared to participants who are getting started with medication reconciliation in long term care. At the completion of the call, participants will understand the process of medication reconciliation, what to measure, how to join the SHN campaign and access resources on the communities of practice. Participants will also learn from experienced practitioners who will share their journeys of implementing medication reconciliation successfully in their own institutions.	Jo-Anne Thompson**,** South Eastman Health/Sante Sud-Est Inc. Jeannette Cameron**,** Inverary Manor Renee Claire Fox**,** CSSS Jeanne-Mance	127
29/09/2010	**Getting Started With Medication Reconciliation in Acute Care**	The call was geared to participants who are getting started with medication reconciliation in acute care. At the completion of the call, participants will understand the process of medication reconciliation, what to measure, how to join the SHN campaign and access resources on the communities of practice.	Marg Colquhoun, ISMP Canada Alice Watt, ISMP Canada	76
19/01/2011	**A New Approach to MedRec**	Dr. Gardam and Leah Gitterman introduce the concept of Positive Deviance and discussed how it could be used when implementing MedRec.	Michael Gardam, University Health Network, Toronto and Leah Gitterman, University Health Network, Toronto	300

National MedRec Webinars and Virtual Actions Series- Proposed Schedule

Proposed Pan-Canadian Teleconference Calls for 2001	
Ambulatory Care and the New Accreditation Canada Required Organizational Practices (ROPs)	Marg Colquhoun, Alice Watt and Accreditation Canada representation
Getting Started with MedRec in Home Care	Debbie Conrad
MedRec In Long-Term Care	LTC MedRec teams, ISMPC staff,
MedRec To Go – Virtual Action Series (March to May 2011)	ISMP Canada staff, teams from across Canada with success in implementing MedRec at discharge
Home is Where the Heart is! – Part 1	Repeat session? Debbie Conrad and teams???
Home is Where the Heart is! – Part 2	Debbie Conrad and teams???

safer healthcare now!

Reducing Harm | Improving Healthcare | Protecting Canadians

call to action

MARK YOUR CALENDARS!

Information Sessions
Feb 15th, 2011 - English
Feb 22nd, 2011 - French

WebEx Training Session
March 1st, 2011 - English
March 8th, 2011 - French

Virtual Session 1
March 22, 2011
On Your Mark: Creating Momentum

Virtual Session 2
April 19, 2011
Get Set: Heading in the Right Direction

Virtual Session 3
May 10, 2011
Go! – Just Do it!

Virtual Session 4
May 31, 2011
Keep Going – Persevere Through the Trials

Virtual Session 5
June 21, 2011
Pass the Baton: Partner with your Patient, Community and Long-term Care Providers

All sessions scheduled from:
1200 PM – 1:30 PM ET

REGISTRATION OPENING SOON

MedRec to Go! – Creating a Reliable Discharge Process
Medication Reconciliation at Discharge Virtual Action Series

MedRec is like running a marathon. It takes hard work, perseverance, making sacrifices and seeing it through to the end because you know it's the right thing to do - not only for you and your organization but most importantly for your patients.

This interactive series is a kick-start for medication reconciliation at discharge. It will give you tools, resources and ideas you need to get MedRec at discharge up and running in one unit with a plan for spread across your organization. It will help you develop internal and external partnerships with key team players in the MedRec at discharge process and renew your passion for medication reconciliation.

This virtual action series is presented by Safer *Healthcare Now!* in partnership with the Canadian Patient Safety Institute (CPSI) and the Institute for Safe Medication Practices Canada (ISMP Canada).

Who Should Attend?

This series is ideal for anyone involved in implementing medication reconciliation at discharge in their acute care hospital.

We recommend cross continuum teams including representatives from long-term care, home care organizations, community pharmacists and primary care teams to give input to the acute care team during the last session.

This Series will help you:

- Implement medication reconciliation at discharge;
- Network and share learning with colleagues across Canada;
- Learn from and have access to faculty and topic experts;
- Apply improvement methodology to achieve local success.

Criteria to Participate:

- Executive Sponsor approval and support/Enrolled in SHN
- Have implemented MedRec at admission
- Commitment to attend all learning sessions, complete the assigned tasks and report progress
- Have enthusiasm for learning and sharing

Benefits of Participation:

This interactive series is a kick-start for medication reconciliation at discharge. It will give you tools, resources and ideas you need to get MedRec at discharge up and running in one unit with a plan for spread across your organization. It will help you develop internal and external partnerships with key team players in the MedRec at discharge process and renew your passion for medication reconciliation.

Participation Fee: $250 plus taxes per team

For More Information Contact: Alice Watt awatt@ismp-canada.org or Brenda Carthy bcarthy@ismp-canada.org or visit www.saferhealthcarenow.ca.

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RÉSERVER VOS DATES!

Séances d'information
15 fév 2011 en anglais
22 fév 2011 en français

Séance de formation WebEx
1er mars 2011 en anglais
8 mars 2011 en français

Séance virtuelle 1
le 22 mars, 2011
À vos marques: Créer le momentum

Séance virtuelle 2
le 19 avril, 2011
Prêt: Se diriger dans la bonne direction

Séance virtuelle 3
le 10 mai, 2011
Partez! – Faites-le!

Séance virtuelle 4
le 31 mai, 2011
Continuez – Persévérer à travers les obstacles

Séance virtuelle 5
le 21 juin, 2011
Faire le relais: Partenariat avec le patient,les prestataires de soins dans la communauté et de soins de longue durée.

Toutes les séances ont le même horaire:

12 :00 – 13:30 HE
LES INSCRIPTIONS COMMENCENT BIENTÔT!

Le BCM pour emporter!- Élaboration d'un processus de congé fiable!

Série d'apprentissage virtuel sur le bilan comparatif des médicaments (BCM) au congé

L'élaboration d'un processus BCM est comparable à la préparation d'un marathon : cela nécessite beaucoup d'efforts, de la persévérance et des sacrifices. Il est important d'y aller jusqu'au bout parce que c'est la bonne chose à faire non seulement pour vous mais pour votre établissement et surtout vos patients.

Cette série interactive est le point de départ pour le BCM au congé. Elle fournira des outils, des ressources et des idées pour démarrer le BCM au congé dans une unité de soins ainsi que l'élaboration d'un plan de déploiement organisationnel. Ce projet vous permettra de développer des partenariats à l'interne et à l'externe avec des membres clés impliqués dans le processus du BCM au congé tout en renouvelant votre passion pour le BCM.

La série d'apprentissage virtuel est présentée par *Des soins de santé plus sécuritaires maintenant*! en collaboration avec l'Institut canadien pour la sécurité des patients (ICSP) et l'Institut pour l'utilisation sécuritaire des médicaments du Canada (ISMP Canada).

Qui devrait assister?

Cette série est conçue pour toute personne impliquée dans la mise en œuvre du BCM au congé dans un établissement de soins aigus.

Nous recommandons des équipes composés de membres provenant de différents milieux de soins incluant des représentants en soins de longue durée, des établissements de soins à domicile, des pharmaciens communautaires et des équipes de soins de première ligne, pour donner leur avis aux équipes de soins aigus lors de la dernière séance.

Cette série vous aidera à:

- Mettre en œuvre le BCM au congé;
- Faire du réseautage tout en partageant votre expérience d'apprentissage avec des collègues à travers le Canada;
- Avoir accès aux membres de la faculté et des experts en contenu et apprendre d'eux;
- Mettre en application la méthodologie d'amélioration pour obtenir un succès à l'échelle locale.

Critères de participation:

- Obtenir le soutien et l'approbation de la Haute direction et être inscrit aux Soins de santé plus sécuritaires maintenant!
- Avoir déjà mis en œuvre le BCM à l'admission
- S'engager à vouloir assister à l'ensemble des séances d'apprentissage, de compléter les tâches assignées et de rapporter l'état d'avancement
- Avoir de l'enthousiasme pour l'apprentissage et le partage

Avantages de participer: Cette série interactive est le point de départ pour le BCM au congé. Elle fournira des outils, des ressources et des idées pour démarrer le BCM au congé dans une unité de soins ainsi que l'élaboration d'un plan de déploiement organisationnel. Ce projet vous permettra de développer des partenariats à l'interne et à l'externe avec des membres clés impliqués dans le processus du BCM au congé tout en renouvelant votre passion pour le BCM.

Frais de participation: $250 plus taxes par équipe

Pour de plus amples informations: Alice Watt awatt@ismp-canada.org ou Brenda Carthy bcarthy@ismp-canada.org ou consultez le site http://www.saferhealthcarenow.ca/FR/Pages/default.aspx .

Participant Guide DRAFT

Spring training begins March 22, 2011

Welcome!

Safer Healthcare Now! in partnership with the Canadian Patient Safety Institute, Victorian Order of Nurses for Canada and the Institute for Safe Medication Practices Canada welcome you to the ***MedRec to Go! – Creating a Reliable Discharge Process*** **- Medication Reconciliation at Discharge Virtual Action Series**

This participant guide will provide you with pertinent information to prepare for the virtual action series. It includes the following:

- A basic background on Medication Reconciliation at Discharge
- Events and details of this virtual action series including important dates and WebEx links
- Getting started check list for this virtual action series
- Discharge MedRec Resources

For additional information, please feel free to contact Alice Watt at awatt@ismp-canada.org or Brenda Carthy at bcarthy@ismp-canada.org or visit http://www.saferhealthcarenow.ca.

Medication Reconciliation at Discharge

Definition

Medication reconciliation is "a formal process in which health care professionals' partner with clients to ensure accurate and complete medication information transfer at interfaces of care. It involves a systematic process for obtaining a medication history, and using that information to compare to medication orders in order to identify and resolve discrepancies. It is designed to prevent potential medication errors and adverse drug events"[1]

Background

The Problem

- Adverse drug events (ADEs) are occurring at an alarming rate across all sectors of healthcare. In the Canadian Adverse Events study, drug and fluid related events were the second most common type of procedure or event to which adverse events were related. (Baker et al, 2004)[2]
- At the core of ADEs is miscommunication and fragmented care processes (Institute of Medicine Report, 2007)
- In a study to determine the risk, severity and type of adverse events (AEs) after discharge, Forster et al. (2004)[3] followed 361 patients discharged from a general internal medicine service at a Canadian teaching hospital to independent or residential living. Ninety-one percent (n=328) of those eligible for inclusion were contacted by telephone 30 days post-discharge. The physician reviewers determined that 72 patients (23%) experienced an AE post-discharge. Of all AEs, 72% were medication related, and the majority were considered either preventable or ameliorable. The authors concluded that improved monitoring and communication with community care providers is needed to improve safety after discharge.
- A randomized, controlled trial in a hospital in Moncton, NB[4] showed the clinical impact of drug discrepancies in hospital discharge medication orders identified by a pharmacist as part of the medication reconciliation process. The intervention group of 134 patients showed 40% of these patients had at least one discrepancy at the time of discharge. Altogether, ninety-nine discrepancies, at a rate of 0.74 discrepancies per patient, were identified and resolved by the pharmacist before the patient was discharged. Ninety of the ninety-nine discrepancies had an

[1] ISMP Canada, Assuring Medication Accuracy at Transitions in Care: Medication Reconciliation High 5s: Action on Patient Safety Getting Started Kit, 2008

[2] Baker, R., Norton, P., Flintoff, V., Blais, R., Brown, A., Cox, J., Etchells, E., Ghali, W.A., Hebert, P., Majumdar, S.R., O'Beirne, M., Palacios-Derflingher, L., Reid, RJ., Sheps, S. Tamblyn, R. 2004. "The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada". Canadian Medical Association Journal 170(11): 1678-86

[3] Forster AJ, Clark HD, Menard A, et al. Adverse events among medical patients after discharge from hospital [published correction appears in Canadian Medical Association Journal. 2004;170(5). Doi:10.1503/cmaj.1040215] Canadian Medical Association Journal. 2004;170(3):345-349. http://www.cmaj.ca/cgi/data/170/3/345 Accessed June 10, 2008

[4] Nickerson A, Mackinnon NJ, Robets N, Sulnier L, Drug-therapy problems, inconsistencies and omissions identified during a medication reconciliation and seamless care service, Healthcare Quarterly. 2005;8 Spec No;65-72

intervention ranking of significant or very significant. In the control group of 119 patients, a retrospective chart review showed that 56% of patients were discharged with at least one unresolved discrepancy.

Drivers for Change

Evidence continues to build:

- Lessons learned from the SHN interventions in acute and long term care validate the data and support the need for medication reconciliation as a practice to reduce adverse events related to medications
- Changes in Accreditation Canada standards acknowledge the benefits of medication reconciliation as a means of reducing medication errors.

To further support the case for medication reconciliation at discharge please refer to the Getting Started Kit for Medication Reconciliation in Acute Care.

Goals and Objectives

The goal of MedRec to Go! Virtual Action Series is to:

Work together, learn together so that….
Together WE CAN
move MedRec at discharge forward…
because it's the right thing to do.

Overview of Objectives: Beginning with an End in Mind

- **Share** stories and share innovation
- **Practice and Build** MedRec skills
- **Implement** MedRec at discharge on one unit in a targeted population.
- **Test and develop** a process that works
- **Liaise** with community and LTC providers
- **Focus** on the patient and their needs at discharge.
- **Assess** resources needed to sustain the improvement.

This interactive series is a kick-start for medication reconciliation at discharge. It will give you tools, resources and ideas you need to get MedRec at discharge up and running in one unit with a plan for spread across your organization. It will help you develop internal and external partnerships with key team players in the MedRec at discharge process and renew your passion for medication reconciliation.

This Series will help you:

- Implement medication reconciliation at discharge;

- Network and share learning with colleagues across Canada;
- Learn from and have access to faculty and topic experts;
- Apply improvement methodology to achieve local success.

Virtual Sessions

Each virtual session is 90 minutes in length. All sessions are scheduled on Tuesdays, 3 weeks apart, at the same time for consistency and are delivered virtually via Webinar (WebEx). There will be time for delivery of subject matter, sharing of information and experiences as well as breakout groups for discussion. All learning sessions will be delivered in English with the support of francophone faculty.

Structure of each Session

- **Warm-Up - What's your story?**
  Featuring real-life stories from teams

- **All-Star Profile**
  Features innovation and success stories from hospitals that did it!

- **Coach's Corner**
  Refine MedRec skills at Discharge or learn a quality improvement principle.

- **The Workout**
  Applying what you've just learned in MedRec Case Studies and Change Ideas. Teams will implement and test change ideas over the next 3 weeks.

- **Cool Down**
  Question Period

Calendar and Outline of the Virtual Session Details (Tentative)

Virtual Session 1 March 22, 2011	**On your Mark:** Creating Momentum • Team Goal: o Select your target population based on need and resources available. o Obtain baseline data and local stories to drive change. o Learn how to do MedRec at Discharge. • All-Star Profile: The Hennepin County Story
Virtual Session 2 April 19, 2011	**Get Set:** Heading in the Right Direction • Team Goal: • Re-engineer the Discharge • Map the current and ideal process • All-Star Profile: Five Hills Health Region
Virtual Session 3 May 10, 2011	**Go!** : Just Do it! • Team Goal: • Understand the model for improvement as a tool to implement change and how it can be applied to initiate improvements to the MedRec discharge process. • Test change concepts and make improvements to MedRec discharge tools and processes. • Explore electronic and paper tools currently in use by hospitals. (Breakout session/Discussion panel) • All-Star Profile • (Electronic): Sunnybrook, NYGH • (Paper): Alberta Health Services, Jewish General Hospital
Virtual Session 4 May 31, 2011	**Keep Going! :** Persevere Through the Trials Goal: • Making your improvement stick • Explore electronic and paper tools currently in use by hospitals. • Find out what works well in practice. (Breakout session/Discussion Panel). • All-star Profile: Electronic: McGill University Hospital (Research), UHN • Paper:
Virtual Session 5	**Pass the Baton:** Partner With Your Patient, Community and Long-term Care Partners

June 21, 2011	Team Goal: • Understand patient literacy and 'teach-back' counseling technique and other counseling techniques. • Liaise with patients, community pharmacists, long-term care providers, home care teams, primary care. • Plan how you will work together to improve communication of medication information to and from your facility. • Hear the stories from patients, community and long-term care partners and understand their needs for medication information. • All-Star Profile: The Novant Story

Action Periods

An action period is the time between virtual sessions. The four action periods of this series are 3 weeks long and will allow teams to do the work needed to move discharge forward. Tasks will be discussed and assigned during the virtual session in the 'The Workout' segment of each virtual session.

It is understandable that not all teams will be able to complete all of the tasks assigned. This series is focused on facilitating learning at the speed and level needed for each organization. It is expected that some organizations are further along than others therefore teams will be encouraged and supported along the learning curve at their own speed.

Resource material will be delivered to participating teams for use during the virtual sessions to be used at the discretion of the teams.

- Change (Workout) package.
- Reference pages from the GSK
- Applicable tools, guides.
- Questions to stimulate discussion or brainstorming within the team

Team Support

Toll-Free Number for Assistance: 1-866-544-7672 x 250

Coaching:
Faculty will be available to participants via email or phone.

Coaches:

- Caroline Robitaille
- Doris Doidge
- Mary Lou Lester
- Lynn Riley
- Alice Watt
- Marg Colquhoun
- All-Star Speakers will be available for questions during the Cool Down period.

Note: See Appendix B for faculty details.

SHN! Communities of Practice (COP)
Please join the medication reconciliation community of practice. (Register Now!)
This will enable to

- see what is happening across the country with MedRec
- engage in on line discussion with colleagues, coaches and faculty across the country working on MedRec at Discharge
- ask MedRec experts questions
- share your stories
- access resource material including tools, national calls, webinars related to your improvement initiative.

For more information see: www.saferhealthcare.ca

Benefits of Participation
This VAS will provide you with the opportunity to learn how to implement medication reconciliation within the home care environment with the support of clinical experts, and improvement professionals to successfully implement practice change.

You will:

- have access to and learn from faculty and topic experts
- have access to a network of shared learning with colleagues across Canada
- learn to apply improvement methodology to achieve local success
- have access , share and adapt change ideas, tool and resources

Criteria for Participation

- ✓ Secure sponsor
- ✓ Join SHN www.saferhealthcarenow.ca
- ✓ Choose a unit
- ✓ Form a team
- ✓ Register for VAS online
- ✓ Attend WebEx/COP/web-based PS metric tool training
- ✓ Establish meeting time spaces
- ✓ Review Participant guide/change packages

Safer Healthcare Now!
In order to participate in this virtual action series, your team/organization will need to be enrolled in *Safer Healthcare Now!* Your organization may already be enrolled and involved with one of the existing interventions, so check with your quality/risk manager.

If not, please visit www.saferhealthcarenow.ca and join!

Executive Sponsor

Demonstrated buy in from the top down is essential to the success of a project. All teams enrolled in this series are expected to have executive sponsor approval and support.

Computer & Telephone Access

All sessions will be delivered by WebEx. In order to do this the team will need access to a computer, internet, and telephone. It will also be important to have access to a meeting room to facilitate productive learning.

Commitment

It is imperative that established core team members be present at all learning sessions and be designated to ensure information is communicated to all members of the team and to ensure assigned tasks are completed. It is understandable that not all members will be able to attend all learning sessions although 100% attendance will enhance success.

Enthusiasm

Engage individuals who are willing to learn and take on the challenge. Recruit your champions!

Team Membership

Membership will vary among organizations depending on programs, and resources available. Some key people for consideration might be:

Roles to Consider

Team Captain

- Select someone with strong leadership skills. This person needs to be in a position to attend all learning sessions and will take the responsibility to ensure the assigned tasks are completed
- Coordinates the team, delegates tasks and keeps the team on track. Accountable to senior management. Brings snacks.

The Reporter

- Record action items. Captures and disseminates the ideas and stories generated by team to the unit and to the rest of the hospital.

Pacesetter

- These might pharmacists, nurses, nurse practitioners, physicians. These individuals will be testing your ideas for change.
- Works through MedRec case studies and does MedRec at discharge. Teaches clinicians how to do it.

Anchor

- Coordinates flow and quality improvement process on the front line. Engages patients/community/LTC providers, front line, clerical, physicians, and pharmacists.

Cheerleader

- Spreads the word about the team's progress and encourages the team and updates the unit on the progress. Champion on the front-line.

Techno-Super Star

- WebEx, Web-based data collection; Community of Practice - posts, chats and discussion boards; electronic MedRec software; social media.

Preparation for the Virtual Action Series

Secure your sponsor.

You will need the name and email address of your sponsor for registration

Join SHN.

Visit the safer health care now home page at www.saferhealthcarenow.ca and join.

Form your team.

Your core members should have been confirmed at the time of your registration. You may add more as necessary once you get yourself organized.

Establish three key roles within your team.

- Clinical Leader: This person will be responsible for subject matter, knowledge and processes of care. It is critical to have at least one clinical leader/champion on the team. This person may or may not have a formal leadership role, but will usually play a lead (or very active) role on the improvement team. This clinical champion should have a good working relationship with colleagues and with the team leader described below, and be interested in driving change in the system.
- Team Leader: This person is responsible for driving the improvement process every day. This person manages the team, arranges meetings, and assures tests are completed and data is collected. The team leader needs to be able to "get things done", to coordinate and track all aspects of the team's work, and to work effectively with all involved in the effort.
- Key Contact: The individual on the team who takes responsibility for two-way communication between the team and the virtual action series leadership, including reporting and disseminating project information to team members. The key contact is often the team captain.

  Note: It is important to update the series coordinator with any change of email addresses as this will be the primary means of communication throughout the series.

Establish meeting information

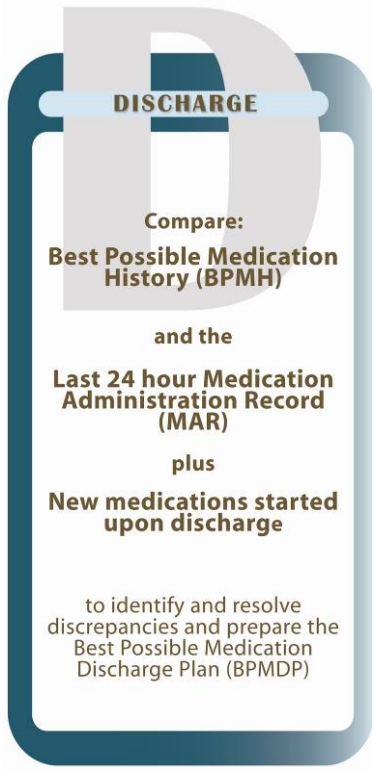
- Get organized! Take care of the basics.
- Arrange for team meeting dates, times, and location.
- It may be helpful to have meetings off-site to help the team bond and to get away from distractions like pagers and clinical work.
- Make sure the meeting room will have a computer with internet access and a telephone. If face to face is not possible and you have access to virtual networking you may choose to set virtual meetings.
- Ensure all team members have the basic information around the series sessions and team meetings.

Participate in Web Ex education

- SHN has set up Web Ex training sessions. All team members should participate in one of these sessions.

Note: See Appendix A for a check list for preparation for VAS including session one

Appendix A: Process for Medication Reconciliation at Discharge



The goal of discharge medication reconciliation is to reconcile the medications the patient is taking prior to admission (BPMH) 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. This should result in avoidance of therapeutic duplications, omissions, unnecessary medications and confusion.

Discharge medication reconciliation clarifies the medications the patient should be taking post-discharge by reviewing:

- Medications the patient was taking prior to admission (BPMH)
- Previous 24 hour MAR (medication administration record)
- New medications planned to start upon discharge

Using the Best Possible Medication History (BPMH) and the last 24-hour medication administration record (MAR) as references, create the **Best Possible Medication Discharge Plan (BPMDP)** by evaluating and accounting for:

- New medications started in hospital
- Discontinued medications (from BPMH)
- Adjusted medications (from BPMH)
- Unchanged medications that are to be continued (from BPMH)
- Medications held in hospital
- Non-formulary/formulary adjustments made in hospital
- New medications started upon discharge
- Additional comments as appropriate - e.g., status of herbals or medications to be taken at the patient's discretion

The **Best Possible Medication Discharge Plan (BPMDP)** may include:

- An up-to-date BPMH which is the most accurate list of medications the patient should be taking on discharge.
- A medication information transfer letter to the next care provider
- A structured discharge prescription to the next care provider or community pharmacist
- A patient information grid and/or wallet card

The Best Possible Medication Discharge Plan (BPMDP) should be communicated using a systematic process to the:

- Patient/caregiver
- Community physician
- Community pharmacy
- Long term care provider
- Home Care provider
- Alternative care facility or service

Each time a patient moves from one healthcare facility to another or to home, providers should review with the patient/caregiver all previous medication lists alongside the list of medication prescribed at discharge and reconcile the differences. This process should take place both prior to leaving the hospital and again promptly after transition to the new setting of care.[5]

Medication Reconciliation at Discharge*

1. **Create the BPMDP**
   - Review the last 24-hour MAR prior to discharge and record medications on the BPMDP that are relevant for discharge;
   - Compare these medications to the BPMH obtained at admission and record any medications on the BPMDP that are not included on the MAR;

2. **Identify** all discrepancies between the BPMH and the last 24-hour MAR
   - Omitted medications, dose adjustments, non-formulary/formulary adjustments;
   - Complete documentation for each medication on the BPMDP indicating: continue as prior to admission, adjusted, discontinued or new in hospital.

3. **Resolve and document** any discrepancies with the prescriber.
   - Prescriber reviews and completes the BPMDP, makes adjustments and writes new prescriptions as appropriate.

4. **Communicate** BPMDP to the patient and the next providers of care
   - Conduct a BPMDP patient/caregiver interview using a systematic process and document;
   - Refer patient for community medication review program follow-up where applicable;
   - Communicate BPMDP to the community pharmacy, primary care physician, alternative care facility, family health team, ambulatory clinics and home care as applicable.

Note: *Unless specified, each institution and/or individual unit should determine who is primarily responsible for completing each step based on available resources (e.g., RPh, RN, MD)*

* Refer to the Discharge Medication Reconciliation Checklist

[5] Gursitx JH. Double Trouble, AHRQ Web M&M, accessed August 1, 2006. (Fix Reference)

Appendix B: Discharge Resources

Literature Search: Medication Reconciliation on Discharge.
Prepared by Holly van Heukelom, July 5, 2010, Providence Health Centre <Insert File>

1. Without MedRec, patients were more than twice as likely to be readmitted (14.3% vs. 6%) (p=0.04)(Coleman et al. *Arch Intern Med* 2005;165:1842-47)

2. MedRec dramatically reduces preventable adverse drug events 30 days after discharge (11% vs1%)(p=0.01)(Scnipper et al. *Arch Intern Med*2006;166:565-571)

3. STAAR State Based Strategy - Boutwell, A. Jencks, S. Nielsen, GA. Rutherford, P. STate Action on Avoidable Re-hospitalizations (STAAR) Initiative: Applying early evidence and experience in front-line process improvements to develop a state-based strategy. Cambridge, MA: Institute for Healthcare Improvement; 2009.

4. BOOST - Society of Hospital Medicine. Project BOOST: Better Outcomes for Older adults through Safe Transitions. *Care Transitions Implementation Guide*. Available at: http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm.

5. RED – AHCP Sample Discharge Plan – Boston Medical (insert file)

6. Harrison et al, 2007 **A Structured Evidence-Based Literature Review on Discharge, Referral and Admission Australia.**

   
   Jack.pdf

7. Potential Risk of Medication Discrepancies and Reconciliation Errors at Admission and Discharge from an Inpatient Medical Service Mónica Climente-Martí, Elda R García-Mañón, Arturo Artero-Mora, and N Víctor Jiménez-Torres *Ann Pharmacother* 2010;44 Published Online, 5 Oct 2010, *theannals.com*.

Appendix C: International MedRec Resources/Websites

Organization Site/Name	URL	Content and function
Institute for Health Care Improvement	http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Measures/	A range of materials available from the *5 million lives* campaign (2006 – 2008) including a medication reconciliation How-to-Guide, articles, educational leaflets, webinars and sample reconciliation forms. The site also provides a number of tools for measuring medication reconciliation including some performance measures and an improvement tracker tool which allows hospitals to create and chart their own performance measure results over time.
Massachusetts Coalition for the Prevention of Medical Errors	http://www.macoalition.org/index.shtml	A range of materials available from the *Reconciling Medications Collaborative (2002 – 2004)* - a statewide patient safety initiative for Massachusetts hospitals to reduce medication errors by reconciling medicines. Materials developed as part of the collaborative include policies, staff education materials, examples of successful implementation strategies, implementation worksheets, guidelines for getting started, and references. A set of measurement protocols and accompanying excel spreadsheets for collecting data and generating graphs of the core evaluation measure – Percent Medications Unreconciled are also available.
Northwestern Memorial Hospital MATCH website	http://www.nmh.org/nm/for+physicians+match	The MATCH website is an initiative of the Northwestern Memorial Hospital, Illinois. The site provides a thorough explanation of how to approach medication reconciliation and includes a medication reconciliation toolkit which can be used for inpatient and outpatient practice settings. Resources include case studies, sample forms, PowerPoint presentations and a business case for clinicians and senior management, project planning materials, performance measures and case studies.

Better Outcomes for Older adults through Safe Transitions (BOOST) project website	http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/01HowtoUse/00_Howtouse.cfm	The ***B****etter* ***O****utcomes for* ***O****lder adults through Safe Transitions* (BOOST) initiative, organized by the Society of Hospital Medicines in the US, provides resources to optimize the hospital discharge process. The resource room includes expert- and evidence-based interventions to promote a safe and high quality hospital discharge as patients transition out of the hospital setting. Although not specific to medication reconciliation the *Care Transitions implementation Guide* provides valuable guidance on using quality improvement methodology in effecting changes in discharge practices in an organization.
National Institute for Health and Clinical Excellence (NICE) website	http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11897	Provides details on the NICE patient safety guidance 1: *Technical patient safety solutions for medicines reconciliation on admission of adults to hospital* a policy which required all public hospitals in the UK and Wales to put in place formal systems for admission reconciliation by December 2008. As well as the guidance document the site provides an audit tool, PowerPoint presentation, costing tools and other useful information
National Prescribing Service NHS Medicinces Reconciliation: A guide to implementation.	http://www.npci.org.uk/medicines_management/safety/reconcil/resources/reconciliation_guide-a5ordered.pdf	Medicines Reconciliation: A guide to implementation: This guide will help you to understand the importance of obtaining accurate and timely information about patients medicines, and the part that each of us has to play in ensuring that every patient receives a personalized service as far as their medicines are concerned

Appendix D: Making your Improvement Stick:

Sustainability Resource from Regina Qu-Appelle Health Region – Quality Improvement Unit – (Used with Permission)

Sustaining an Improvement Initiative
Process Owners: Transition to Operations

Why do many pilot projects produce fantastic results which fizz out and die when the pilot is over? The answer lies in the lack of sustainability, and sustainability is the greatest challenge to any improvement effort. Lean principles recognize that Process Owners are the missing link. **A process owner is an individual (s) who has the authority to ensure that portions of a new or improved process are operationalized.** The matrix below initiates and guides the important and on-going discussions with individuals who will be tasked to operationalize, monitor and sustain the improved process.

How to construct a Process Owners Matrix:
The matrix template is completed at the *end* of the kaizen (or finalized after the trial period). Keep the matrix in draft form until all sponsors and process owners have had a chance to comment on the initiative and their role and responsibility for sustaining the process. The examples in the stages below are also found in the matrix.

Step 1. List the operational steps of the process in the 3rd column called Portion of the Process. Portions of the Process describe the operational process steps. (Note: this column also identifies key process measures that will allow the organization to monitor the process overall, and can determine if the process is sustained).
Step 2. Describe how the operational activity benefits the patient/client/resident and family or the internal customer, and write this in Column 4, Benefit to Patient/Internal Customer.
Step 3. Name the Process Owner for that portion of the process in Column 2, i.e. the person who supports the employee or physician and builds this responsibility into the employee's/physician's work plan. *e.g. Manager.* The Process Owner will oversee the staff or physicians and ensure adequate awareness or education has been provided, address issues raised by staff/physicians and ensure that the process is followed.

Step 4. Name the Senior Leader for each portion of the process in Column 1, i.e. the person who supports that process owner to build this responsibility into the process owner's work plan, and discusses the success of this work on a regular basis. *e.g. Executive Director, Support Services and Central Scheduling.* The Sponsor will have the authority to address barriers and allocate resources in order to ensure the portion of the process is sustained.

Step 5. Communication Strategy Step one: Discuss this document with all Process Owners identified on the matrix and ask for their feedback. This document fosters an important discussion about owning and operationalizing this work on behalf of the patients receiving care in our organization. Process Owners should be given the time and opportunity to understand the initiative before it is fully operationalized. They should have a voice in its implementation, and a full understanding of their unique role and responsibilities in sustaining the work.

Process owners ensure that their staff/physicians are aware of the job duties within the process.

Step 6. Communication Strategy step two: Discuss this document with all Senior Leaders identified on the matrix and ask for their feedback. Explain what data will be collected related to this process, and how they will receive it. Explain each senior leader's unique role and responsibilities in sustaining the work

Step 7. Monitoring and Reporting Plan: Determine which key portion(s) of the process will become the source of data to determine if the process is on track and sustained. Select a one or two key process measures from Column 3 and determine how the measure information will be collected, compiled, analyzed and reported. Identify the individual(s) responsible for each of these tasks. State who this data will be reported to, and frequency (monthly vs. quarterly).

Step 8. Action to Sustain Process: When problems are identified through the Monitoring and Reporting Plan, the process owner of the problematic step will investigate the issues and take action to develop solutions. This process owner will report problems encountered and resolutions implemented to their senior leader, as well as to other key process owners as applicable to sustain the process.

Sustaining Medication Reconciliation in Acute Care Sites

Regina Qu-Appelle Health Region QI Unit Used with permission

Senior Leader: Provides support to the process owner, addressing system barriers	Process Owner: Has the authority and influence to ensure the portion of the process is sustained	Assigned To: Responsible individual/ group to carry out the process activity	Portion of the Process: The portion of the new or improved process that the process owner influences *(note: list job title and operational activity)*	Benefit to Patient/Internal Customer: The beneficial outcome for the patient
Director, SWADD	SWADD Mgr, Admissions	SWADD Admissions Clerk	Print the Pharmacy Information Program (PIP) Preadmission Medication/ Physician Order form for every all visits	Use of PIP Physician Order form prevents transcription medication errors and reduces hunting & gathering of medication information
Exec Director, Emergency Services	Director, Emerg Dept	Nurse caring for patient	On the PIP form: record the dose and interval for each medication that the patient is still taking prior to arriving in the ED Cross out all medications the patient had stopped taking prior to arriving in the ED	Complete, concise and accurate Information about the medications taken by the patient prior to arriving at the facility prevents medication errors of omission or incorrect dose/interval. This information will ensure that medications are not
Executive Director(s), Specialty Care	Nurse Manager, Patient Care Units	Nurse caring for patient	If not completed prior to arriving on the unit: On the PIP form: record the dose and interval for each medication that the patient is still taking prior to arriving in the facility Cross out all medications the patient had stopped taking prior to arriving in the facility	

				inappropriately changed or abruptly stopped in error.
Department Head or Senior Medical Officer	Section Head Or Department Head	Physician	Utilize the PIP form with the medication history now documented on it, to address all medications taken by the patient prior to visit/admission, and determine if the medication should be stopped/changed or continued	Use of a complete and accurate home medication list for the purpose of determining appropriate medications during hospital stay will prevent serious patient harm secondary to inadvertent changes or abrupt stops in medications.
Executive Director	Nurse Manager	Charge Nurse	1) Complete MedRec audit form for five charts each week (during project phase September 2008 – August 2009). 2) Post run charts each month as they are generated by the audit excel workbook (self-populated as data is entered). 3) Send excel workbook to QI each month.	Close monitoring of how successfully a patient safety process is functioning can ensure early intervention for areas that are struggling, and assist senior leaders to address barriers faced by staff and physicians.
Vice President	Executive Director	Nurse Manager	Share monthly data run charts with executive director and discuss any concerns that need to be addressed.	
Senior Medical Officer	Department Head	Section Head	Share monthly data run charts with department head and discuss any concerns that need to be addressed	

Appendix E: MedRec To Go! *A Reliable Discharge Process* Virtual Action Series Session Schedule/Details

Virtual Session 1
March 22, 2011
	On your Mark: Creating Momentum
	• Team Goal:
	  o Select your target population based on need and resources available.
	  o Obtain baseline data and local stories to drive change.
	  o Learn how to do MedRec at Discharge.
	• All-Star Profile: The Hennepin County Story

Virtual Session 2
April 19, 2011
	Get Set: Heading in the Right Direction
	• Team Goal:
	  • Re-engineer the Discharge
	  • Map the current and ideal process
	• All-Star Profile: Five Hills Health Region

Virtual Session 3
May 10, 2011
	Go! : Just Do it!
	• Team Goal:
	  • Understand the model for improvement as a tool to implement change and how it can be applied to initiate improvements to the MedRec discharge process.
	  • Test change concepts and make improvements to MedRec discharge tools and processes.
	  • Explore electronic and paper tools currently in use by hospitals. (Breakout session/Discussion panel)
	• All-Star Profile
	  • (Electronic): Sunnybrook, NYGH
	  • (Paper): Alberta Health Services, Jewish General Hospital

Virtual Session 4
May 31, 2011
	Keep Going! : Persevere Through the Trials
	Team Goal:
	• Making your improvement stick
	• Explore electronic and paper tools currently in use by hospitals.
	• Find out what works well in practice. (Breakout session/Discussion Panel).
	All-star Profile:
	  • Electronic: McGill University Hospital (Research), UHN
	  • Paper:

Virtual Session 5 June 21, 2011	**Pass the Baton:** Partner With Your Patient, Community and Long-term Care Partners Team Goal: • Understand patient literacy and 'teach-back' counseling technique and other counseling techniques. • Liaise with patients, community pharmacists, long-term care providers, home care teams, primary care. • Plan how you will work together to improve communication of medication information to and from your facility. • Hear the stories from patients, community and long-term care partners and understand their needs for medication information. • All-Star Profile: The Novant Story

Appendix F: MedRec to Go! Virtual Action Series Faculty and Staff

The action series faculty represents a range of expertise in medication reconciliation, quality improvement, risk management and change implementation. Listed below is the faculty for this series.

Brenda Carthy
ISMP Canada
Brenda is a Project and Event Coordinator at the Institute for Safe Medication Practices Canada. Although Brenda's educational background is Information Technology, her recent work experience has been in hospital pharmacy and medication safety. She has worked for ISMP Canada since 2000 and has worked with Marg Colquhoun on multiple projects and events intended to assist healthcare facilities implement safeguards in their medication systems. Brenda has been involved in the *Safer Healthcare Now!* Medication Reconciliation intervention as national coordinator since 2005.

Margaret Colquhoun
ISMP Canada
Marg Colquhoun is a Project Leader at the Institute for Safe Medication Practices Canada. In addition to over twenty years' experience in hospitals, in several administrative positions, Marg consulted both inside and outside of health care for 7 years, including work at the Mayo Clinic in Rochester. She has worked with ISMP Canada in 2000 to lead the Ontario Medication Safety Support Service in multiple projects, including assisting hospitals to implement safeguards to reduce the potential for error with concentrated potassium chloride and narcotics (opioids). Marg leads the Medication Reconciliation intervention on behalf of ISMP Canada for *Safer Healthcare Now!,* supporting teams in acute care, long term care and home care. As a result Marg is assisting the WHO High-5's medication reconciliation intervention at an international level.

Doris Doidge
SHN Ontario Node Safety & Improvement Advisor
Doris Doidge is Project Manager for a Project funded by the Ontario Health Quality Council. Doris is a Nurse who received her Masters Degree in Nursing in 1999 from the University of Toronto. Doris has worked in a variety of nursing positions over her 30 plus years in healthcare. Her interest in quality and quality improvement evolved over the years. She was involved in teaching quality improvement and accreditation. Over the past 10 years she has had a variety of positions in quality as Program Leader, Director and Safety Improvement Advisor. Recently as Director of Quality at Whitby Mental Health Centre she introduced the Model for Improvement at that facility prepared the quarterly Balanced Scorecard during her tenure there.

Anne MacLaurin
Canadian Patient Safety Institute Project Manager

Anne MacLaurin is a Project Manager for the Canadian Patient Safety Institute. Her primary role is supporting and coordinating the *Safer Healthcare Now!* network. Anne has held various positions during her career, such as staff nurse with the IWK Health Center in Halifax and the Prince County Hospital in PEI; clinical instructor for the University of Prince Edward Island; and Utilization Coordinator for the Provincial Health Services Authority. She was first introduced to *Safer Healthcare Now!* through her work as the Quality/Risk Coordinator, with the PEI Department of Health. Anne holds a B.Sc. in nursing from St. Francis Xavier University and completed her masters of nursing studies through Dalhousie University in 2007. The clinical focus of her graduate work was in the care of ill children and their families.

Caroline Robitaille
Quebec Node Safety Improvement Advisor, Campagne Quebecoise EAPSSS!
Caroline Robitaille obtained a Bachelor of Pharmacy degree in 2002 and a Master's degree in Hospital Pharmacy in 2003 from the University of Montreal. Mrs. Robitaille practices primarily in the Emergency Department at the Jewish General Hospital (Montreal, QC). She is an associated clinician to the University of Montreal's Faculty of Pharmacy, and supervises pharmacy students and residents. She is currently serving as president of the critical care pharmacists working group, affiliated to Quebec's *Association des Pharmaciens en Etablissement de Sante (APES)*.

She has participated actively in developing the medication reconciliation process at the Jewish General Hospital. Since 2009, Mrs. Robitaille has been a Safety and Improvement Advisor for Safer Healthcare Now's Quebec Node.

Tanis Rollefstad
SHN! Western Node Safety & Improvement Advisor
Tanis Rollefstad joined the *Safer Healthcare Now!* Campaign in October 2005, the year of its inception and continues her role as the Safety and Improvement Advisor for the Western Node. She is an RN by training, has a Bachelor of Nursing Degree and has taken the Patient Safety Officer course in 2002. She has since attended numerous IHI conferences, workshops and courses supporting her continued knowledge of cutting edge quality improvement methodologies. She is currently enrolled in the Masters of Arts in Communication and Technology at the University of Alberta to further her interest in virtual engagement for learning. In addition she is a guest faculty member of the Saskatchewan Quality Improvement Consultant School and the BC Quality Academy. Tanis has a depth of clinical experience spanning the critical care environments to community health care and development in developing countries where her passion for quality improvement began. She continues as a member of an international group of improvement practitioners organized by the IHI, learning about large scale improvement and has special interest and training in Reliability science, Spread and Sustainability.

Alice Watt
ISMP Canada

Appendix C: MedRec to Go! Virtual Action Series Check List

The below check list is a reference to support your preparation for first session of the webinar series.

- ☐ Confirm support of your executive sponsor.
- ☐ Confirm your team members. Establish who your team leader and core team members will be. These core team members should attend all of the sessions. Assign team roles as needed.
  - Key Contact Person: _____
- ☐ Confirm team meeting dates and times, location to ensure dedicated time is allocated to work on series activities between sessions.
- ☐ Arrange meeting room including access to computer and telephone for each session and team meeting.
- ☐ Ensure one of the core team members attend the WebEx Training/COP/Web-based measurement tool sessions being delivered by SHN if virtual learning is new to your team.
- ☐ Explore the SHN Virtual Program site for additional information related to the;
  - ☐ Medication Reconciliation Intervention English
  - ☐ Bilan comparatif des médicaments en courte durée (BCM) French
  - ☐ MedRec To Go! A Reliable Discharge Process Virtual Action Series English
  - ☐ Série d'apprentissage virtuel sur le bilan comparatif des médicaments (BCM) au conge French
- ☐ Prepare for Session One!

Preparation for Session One, "*Creating Momentum":*

- ☐ Ensure all team members have reviewed the participant/change package.
- ☐ What does your team hope to accomplish and learn from this Virtual Action Series?
- ☐ Come up with a team name. Take a picture of your team that reflects who you really are. Be Creative. (Send picture to awatt@ismp-canada.org)
- ☐ Ensure all members have information for logging into the WebEx especially any team members who will be listening off site.
- ☐ Log in 15-30 minutes before start time, to prevent any last minute problems especially if you are new to Web Ex. Please remember ***to log on to the WebEx training center first*** then call in with the attendee number. There should be a telephone by your name.
- ☐ Delegate the pre-session workout exercises.

Pre-session Workout (www.surveymonkey.com)

- ☐ Gather any established processes, tools, guides, policies your organization currently has related MedRec at discharge. (estimated time to complete: 1 hour)
- ☐ How reliable is MeRec at admission in your facility? (consider quality and quantity) (estimated time to complete: 1 hour)
    - o If you're not sure, do a quick audit on your unit randomly of 10 charts.
    - o What % of your patients had a BPMH on admission?
    - o Do an audit of one chart with a BPMH. What was the quality of the BPMH?
- ☐ Find out some basic statistics about your unit: (estimated time to complete: 1 hour)
    - o Estimate the percentage of your patients who are discharged:
        - directly home
        - home with home care
        - Long-Term Care
        - other institutions
    - o Contact Phone and community pharmacist, LTC nurse manager or home care team coordinator
    - o How many patients are discharged per week?
    - o What are the 5 top admission diagnoses?
    - o What additional resources do you have to do MedRec at discharge?

Appendix

3

Speaking Engagements

Speaking Engagements

Date	Speaker	Topic and Location/ Event
April 1, 2010	Alice Watt	**"Tea and a Talk"** ***Dialogue Amongst Teams Working on Medication Reconciliation.*** A Virtual Interactive Series Topic: Acute Care and Ambulatory Care. Participated in Panel discussion.
April 15, 2010	Alice Watt	**"Tea and a Talk"** ***Dialogue Amongst Teams Working on Medication Reconciliation.*** A Virtual Interactive Series Topic: Long-Term Care, Community and Mental Health. Presented Key Concepts in MedRec for LTC.
June 21, 2010	Alice Watt	**Taking the First Bite - BPMH Training**, Ontario Node MedRec Teleconference. One Bite at a Time: Eating the Medication Reconciliation Elephant.
June 22, 2010	Alice Watt	**Getting Started with MedRec at Admission** Ontario Node MedRec Teleconference. One Bite at a Time: Eating the Medication Reconciliation Elephant.
October 12 , 2010	Alice Watt	**Creating the Best Possible Medication History** – Home is Where the Heart Is! MedRec in Home Care Virtual Action Series
March 3, 2011	Alice Watt	**Refuelling your Quality Engine: Sparking Action for Complex Problems Checkpoint: Where Are We with MedRec?** • Check-In With Accreditation Canada • Cross Country Check-up **Go the Distance with MedRec** • Emerging Ideas and Success Stories To Keep You Going
April 1, 2011	Marg Colquhoun	**"Tea and a Talk" Acute Care and Ambulatory Care**. A Virtual Interactive Series for BC Patient Safety Task Force.
April 8, 2010	Marg Colquhoun	**Cross Country Check Up – National and Ontario Node Progress and Insights on Medication Reconciliation,** One Bite at a Time: Eating the MedRec Elephant Ontario Node MedRec Workshop, Ottawa ON **Who Wants to be a Millionaire???,** One Bite at a Time: Eating the MedRec Elephant Ontario Node MedRec Workshop, Ottawa ON
April 12-15, 2010	ISMPC Staff	**Medication Reconciliation in Home Care: A Collaboration Between VON Canada, ISMP Canada and Safer Healthcare Now!** Poster Presentation at Canada's Forum on Patient Safety and Quality Improvement

Date	Speaker	Topic and Location/ Event
April 12, 2010	Marg Colquhoun	**Medication Reconciliation in Home Care - the New Getting Started Kit! -** Safer Healthcare Now! Moving Forward with Vigour
April 12, 2010	Marg Colquhoun	**Medication Reconciliation in Acute and Long-term Care Rapid Fire Presentation -** Safer Healthcare Now! Moving Forward with Vigour
April 15, 2010	Marg Colquhoun	**Long-Term Care, Community and Mental Health,** A Virtual Interactive Series for BC Patient Safety Task Force.
April 29, 2010	Marg Colquhoun	**ISMP Canada and Safer *Healthcare Now!* Findings,** Optimizing Transitions in Care - Invitational Roundtable, Toronto ON
May 25, 2010	Marg Colquhoun	**ISMP Canada and Safer *Healthcare Now!* Findings,** Optimizing Transitions in Care - Invitational Roundtable, London ON
June 17 & 18, 2010	Marg Colquhoun	**The Lay of the Land: Medication Reconciliation Across the Continuum,** Medication Reconciliation: Summer School – Kelowna **Accreditation Canada in the Spotlight,** Medication Reconciliation: Summer School – Kelowna **Medication Reconciliation Across a System: Dialogue on Key Enablers and Challenges,** Medication Reconciliation: Summer School – Kelowna **Establishing Key Partnerships ~ community pharmacists, physicians, and others!**, Medication Reconciliation: Summer School – Kelowna
June 22, 2010	Marg Colquhoun	**Getting Started with MedRec at Admission** Ontario Node MedRec Teleconference. One Bite at a Time: Eating the Medication Reconciliation Elephant.
July 9, 2010	Marg Colquhoun	**Successful Strategies for MedRec from across Canada and Conversation with Accreditation Canada** Medication Reconciliation Ontario Node Call Series June - July 2010
July 12, 2010	Marg Colquhoun	**Successful Strategies for MedRec from across Canada** Medication Reconciliation Ontario Node Call Series June - July 2010
September 23, 2010	Marg Colquhoun	BPMH training, London ON
September 28, 2010	Marg Colquhoun	**Introduction to Medication Reconciliation,** Medication Reconciliation in Home Care: Home is where the heart is! VAS
October 25, 2010	Marg Colquhoun	BPMH training, London ON

Date	Speaker	Topic and Location/ Event
November 02, 2010	Marg Colquhoun	**Medication Reconciliation – State of the Union / Réconciliation de médicaments – État de l'union** – Patient Safety Week Webinar
November 20, 2010	Marg Colquhoun	**What's Next? MedRec SHN Intervention** – MedRec in Home Care: Home is where the heart is! Virtual Action Series
November 2010	Marg Colquhoun	**Solving the MedRec Mystery – Medication Reconciliation *Where we are in 2010*** –– BC Patient Safety Webinar
December 2 & 3, 2010	Marg Colquhoun	**Highlighting Success Across the Country** –– Western Node MedRec Workshop, Saskatoon **Using Pharmacy Systems to Automate Medication Reconciliation** – – Western Node MedRec Workshop, Saskatoon **Discovering Ideas – A Walk About to Solving Issues** –– Western Node MedRec Workshop, Saskatoon **Solving the Transfer and Discharge Dilemma** –– Western Node MedRec Workshop, Saskatoon **Conversations that Matter – Sector Specific Table** –– Western Node MedRec Workshop, Saskatoon
February 1, 2011	Marg Colquhoun	**Medication Reconciliation: Communication Must be Key,** CSHP Professional Practice Conference 2011, Toronto, ON
February 2, 2011	Marg Colquhoun	**ISMP Canada and Ontario Branch: Optimizing Communication about Medications at Transitions of Care,** CSHP Professional Practice Conference 2011, Toronto, ON
February 2, 2011	Marg Colquhoun	**The Essential Role of Pharmacists in *Safer Healthcare Now!:* VTE and Medication Reconciliation,** CSHP Professional Practice Conference 2011, Toronto, ON
February 10, 2011	Marg Colquhoun	**National MedRec Summit, Toronto ON**
March 16, 2011	Marg Colquhoun	**"Discover New Medication Practices"** - medication reconciliation and how nurses have implemented successful practices across Canada through the work of *Safer Healthcare Now!* teams. CNA Webinar

Appendix

4

INSTITUTE FOR SAFE MEDICATION PRACTICES CANADA

ISMP Canada Annual Report: Medication Reconciliation Intervention, April 2010 to March 2011

Posters and Tools

Risk Points for Medication Reconciliation in Home Care

Acute Care

Admission

Home Care

Circle of Care

Physician/Clinic appointments

Discharge

Self Care

Long Term/Acute Care

Goal: To establish a complete, accurate medication list including prescribed and non-prescribed medications upon admission to home care.

Once all discrepancies have been identified and resolved using medication reconciliation, the result is the active and reconciled medication list.

Goal: To communicate an up-to-date, complete and accurate medication list when visiting or consulting with a health care practitioner within the clients' circle of care.

Risk points requiring medication reconciliation may include: health care or clinic appointments, change in client health status, standards set by organization, care transferred to an alternate level of care within the organization.

The home care clinician updates the medication list after each clinician consultation or client visit to a health care practitioner within the clients' circle of care.

Goal: To communicate an up-to-date, complete and accurate medication list to the next provider of care after discharge from home care.

If the client is being discharged to acute or long -term care, the clinician updates and communicates the client's current reconciled medication list to the next provider of care.

If the client is being discharged into self care, the clinician verifies that the client/family understands any changes to their medication regimen.

At all interfaces of care, the home care clinician should verify that the client/family understands all changes to their medication regimen.

The Medication Reconciliation Process in Home Care

1 IDENTIFY CLIENT

Identify and target high risk clients using a medication risk assessment tool (MedRAT), if necessary.

The target criteria is set by the organization.

Goal: All clients are to have Medication Reconciliation.

2 CREATE THE BPMH AND IDENTIFY DISCREPANCIES

Interview the client using a systematic process to establish what medications the client is actually taking.

Compare information from client interview with information gathered from other sources, including:

- Referrals/physicians orders
- Discharge/transfer information
- Medication calendars
- Medication labels, vials, and bottles
- Pharmacy lists
- Current reconciled medication list
- Prescriptions: new and existing
- Electronic client database

Identify discrepancies among the sources of information.

Document any discrepancies on the Best Possible Medication History (BPMH) tool.

3 RESOLVE AND COMMUNICATE DISCREPANCIES

Resolve appropriate discrepancies (with the client/family) based on information gathered.

Identify discrepancies requiring resolution by:

- Physician/Nurse Practitioner
- Pharmacist
- Other

Communicate the BPMH and discrepancies requiring resolution (depending on urgency and resources available), via:

- Phone
- Fax
- Hand delivered by clinician
- Hand delivered by client/family
- Other

Document actions taken in the client record for follow up on the next visit if necessary.

4 CLOSE THE MEDICATION RECONCILIATION LOOP

Confirm resolution of discrepancies by physician/nurse practitioner or pharmacist.

Communicate reconciled medication list to client/family. This may be done directly by physician/nurse practitioner, or pharmacist to the client or through the home care clinician for delivery to the client.

Verify the client/family understands any changes to the medication regimen and the importance of keeping this medication list up-to-date.

Created by ISMP Canada and VON Canada for the *Safer Healthcare Now!* campaign. Graphic adapted from St. Mary's Hospital & Regional Medical Center, Grand Junction, Colorado, USA.

Situations à risque pour le Bilan comparatif des médicaments en soins à domicile

Soins de courte durée

Admission

Soins à domicile

Cercle de la prestation des soins

Rendez-vous chez le médecin / à la clinique

Congé

Auto-soins

Soins longue durée / courte durée

Objectif : Établir une liste de médicaments complète et précise incluant les médicaments sous ordonnance et en vente livre lors de l'admission en soins à domiclle.

Une fois les divergences identifiées et résolues grâce au BCM, on obtient une liste de médicaments finalisée et à jour.

Objectif: Communiquer une liste de médicaments précise, complète et à jour lors d'une visite ou d'une consultation avec un professionel de la santé qui se retrouve au sein du cercle de la prestation des soins du client.

Les situations à risque nécessitant un BCM peuvent inclure: la prise de rendez-vous à la clinique ou dans un établissement de santé, le changement de l'état de santé du client, les normes fixées à cet égard par l'établissement, transfert à un niveau de soins altenatif au sein de l'établissement.

Le clinicien en soins à domicile met la liste de médicaments à jour après chaque consultation avec un clincien ou à chaque visite du client chez un professionel de la santé qui se trouve au sein du cercle de la prestation des soins du patient.

Objectif : Communiquer une liste de médicaments précise, complète et à jour au prochain professional de la santé lors du congé des soins à domicile.

Si le cient obtient son congé en soins de courté ou de longue durée, le clinicien met la liste de médicaments à jour et communique celle-ci au prechain professionnel de la santé.

Si le cient obtient son congé et est dirigé vers l'autosoins, le clinicien vértifie que le client / la famille comprennent les changements qui ont été apportés à la pharmacothérapie.

À toutes les interfaces de soins, le clinicien en soins à domicile vérifie que le client / la famille comprennent les changements qui ont été apportés à la pharmacothérapie.

Créé par la norme ISMP Canada et VON Canada pour "des soins de sante plus securitaires Maintenant !"

Schéma du BCM en soins à domicile

1 IDENTIFIER LE CLIENT

Identifier et prioriser les cleints à risque en utilisant, au besoin, un outil d'évaluation du risque lié à la médication.

Les critères sont établis par l'établissement.

Objectif : Tous les clients doivent avoir le bilan comparatif de médicaments

2 ÉLABORER LE MSTP ET IDENTIFIER LES DIVERGENCES

Entrevue avec le client en utilisant un processus systematique pour connaître les médicaments pris par le patient.

Comparer cette information avec d'autres sources :

- Références
- Informations sur le transfert et le congé
- Calendrier pour la prise des médicaments
- Étiquettes de médicaments
- Profil de la pharmacie
- La liste actuelle de médicaments comparés
- Préscriptions : nouveaux et existants
- Base de données électronique client

Identifier les divergences qui se trouvent dans les sources d'information.

Documenter le tout dans l'outil Meilleur Schéma Thérapeutique Possible (MSTP).

3 RÉSOUDRE ET COMMUNIQUER LES DIVERGENCES

Résoudre les divergences (avec le client et la famille) en fonction de la collecte d'information.

Identier les divergences qui ont besoin d'être résolues par :

- le MD/l'infirmière practicienne
- le pharmacien
- tout autre membre de cercle de la prestation des soins

Communiquer le MSTP et les divergences qui ont besoin d'être résolues (dépendant du niveau d'urgence et des ressources disponibles) via :

- le téléphone
- le télécopieur
- la livraison en main propre par le clincien
- la livraison en main propre par le client ou sa famille
- Autre

Documenter les mesures prises dans le dossier pour faire le suivi lors de la prochaine visite.

4 FERMER LA BOUCLE DU BCM

Confirmer las résolution des divergences par le MD, l'infirmière praticienne ou le pharmacien.

Communiquer la nouvelle liste des médicaments au client et à sa famille. Ceci peut être fait directement par le MD / l'infirmière praticienne ou le pharmacien au client ou bien par livraison chez le client par le clinicien en soins à domicile.

Vérifier que le client / la famille comprennent les changements qui ont été apportés à la pharmacothérapie.

Créé par la norme ISMP Canada et VON Canada pour "des soins de sante plus securitaires Maintenant !" Graphique adapté de l'hôpital régional de & Medical Center Sainte-Marie de, Grand Junction, Colorado, Etats-Unis.

MEDICATION RECONCILIATION (HOME CARE)

safer healthcare now!

Goal

TO ESTABLISH A COMPLETE AND ACCURATE MEDICATION LIST UPON ADMISSION, TRANSFER AND DISCHARGE TO/FROM HOME CARE TO FACILITATE THE RECONCILIATION OF IDENTIFIED DISCREPANCIES. THIS MEDICATION LIST WILL BE COMMUNICATED TO THE NEXT PROVIDER OF CARE WITHIN THE CLIENT'S CIRCLE OF CARE.

Background

- Adverse drug events (ADEs) are occurring at an alarming rate across all sectors of healthcare. In the Canadian Adverse Events study, drug and fluid related events were the second most common type of procedure or event to which adverse events were related. (Baker et al, 2004)[1]
- In another Canadian study, Forster et al. (2004)[1] concluded that approximately one-quarter of patients in their study had an adverse event after hospital discharge and half of the adverse events were preventable or ameliorable. In this study the most common (72%) adverse events noted were drug related.
- The Safer Healthcare Now! Medication Reconciliation in Home Care Pilot Project (2008-2009) found that of the 611 home care clients who were selected to undergo medication reconciliation, 45.2% (275) had at least one discrepancy in their medication regimen that required clarification by a physician/nurse practitioner with an average of 2.3 discrepancies per client.[2]
- Accreditation Canada defines Medication Reconciliation as "a structured process in which healthcare professionals partner with clients, families and caregivers for accurate and complete transfer of medication information at transitions of care"[1]

Intervention

Medication reconciliation in home care starts and ends with the client and involves four basic steps:

1. Identifying the client;
2. Creating the Best Possible Medication History (BPMH) and identifying discrepancies;
3. Resolving and communicating discrepancies; and
4. Closing the medication reconciliation loop.[1]

Accreditation Canada includes medication reconciliation as part of its required organizational practices which includes:

- Reconciling the clients' medications upon admission to the organization, with the involvement of the client.
- Reconciling medications with the client at referral or transfer and communicating the clients' medications to the next provider at referral or transfer to another setting, service, service provider or level of care within or outside the organization [5]

Intervention Measures

The core measure is:

Percentage (%) of Eligible Clients with a Best Possible Medication History (BPMH)
Goal: 95% of all eligible home care clients have a BPMH.

The optional measures are:

Average Time to Complete a Best Possible Medication History (BPMH)
Goal: Set by individual team

The Percentage (%) of Eligible Clients with At Least One Discrepancy
Goal: Target determined by individual team

Percentage (%) of Medication Discrepancies Identified by Type
Goal: 100% of all identified medication discrepancies

Success Stories

- The Medication Reconciliation in Home Care Pilot Project of 2008/09 demonstrated that implementing a formal medication reconciliation process in the home care environment can positively impact the safety of clients at home. Data supported this; as well, anecdotal evidence[6] from clinicians told of potential adverse events being prevented that were directly related to the medication reconciliation process. Strategies to address identified challenges were regularly tested and results shared across the teams.

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[1] Baker, R., Norton, P., Flintoff, V., Blais, R., Brown, A., Cox, J., Etchells, E., Ghali, W.A., Hebert, P., Majumdar, S.R., O Beirne, M., Palacios-Derflingher, L., Reid, RJ., Sheps, S. Tamblyn, R. 2004. "The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada". Canadian Medical Association Journal 170(11): 1678-86

[2] Forster AJ, Clark HD, Menard A, et al. Adverse events among medical patients after discharge from hospital [published correction appears in Canadian Medical Association Journal. 2004;170(5). Doi:10.1503/cmaj.1040215] Canadian Medical Association Journal. 2004;170(3):345-349. http://www.cmaj.ca/cgi/data/170/3/345 Accessed June 10, 2008

[3] *Safer Healthcare Now!* Medication Reconciliation in Home Care Pilot Project 2008 – 2010. Co-lead by VON Canada and ISMP Canada

[4] Accreditation Canada ROP Hand Book April 2010 page 20

[5] *Safer Healthcare Now!* Medication Reconciliation in Home Care Getting Started Kit August 2010

The Medication Reconciliation Process in Home Care

1 IDENTIFY CLIENT

Identify and target high risk clients using a medication risk assessment tool (MedRAT), if necessary.

The target criteria is set by the organization.

Goal: All clients are to have Medication Reconciliation.

2 CREATE THE BPMH AND IDENTIFY DISCREPANCIES

Interview the client using a systematic process to establish what medications the client is actually taking.

Compare information from client interview with information gathered from other sources, including:

- Referrals/physicians orders
- Discharge/transfer information
- Medication calendars
- Medication labels, vials, and bottles
- Pharmacy lists
- Current reconciled medication list
- Prescriptions: new and existing
- Electronic client database

Identify discrepancies among the sources of information.

Document any discrepancies on the Best Possible Medication History (BPMH) tool.

3 RESOLVE AND COMMUNICATE DISCREPANCIES

Resolve appropriate discrepancies (with the client/family) based on information gathered.

Identify discrepancies requiring resolution by:

- Physician/Nurse Practitioner
- Pharmacist
- Other

Communicate the BPMH and discrepancies requiring resolution (depending on urgency and resources available), via:

- Phone
- Fax
- Hand delivered by clinician
- Hand delivered by client/family
- Other

Document actions taken in the client record for follow up on the next visit if necessary.

4 CLOSE THE MEDICATION RECONCILIATION LOOP

Confirm resolution of discrepancies by physician/nurse practitioner or pharmacist.

Communicate reconciled medication list to client/family. This may be done directly by physician/nurse practitioner, or pharmacist to the client or through the home care clinician for delivery to the client.

Verify the client/family understands any changes to the medication regimen and the importance of keeping this medication list up-to-date.

Created by ISMP Canada and VON Canada for Safer Healthcare Now!

Bilan comparatif des médicaments (soins à domicile)

des soins de santé plus sécuritaires maintenant!

But

ÉTABLIR AU MOMENT DE L'ADMISSION ,DU TRANSFERT ET DU CONGÉ D'UN CLIENT VERS/D'UN SERVICE DE SOINS À DOMICILE, UNE LISTE COMPLÈTE ET PRÉCISE DES MÉDICAMENTS AFIN DE FACILITER LA RÉSOLUTION DES DIVERGENCES IDENTIFIÉES.

CETTE LISTE DE MÉDICAMENTS SERA COMMUNIQUÉE AU PROCHAIN PRESTATAIRE DE SOINS QUI FAIT PARTIE DU CERCLE DE LA PRESTATION DES SOINS DU CLIENT.

Contexte

- Les événements indésirables liés à la médication surviennent à un taux alarmant dans tous les secteurs des soins de santé. Selon l'Étude canadienne sur les événements indésirables, des événements liés à médication et aux solutés arrivent à la deuxième position par rapport aux événements indésirables les plus courants (Baker et *al*., 2004)[1]
- Dans une autre étude canadienne, Forster et al. (2004)[1] ont conclu qu'approximativement un quart des patients participant à l'étude avait un événement indésirable à la suite de leur congé de l'hôpital et que la moitié de ces événements indésirables aurait pu être prévenus ou atténués». Dans le cadre de cette étude, l'événement indésirable le plus courant était relié à la médication (72%).
- Les résultats du projet pilote sur le bilan comparatif des médicaments en soins à domicile des *Soins de santé plus sécuritaires maintenant*! (2008-2009) ont démontré que parmi les 611 clients sélectionnés pour faire l'objet d'un bilan comparatif des médicaments, 45,2 % (275) avaient au moins une divergence nécessitant une clarification par un prescripteur autorisé et qu'en moyenne, 2,3 divergences survenaient par client.[2]
- Selon la définition d'Agrément Canada, « le bilan comparatif des médicaments s'avère un processus structuré au cours duquel les professionnels de la santé travaillent en partenariat avec les clients, les familles et les soignants pour assurer la transmission d'une information exacte et complète sur les médicaments aux points de transition des soins ».[3]

Stratégie

Le bilan comparatif des médicaments commence et termine avec le client et comporte quatre étapes de base :

1. Identifier le client;
2. Élaborer le meilleur schéma thérapeutique possible (MSTP) et identifier les divergences;
3. Résoudre et communiquer les divergences; et
4. Fermer la boucle du BCM Déterminer le client ciblé;

Le bilan comparatif des médicaments fait partie des pratiques organisationnelles requises d'Agrément Canada et comprend les exigences suivantes:

- Établir un bilan comparatif des médicaments du client lors de son admission dans l'établissement, et ce, avec la participation du client;
- Établir un bilan comparatif des médicaments avec le client au moment où celui-ci est référé ou transféré à une autre unité, à un autre service ou à un autre niveau de soins dans l'établissement ou à l'extérieur de celui-ci et transmettre ce bilan au prochain prestataire de soins. [5]

Indicateurs de mesure

Mesure obligatoire :

Pourcentage (%) de clients éligibles ayant eu un meilleur schéma thérapeutique possible (MSTP)
Objectif : 95 % des clients éligibles en soins à domicile ont un MSTP.

Mesures facultatives :

Temps moyen pour compléter un meilleur schéma thérapeutique possible (MSTP)
Objectif : Chaque équipe établit son propre objectif

Pourcentage (%) de clients éligibles qui ont au moins une divergence
Objectif: Chaque équipe établit son propre objectif

Pourcentage (%) de divergences liées aux médicaments identifiées selon le type
Objectif: 100 % de toutes les divergences identifiées

Réussites

- Le projet pilote sur le bilan comparatif des médicaments en soins à domicile 2008-2009 a démontré que la mise en œuvre d'un processus formel de bilan comparatif des médicaments dans le contexte des soins à domicile peut avoir une incidence favorable sur la sécurité des clients. Des données probantes le confirment; des anecdotes[6] fournies par des médecins font état d'événements indésirables potentiels évités, et ce, directement grâce au processus du bilan comparatif des médicaments. Des stratégies visant à relever les défis ont été régulièrement mises à l'épreuve et les résultats ont été communiqués à toutes les équipes.

[1] Baker, R., Norton, P., Flintoft, V., Blais, R., Brown, A., Cox, J., Etchells, E., Ghali, W.A., Hebert, P., Majumdar, S.R., O'Beirne, M., Palacios-Derflingher, L., Reid, RJ., Sheps, S. Tamblyn, R. 2004. "The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Clients in Canada". Journal de l'Association médicale canadienne 170(11) : 1678-86

[2] Forster AJ, Clark HD, Menard A, et al. Adverse events among medical clients after discharge from hospital [la correction publiée paraît dans le Journal de l'Association médicale canadienne. 2004;170(5). Doi:10.1503/cmaj.1040215] Journal de l'Association médicale canadienne. 2004;170(3):345-349. http://www.cmaj.ca/cgi/data/170/3/345 consulté le 10 juin 2008

[3] *Des soins de santé plus sécuritaires maintenant!* Projet pilote pour le bilan comparatif des médicaments dans les soins à domicile 2008–2010. Codirigé par les Infirmières de l'Ordre Victoria du Canada et l'ISMP Canada.

[4] Agrément Canada, Guide des POR, avril 2010, page 20

[5] *Des soins de santé plus sécuritaires maintenant!*, Trousse En avant! sur le bilan comparatif des médicaments en soins à domicile, août 2010

[6] *Des soins de santé plus sécuritaires maintenant!*, Collimage de témoignages issus des membres du projet pilote sur le Bilan comparatif des médicaments en soins à domicile

Schéma du BCM en soins à domicile

1 IDENTIFIER LE CLIENT

Identifier et prioriser les cleints à risque en utilisant, au besoin, un outil d'évaluation du risque lié à la médication «(MedRAT)».

Les critères sont établis par l'établissement.

Objectif : Tous les clients doivent avoir le bilan comparatif de médicaments

2 ÉLABORER LE MSTP ET IDENTIFIER LES DIVERGENCES

Entrevue avec le client en utilisant un processus systematique pour connaître les médicaments pris par le patient.

Comparer cette information avec d'autres sources :

- demandes de consultation/ ordonnances médicales
- informations sur le transfert et le congé
- grille horaire des médicaments
- étiquettes, fioles et bouteilles de médicaments
- liste de la pharmacie
- liste actuelle des médicaments comparés
- ordonnances actuelles et nouvelles
- base de données électronique du client

Identifier les divergences qui se trouvent dans les sources d'information.

Documenter le tout dans l'outil Meilleur Schéma Thérapeutique Possible (MSTP).

3 RÉSOUDRE ET COMMUNIQUER LES DIVERGENCES

Résoudre les divergences (avec le client et la famille) en fonction de la collecte d'information.

Identier les divergences qui ont besoin d'être résolues par :

- le MD/l'infirmière practicienne
- le pharmacien
- tout autres

Communiquer le MSTP et les divergences qui ont besoin d'être résolues (dépendant du niveau d'urgence et des ressources disponibles) via :

- le téléphone
- le télécopieur
- la livraison en main propre par le clincien
- la livraison en main propre par le client ou sa famille
- Autre

Documenter le tout dans l'outil pour élaborer le meilleur schéma thérapeutique possible (MSTP).

4 FERMER LA BOUCLE DU BCM

Confirmer la résolution des divergences par le MD, l'infirmière praticienne ou le pharmacien.

Communiquer la nouvelle liste des médicaments au client et à sa famille. Ceci peut être fait directement par le MD / l'infirmière praticienne ou le pharmacien au client ou bien par livraison chez le client par le clinicien en soins à domicile.

Vérifier que le client / la famille comprennent les changements qui ont été apportés à la pharmacothérapie.

Créé par l'ISMP Canada et VON Canada pour des Soins de santé plus sécuritaires maintenant!

Appendix

5

INSTITUTE FOR SAFE MEDICATION PRACTICES CANADA

ISMP Canada Annual Report: Medication Reconciliation Intervention, April 2010 to March 2011

Accreditation Canada Required Organizational Practices (ROPs) Medication Reconciliation

ROPs

Required Organizational Practices

April 2010

ACCREDITATION CANADA
AGRÉMENT CANADA

Driving Quality Health Services
Force motrice de la qualité des services de santé

ACCREDITATION CANADA
AGRÉMENT CANADA
Driving Quality Health Services
Force motrice de la qualité des services de santé

Medication Reconciliation

For *Effective Organization Standards*
The organization reconciles clients' medications at admission and discharge, transfer, or end of service.

Guidelines

Medication reconciliation is a structured process in which healthcare professionals partner with clients, families and caregivers for accurate and complete transfer of medication information at transitions of care.

Medication reconciliation is widely recognized as an important safety initiative. Research suggests that over 50% of patients have at least one medication discrepancy upon admission to hospital, with many discrepancies carrying the potential to cause adverse health effects. Evidence shows that medication reconciliation reduces the potential for medication discrepancies such as omissions, duplications, and dosing errors, while cost-effectiveness analyses have also demonstrated that medication reconciliation is an extremely cost-effective strategy for preventing medication errors. Additional research highlights that successful medication reconciliation can also reduce workload and rework associated with patient medication management.

In Canada, *Safer Healthcare Now*! identifies medication reconciliation as a safety priority. The World Health Organization (WHO) has also developed a Standard Operating Protocol for medication reconciliation as one of its interventions designed to enhance patient safety.

Medication reconciliation is a shared responsibility which must involve the client or family. Liaison with the primary care provider and community pharmacist may be required.

Tests for Compliance

- Medication reconciliation is implemented in one client service area at admission.
- Medication reconciliation is implemented in one client service area at transfer, discharge, or end of service.
- The organization has a documented plan to implement medication reconciliation throughout the organization.
- The plan includes locations and timelines for implementing medication reconciliation throughout the organization.

(Cont'd on next page...)

Medication reconciliation (cont'd)

Reference Material

(1) Institute for Healthcare Improvement. How To Guide: Prevent Adverse Drug Events. <http://www.ihi.org/NR/rdonlyres/98096387-C903-4252-8276-5BFC181C0C7F/0/ADEHowtoGuide.doc>
(2) World Health Organization. High 5s - Action on Patient Safety Getting Started Kit. Assuring Medication Accuracy at Transitions of Care: Medication Reconciliation. <http://www.who.int/patientsafety/solutions/high5s/en/index.html>
(3) Safer Healthcare Now! Getting Started Kit: Medication Reconciliation Prevention of Adverse Drug Events. <http://www.saferhealthcarenow.ca/EN/Interventions/medrec_acute/Pages/gsk.aspx>
(4) Cornish PL, et al. Unintended medication discrepancies at the time of hospital admission. *Arch Intern Med*. 2005;165:424-429.
(5) Vira T, et al. Reconcilable differences: correcting medication errors at hospital admission and discharge. *Qual Saf Healthcare*. 2006;000:1–6.
(6) Pippins JR, et al. Classifying and predicting errors of inpatient medication reconciliation. *Journal of General Internal Medicine*. 2008;23:1414.
(7) Kwan Y, et al. Pharmacist medication assessments in a surgical preadmission clinic. Arch Internal Medicine. 2007;167:1034-40.
(8) Rozich JD, et al. Standardization as a mechanism to improve safety in healthcare: impact of sliding scale insulin protocol and reconciliation of medications initiatives. *Jt Comm J Qual Saf*. 2004;30(1):5-14.
(9) Karnon J, et al. Model-based cost-effectiveness analysis of interventions aimed at preventing medication error at hospital admission (medicines reconciliation). *Journal of Evaluation in Clinical Practice*. 2009;15(2):299-306(8).
(10) Karapinar-Carkit F, et al. Effect of medication reconciliation with and without patient counseling on the number of pharmaceutical interventions among patients discharged from the hospital. *Annals of Pharmacotherapy.* 2009;43:1001.

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Medication Reconciliation At Admission

For standards sets other than *Effective Organization, Emergency Department, Ambulatory Care Services,* and *Home Care*
The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.

Guidelines

Medication reconciliation is a structured process in which healthcare professionals partner with clients, families and caregivers for accurate and complete transfer of medication information at transitions of care.

The medication reconciliation process involves generating a comprehensive list of all medications the client has been taking prior to admission – the Best Possible Medication History (BPMH). The BPMH is compiled using a number of different sources, and includes information about prescription medications, non-prescription medications, vitamins, and supplements, along with detailed documentation of drug name, dose, frequency, and route of administration.

Medication reconciliation at admission generally fits into two models - the proactive process, the retroactive process, or a combination of the two:

- In the proactive process, the prescriber uses the BPMH to create admission medication orders. This process includes verification that every medication in the BPMH has been assessed by the prescriber.
- In the retroactive process, the BPMH is generated after the admission medication orders are written. This process requires a timely comparison of the BPMH against the admission medication orders, with any discrepancies identified and resolved with the prescriber.

Medication reconciliation is widely recognized as an important safety initiative. Evidence shows medication reconciliation reduces potential for medication discrepancies such as omissions, duplications, and dosing errors. In Canada, *Safer Healthcare Now!* identifies medication reconciliation as a safety priority. The World Health Organization (WHO) has also developed a Standard Operating Protocol for medication reconciliation as one of its interventions designed to enhance patient safety.

Medication reconciliation is a shared responsibility which must involve the client or family. Liaison with the primary care provider and community pharmacist may be required.

(Cont'd on next page...)

Medication reconciliation at admission (cont'd)

Tests for Compliance

- There is a demonstrated, formal process to reconcile client medications upon admission.
- The team generates a Best Possible Medication History (BPMH) for the client upon admission.
- Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), **OR**, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).
- The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.
- The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.

Reference Material

(1) Institute for Healthcare Improvement. How To Guide: Prevent Adverse Drug Events. <http://www.ihi.org/NR/rdonlyres/98096387-C903-4252-8276-5BFC181C0C7F/0/ADEHowtoGuide.doc>
(2) World Health Organization. High 5s - Action on Patient Safety Getting Started Kit. Assuring Medication Accuracy at Transitions of Care: Medication Reconciliation. <http://www.who.int/patientsafety/solutions/high5s/en/index.html>
(3) Safer Healthcare Now! Getting Started Kit: Medication Reconciliation Prevention of Adverse Drug Events. <http://www.saferhealthcarenow.ca/EN/Interventions/medrec_acute/Pages/gsk.aspx>
(4) Cornish PL, et al. Unintended medication discrepancies at the time of hospital admission. *Arch Intern Med*. 2005;165:424-429.
(5) Vira T, et al. Reconcilable differences: correcting medication errors at hospital admission and discharge. *Qual Saf Healthcare*. 2006;000:1–6.
(6) Pippins JR, et al. Classifying and predicting errors of inpatient medication reconciliation. *Journal of General Internal Medicine*. 2008;23:1414.
(7) Kwan Y, et al. Pharmacist medication assessments in a surgical preadmission clinic. *Arch Internal Medicine*. 2007;167:1034-40.
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(9) Karnon J, et al. Model-based cost-effectiveness analysis of interventions aimed at preventing medication error at hospital admission (medicines reconciliation). *Journal of Evaluation in Clinical Practice*. 2009;15(2):299-306(8).
(10) Karapinar-Carkit F, et al. Effect of medication reconciliation with and without patient counseling on the number of pharmaceutical interventions among patients discharged from the hospital. *Annals of Pharmacotherapy*. 2009;43:1001.

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

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Medication Reconciliation At Admission

For *Emergency Department Standards*
The team reconciles medications for clients with a decision to admit, with the involvement of the client, family or caregiver.

Guidelines

Medication reconciliation is a structured process in which healthcare professionals partner with clients, families and caregivers for accurate and complete transfer of medication information at transitions of care.

The medication reconciliation process involves generating a comprehensive list of all medications the client has been taking prior to admission – the Best Possible Medication History (BPMH). The BPMH is compiled using a number of different sources, and includes information about prescription medications, non-prescription medications, vitamins, and supplements, along with detailed documentation of drug name, dose, frequency, and route of administration.

Medication reconciliation at admission generally fits into two models - the proactive process, the retroactive process, or a combination of the two:

- In the proactive process, the prescriber uses the BPMH to create admission medication orders. This process includes verification that every medication in the BPMH has been assessed by the prescriber.
- In the retroactive process, the BPMH is generated after the admission medication orders are written. This process requires a timely comparison of the BPMH against the admission medication orders, with any discrepancies identified and resolved with the prescriber.

Medication reconciliation is widely recognized as an important safety initiative. Evidence shows medication reconciliation reduces potential for medication discrepancies such as omissions, duplications, and dosing errors. In Canada, *Safer Healthcare Now!* identifies medication reconciliation as a safety priority. The World Health Organization (WHO) has also developed a Standard Operating Protocol for medication reconciliation as one of its interventions designed to enhance patient safety.

Medication reconciliation is a shared responsibility which must involve the client or family. Liaison with the primary care provider and community pharmacist may be required.

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Medication reconciliation at admission (cont'd)

Tests for Compliance

- There is a demonstrated, formal process to reconcile client medications for clients with a decision to admit.
- The team generates a Best Possible Medication History (BPMH) for clients with a decision to admit.
- Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), **OR**, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).
- The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.
- The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.

Reference Material

(1) Institute for Healthcare Improvement. How To Guide: Prevent Adverse Drug Events. <http://www.ihi.org/NR/rdonlyres/98096387-C903-4252-8276-5BFC181C0C7F/0/ADEHowtoGuide.doc>
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(3) Safer Healthcare Now! Getting Started Kit: Medication Reconciliation Prevention of Adverse Drug Events. <http://www.saferhealthcarenow.ca/EN/Interventions/medrec_acute/Pages/gsk.aspx>
(4) Cornish PL, et al. Unintended medication discrepancies at the time of hospital admission. *Arch Intern Med*. 2005;165:424-429.
(5) Vira T, et al. Reconcilable differences: correcting medication errors at hospital admission and discharge. *Qual Saf Healthcare*. 2006;000:1–6.
(6) Pippins JR, et al. Classifying and predicting errors of inpatient medication reconciliation. *Journal of General Internal Medicine*. 2008;23:1414.
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Medication Reconciliation At Admission

For *Ambulatory Care Services Standards*
The team reconciles the client's medications with the involvement of the client, family or caregiver at each visit if medications have been discontinued, altered or changed.

Guidelines

Medication reconciliation is a structured process in which healthcare professionals partner with clients, families and caregivers for accurate and complete transfer of medication information at transitions of care.

The medication reconciliation process involves generating a comprehensive list of all medications the client has been taking prior to a visit – the Best Possible Medication History (BPMH). The BPMH is compiled using a number of different sources, and includes information about prescription medications, non-prescription medications, vitamins, and supplements, along with detailed documentation of drug name, dose, frequency, and route of administration.

Medication reconciliation is widely recognized as an important safety initiative. Evidence shows medication reconciliation reduces potential for medication discrepancies such as omissions, duplications, and dosing errors. In Canada, *Safer Healthcare Now!* identifies medication reconciliation as a safety priority. The World Health Organization (WHO) has also developed a Standard Operating Protocol for medication reconciliation as one of its interventions designed to enhance patient safety.

Medication reconciliation is a shared responsibility which must involve the client or family. Liaison with the primary care provider and community pharmacist may be required.

Tests for Compliance

- There is a demonstrated, formal process to reconcile client medications at each visit if medications have been discontinued, altered or changed.
- The team generates or updates a comprehensive list of medications the client has been taking prior to the visit (Best Possible Medication History).
- The team documents that if medications have been discontinued, altered, or prescribed during the visit, that appropriate modifications have been made to the new medications list; and clients have been provided with clear information about the changes.
- The new medications list is retained for the next client visit.
- The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.

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Reference Material

(1) Institute for Healthcare Improvement. How To Guide: Prevent Adverse Drug Events. <http://www.ihi.org/NR/rdonlyres/98096387-C903-4252-8276-5BFC181C0C7F/0/ADEHowtoGuide.doc>
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(4) Cornish PL, et al. Unintended medication discrepancies at the time of hospital admission. *Arch Intern Med*. 2005;165:424-429.
(5) Vira T, et al. Reconcilable differences: correcting medication errors at hospital admission and discharge. *Qual Saf Healthcare*. 2006;000:1–6.
(6) Pippins JR, et al. Classifying and predicting errors of inpatient medication reconciliation. *Journal of General Internal Medicine*. 2008;23:1414.
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Medication Reconciliation At Admission

For *Home Care Standards*
The team reconciles the client's medication at the beginning of service with the involvement of the client and family or caregiver when medication management is a component of care.

Guidelines

Medication reconciliation is a structured process in which healthcare professionals partner with clients, families and caregivers for accurate and complete transfer of medication information at transitions of care.

The medication reconciliation process involves generating a comprehensive list of all medications the client has been taking prior to the beginning of service – the Best Possible Medication History (BPMH). The BPMH is compiled using a number of different sources, and includes information about prescription medications, non-prescription medications, vitamins, and supplements, along with detailed documentation of drug name, dose, frequency, and route of administration.

Medication reconciliation is widely recognized as an important safety initiative. Evidence shows medication reconciliation reduces potential for medication discrepancies such as omissions, duplications, and dosing errors. In Canada, *Safer Healthcare Now!* identifies medication reconciliation as a safety priority. The World Health Organization (WHO) has also developed a Standard Operating Protocol for medication reconciliation as one of its interventions designed to enhance patient safety.

Medication reconciliation is a shared responsibility which must involve the client or family. Liaison with the primary care provider and community pharmacist may be required.

Tests for Compliance

- There is a demonstrated, formal process to reconcile client medications at each visit if medications have been discontinued, altered or changed.
- The team generates a Best Possible Medication History (BPMH) at the beginning of service when medication management is a component of care.
- The team documents that if medications have been discontinued, altered, or prescribed during a visit, that appropriate modifications have been made to the new medications list; and clients have been provided with clear information about the changes.
- The new medications list is retained for the next client visit.
- The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.

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Reference Material

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Medication Reconciliation At Referral Or Transfer

The team reconciles medications with the client at referral or transfer, and communicates information about the client's medication 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.

Guidelines

Medication reconciliation is a way to collect and communicate accurate information about client medication, including over-the-counter medications, vitamins, and supplements. Evidence shows medication reconciliation can lead to reduced medication discrepancies on admission such as omissions, duplications, and dosing errors, and a reduction in discrepancies in drug frequency and dose at the time of discharge.

Medication reconciliation is a widely recognized as an important safety initiative. In Canada, *Safer Healthcare Now!* identifies medication reconciliation as a safety priority. The World Health Organization (WHO) has also developed a Standard Operating Protocol for medication reconciliation as one of its interventions designed to enhance patient safety.

Medication reconciliation is a shared responsibility which must involve the client or family. Liaison with the primary care provider and community pharmacist may be required.

Tests for Compliance

- There is a demonstrated, formal process to reconcile client medications at referral or transfer.
- The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.
- The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.
- The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.
- The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.

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Medication reconciliation at referral or transfer (cont'd)

Reference Material

(1) Institute for Healthcare Improvement. How To Guide: Prevent Adverse Drug Events. http://www.ihi.org/NR/rdonlyres/98096387-C903-4252-8276-5BFC181C0C7F/0/ADEHowtoGuide.doc
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(4) Vira, T, et al. Reconcilable differences: correcting medication errors at hospital admission and discharge. Quality and Safety in Health Care. 2006;15: 122.
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REQUIRED ORGANIZATIONAL PRACTICES

Our objective of guiding our clients toward safe and quality health care is strengthened by the Required Organizational Practices listed below.
ROPs that will come into effect in 2011 are indicated with a ★ .

SAFETY CULTURE

- Adverse events disclosure
- Adverse events reporting
- Client safety as a strategic priority
- Client safety quarterly reports
- Client safety–related prospective analysis

COMMUNICATION

- Client and family role in safety
- Dangerous abbreviations
- Information transfer
- Medication reconciliation at admission
- Medication reconciliation at referral or transfer
- Surgical checklist ★
- Two client identifiers
- Verification processes for high-risk activities

MEDICATION USE

- Concentrated electrolytes
- Drug concentrations
- Heparin safety
- Infusion pumps training
- Narcotics safety

WORKLIFE/ WORKFORCE

- Client safety plan
- Client safety: roles and responsibilities
- Client safety: education and training
- Preventive maintenance program
- Workplace violence prevention ★

INFECTION CONTROL

- Hand-hygiene audit
- Hand-hygiene education and training
- Infection control guidelines
- Infection rates
- Influenza vaccine
- Pneumococcal vaccine
- Sterilization processes

RISK ASSESSMENT

- Falls prevention strategy
- Home safety risk assessment ★
- Pressure ulcer prevention
- Suicide prevention
- Venous thromboembolism (VTE) prophylaxis ★

02/2010

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Appendix

6

INSTITUTE FOR SAFE MEDICATION PRACTICES CANADA

ISMP Canada Annual Report: Medication Reconciliation Intervention, April 2010 to March 2011

MedRec Stories (the Good and the Bad)

Stories drive change. We believe local stories put a human face to the problem and help engage senior leaders and front line support.

Here are stories from across the country, the good and the bad. These stories offer both hope and help us realize and understand the extent of the problem.

Team Success Stories

Prevented a potential medication error for a patient being transferred to a long term care facility from acute care: 90 year patient - because we had done a BPMH and MedRec, we sent her to the LTC on the right meds and updated the history we had received when she had transferred to our hospital from the LTC facility.

A resistant surgeon to the MedRec process (and any electronic processes) went on to become one of our physician champions, led physician education on MedRec for other surgeons, and now will use the computer system to print off MedRec on Transfer or Discharge Medication Lists. In the past he had refused to use the computer technology completely.

I have a site known for its recalcitrant medical staff who thought Pharmacy was their only to police their prescription habits. The Physicians try to handwrite as little as possible on admission, even initialling a past admission's MAR pages to represent admission medication orders. With the implementation of a single form that acts as the reconciliation and admission medication orders form they can now "tick" away to their heart's content and are also beginning to realize that there are other benefits to having a Pharmacist aboard.

Signed MedRec form not sent to Pharmacy and no MAR checks for 18 days. Pharmacist completing MedRec upon admission to the Rehab unit discovered the error. Patient missed medications for 18 days.

Mrs. I was discharged from hospital. She was diagnosed with DVT; History of Diabetes - Insulin dependent; son is the primary caregiver and concerned how he was going to manage is mother's heavy care needs on discharge; the client no longer mobile; concerns raised by son re: shakiness and behaviour changes; client's dosages were altered while in hospital; client was discharged with anticoagulant therapy with previous medications to be taken at home. CCAC CM visited the client within 24 hours and identified the need for nursing to administer the medication and provide teaching to the son. Pharmacist was arranged to complete medication reconciliation and visited within 48 hours; she identified that the client was prescribed medications that would be considered toxic. The pharmacist contacted the PF and within hours, the medications were readjusted. The community pharmacist was notified regarding the readjustment of dosages and the client was provided with a new medication regimen. Within days, the client starting feeling an improvement in her condition, the primary caregiver – son was relieved to see that mom was no longer shaking and that her behaviours were improved including her mobility. The son identified the situation as 'critical' and would have returned his mother to the emergency dept. if it had not been for the CCAC -Case Manager, nurse and pharmacist all working together to address the issues.

With good planning we were able to complete medication reconciliation for both admission, and transfer/referral from all of our Residential sites. The time put into planning resulted in a relatively short implementation of a process that is being sustained.

When we were finally able to provide our computer-generated order set for all admissions from another (adjacent) health authority in addition to admissions from within our own health authority, each audience that heard the news actually cheered!

76 year old fit, active, but with IHD, previous MI, bypass admitted for chest pain investigation. Stent procedure done in hospital, yet upon D/C hospital did not restart anticoagulants, and client unable to get to GP before he suffered L brain stroke unnecessarily and is now looking at months of rehab with questionable return to previous functional level.

Client admitted to Home Care from acute care late on a Friday. Case Manager went to home to assess client and identified several potentially serious medication discrepancies. She was able to contact Physician and take all meds to his office to sort everything out and resolve the discrepancies. This physician subsequently has made referrals directly to ask the Case Manager to complete the medication assessment and BPMH for his complex home bound clients.

MedRec on an older gentleman - meds had been already ordered according to meds brought in by ambulance. MedRec revealed that most of the medications ordered were his wife's. Name not noted on vials when medications ordered. There were several medications ordered incorrectly and we got them stopped through our MedRec process.

The stories nurses share with me from their experiences with clients and families. MedRec has empowered clients/families to stop taking OTC's/herbal products and to question their physician about their med regime. It is something I had never anticipated and it is THRILLING! The realization that MedRec will have so many different spin offs on so many levels, for example, reduce falls, increase quality of life, save health care dollars, etc.

An elderly non-English speaking client was discharged from an acute medical unit to a long-term care facility. She was hospitalized for a broken shoulder involving her rotator cuff and she had severe intractable pain. Her pain meds were overlooked during her discharge. The error was not picked up by the staff at the new facility. Several days later she attempted to hang herself in her room. She was caught in time to save her life. Medication reconciliation was completed by our mental health team staff when they went out to assess her. They found and corrected the error. The client has stabilized.

The Challenge of Revamping MedRec for Another Province

The MedRec process for our organization in another province looks completely different for many reasons so we reworked the entire process and tried testing out the idea. We no longer have the resources like we did a few years ago in Alberta so through teleconferences we have tried to develop and review the steps involving the key players (Manager, Nurse, Best Practice RN and Pharmacist) at a site. The uptake is difficult as we are trying to have the pharmacist be the keeper of the process but the pharmacy is an outside provider. The pharmacist was somewhat reluctant to adopt the new way as they are "informally completing MedRec" already (if only I had a dollar for each time I have heard this statement I could finance implementation at a new site single handily) and did not want to manage the information/discrepancies

obtained by the RN in conversation with the family (home medication list). So here we go again ... with the added challenge coordinating this process from afar with the added pressure of accreditation this year!

Client recently discharged home from acute. Given several prescriptions along with suppositories as a prn. After reviewing the client's medication, the client happily informed me that the suppository was working well and she was very happy with the shape as it was much easier to swallow. Med review at its best :)

MedRec done on a blind 85 yr old in prep for admission to Enhanced Care from home - Family Physician, Community Pharmacy, and new Primary Care Physician were the 3 players. Process took more than a month for players to respond to needs of each other to create a BPMH for admission orders. Admission orders written and 85 yr old made the move. This was a simple med regime.....insulin, blood pressure lowering agent, calcium, Vit D. On day one, an insulin dosing discrepancy uncovered and resolved (had been receiving higher dose than indicated on BPMH for a year with blood sugars at 2 and 3 in mornings at home a few days each week, resulting in falls, burns, etc). On day two, discrepancy in Blood Pressure Meds flagged by the blind 85 yr old, as she asked where her noon NB med was! Homecare dossette was checked that she had been using at home and was indeed filled with two kinds of BP meds. Only one BP med showed on Community Pharmacy and Family Physician lists. Yet two were dispensed by the pharmacy and used by homecare nurses to fill patient dossette. Conclusion drawn by patient & family is that one BP med was replaced by another a year prior as that was patients' last family physician office visit, and that the Community Pharmacy detected and corrected the discrepancy in their records when they provided the list for admission to Enhanced Care. That was not communicated or disclosed and the 85 year old blind patient flagged the issue. A LTC facility implementing MedRec was doing baseline. 23 discrepancies uncovered for 2/10 residents!!!!

The BPMH that was completed for the client had > 14 medications. When the BPMH was returned the physician had actually discontinued a couple of meds he felt the client did not need to be on.

MedRec on admission and discharge implemented in a paediatric facility - where physicians have taken on the accountability to conduct MedRec on all patient admissions and transfers.

I firmly believe that the acute care MedRec admission piece is working and does reduce discrepancies. I am appalled that physicians see tic boxes and tic away without reading.

What frustrates SHN teams the most? Top issues?

Staffing / Who is responsible?

- everyone thinks it's so easy to implement the need for a comprehensive BPMH is still not understood by nurses and it raises conflict between nursing and pharmacy as to 'who' is truly completing a BPMH
- Physicians demand for a pharmacist-only prepared BPMH. This is very demanding for this scarce HR professional as the Ministry funding model for pharmacists does not recognize this workload & staff funding is for distribution workload not clinical in non-academic hospitals.
- Poor nursing compliance
- Those responsible for orienting / training new staff aren't doing their job so the staff continue to remain ignorant
- Nurses not being able to take an accurate and complete medication history. Nurses not printing off the MedRec form.
- Getting all the players together at one time to agree on a course of action.
- Having sufficient resources to put together a proper training program for staff.

- Some clinicians still do not understand their role in the MedRec process and think it is someone else's responsibility i.e. the physician or pharmacist.

Senior Leadership Support / Buy-In

- The lack of funding for a good integrative technology. The amount of time needed to administer the start-up and coordination with other services.
- Lack of organizational leadership to make MedRec a priority.
- Lack of adequate investment needed to ensure MedRec is implemented and is sustainable.
- Inability to convince senior management that transfer/discharge MedRec requires a charter.
- Inability to convince senior management that MedRec requires additional staff.

IT Support and Systems

- Lack of IT support to move from a paper-based system to an electronic version. We already document in Meditech & then having to hand write out on a medication order form leads to another source of medication errors - transcription.
- IN BC particularly FOI laws restrict using PharmaNet, (which is only a record of what was RX by Physicians not what was dispensed or taken). So though we have a partial data base we cannot use it for BPMH as it is not available to Community Health Centres.
- Completing and sharing the BPMH and the reconciliation of discrepancies in a non-electronic environment is time consuming and makes the communication more difficult
- not having an electronic chart; this would make auditing so much easier
- The lack of integration (electronic) of all our hard work once a patient leaves our organization. A system-wide approach is required.
- lack of technology to facilitate the change
- how this initiative was prioritize: There may have been much more important medication safety system to put in place before doing MedRec. This was force into our practice without having the proper technology support. New hospital information system will address this as we move along.
- Discharge MedRec requires an electronic component.

Resources / Training

- Not enough time/resources to do a good job at capturing more MedRecs.
- Accessing residents in a teaching environment where there is frequent turnover is a challenge that impact initial education on Medication Reconciliation and sustainment of the process
- Competing priorities and multiple change initiatives that the team are involved in
- when we try to train others (e.g. nurses, they often say its not their job and often don't take it as seriously as they should when completing a history so it comes out incomplete)
- Resource intensity to implement and support.
- Ongoing support required to monitor process and facilitate integration into day to day care processes.
- Trying to spread to other locations with the same attention and focus but without the resources used to support the process
- lack of support from the medical staff
- lack of support from community pharmacists
- The need to discharge patients quickly vs. a thorough discharge that captures all the client's needs, education and med review to decrease the chances of being readmitted. Financial constraints, bed shortages, staff shortages leading to the above recipe of catastrophe
- The inability to materialize the beneficial effects of patients getting BPMH and MedRec upon admission. We know this affects outcomes but are unable to prove it especially to be able to get senior support for more resources.
- People not wanting to implement something that could save a life potentially because its going to impact their workflow too much.

Physician Buy-In

- lack of physicians' engagement
- When the staff makes the effort to complete the MedRec forms but the physician does not bother to review and check each medication as per the process or is very tardy in returning the document. This devalues the MedRec process in the nurse's eyes and does not reinforce the need to complete MedRec. Unfortunately; on occasion someone will try to submit the admission medication list recopied without checking other sources as a completed MedRec.
- Physician engagement continues to be an issue. Staff frustrated that they don't hear back from Physicians once BPMH sent to them.
- Physicians who believe that taking medication history is not their job
- very few physicians and other health providers just "do not get it"
- Lack of solidarity from the physicians.
- Physician adherence and buy in is poor. Physicians continually look for someone else to do the work or the shortest method to produce a result (which may not always be perfect).

Other

- Difficulty integrating into day to day care processes.
- We are finding it difficulty getting there. We have staffing allotted but are have issues getting them in place. It has been a very slow progress and the "discharge" piece is the going to be the hardest to cover. I have come to the conclusion that we need a program that the physicians can use at discharge for MedRec. If we can make it easier for them to do the discharge meds and print off their prescriptions rather then have to write them I think that they will use it.
- People don't remember what they've learned unless they regularly practice it.
- There is no single standard form used by all facilities / institutions / sites
- Those with the "power" to implement are so afraid their staff will make mistakes that the entire process is stalled while they (vainly) attempt to idiot-proof the process
- Need for a national direction for medication reconciliation.
    - Commitment from all senior leaders and stakeholders to incorporate MedRec as a standard for all clients particularly on transition of care.
    - Need to improve the communication particularly at transitions of care.
    - More focused education on service providers in home care to incorporate BPMH as part of assessments.
    - Buy-in from all CCAC's to provide a standard approach for medication reconciliation.
- lack of training at the university level especially for non-pharmacy allied health i.e. nursing
- When working within a regional framework, getting consensus on any # of issues, even changing the forms can be a drawn out process
- Accreditation Canada - unrealistic requirements for this ROP. It is easy to identify this as an in important initiative.... implementation is not so easy, and requires TIME to do this work
- Discharges are written and patients gone many times before we even know that they have been written. We love it when we see the good things that come out of this program but it is frustrating trying to get the program universal.
- **When people think it is more work (which it is not) and forget this process is for safety of the client**
- last minute transfers back from Acute Care and unscheduled admissions
- The frustration for SHN staff and customers in our systems is that we have created an unreasonable process for spread and sustainability.....too many measures of discrepancies.....and separation of the MedRec components. Most are favoring some trial of developing a systems approach to MedRec across all patient transition points that can be tested in their systems, refined and then spread. This would help systems move beyond admission.

Appendix

7

INSTITUTE FOR SAFE MEDICATION PRACTICES CANADA

ISMP Canada Annual Report: Medication Reconciliation Intervention, April 2010 to March 2011

New MedRec in Acute Care Getting Started Kit - DRAFT

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Appendix

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INSTITUTE FOR SAFE MEDICATION PRACTICES CANADA

ISMP Canada Annual Report: Medication Reconciliation Intervention, April 2010 to March 2011

National Summit

Optimizing Medication Safety at Care Transitions - *Creating a National Challenge*

February 10, 2011 – Toronto Airport Marriott Hotel, Salon ABC

Objectives

- Inspire national high-level support for medication safety at care transitions by building awareness and knowledge of successful implementation and adoption of medication reconciliation initiatives and the business case for medication reconciliation.
- Accelerate the adoption and benefits realization of drug information systems and electronic health records.
- Create a Canadian Medication Reconciliation Challenge to advance the safety agenda across Canada.

0800 – 0830	**Breakfast and Registration**	
0830 – 0845	**Welcome, Goals for the Day**	**Hugh MacLeod**, President and CEO Canadian Patient Safety Institute
0845 – 0850	**Facilitator Welcome**	**Steven Lewis**, President, Access Consulting Ltd., and Adjunct Professor at the Centre for Health and Policy Studies, University of Calgary
0850 - 0915	**Patient Story**	**Donna Denison**
0915 - 1000	**Key Note Presentation: Value Proposition** *"Medication reconciliation is an absolute requirement to help ensure medication safety during transitions in care," said Dr. Jeffrey Schnipper, who practices at Brigham and Women's Hospital in Boston.*	**Jeffrey Schnipper**, Director of Clinical Research Brigham and Women's Hospital (BWH); Academic Hospitalist Service Associate Physician, Division of General Medicine BWH, Assistant Professor of Medicine at Harvard Medical School
1000-1030	**Break**	
1030- 1130	***Safer Healthcare Now!* Experience** *Implementation experiences*	**Marg Colquhoun - *Moderator*** **Marg Colquhoun**, Project Leader, ISMP Canada; National Medication Reconciliation Intervention Lead *Safer Healthcare Now!* **Susan Wannamaker**, Chief Operating Officer Vancouver Coastal Health – Richmond; Chief Nursing Officer and Executive Lead Professional Practice – Vancouver Coastal Health **Renée Claire Fox**, Risk Management Coordinator Health and Social Services Center Jeanne Mance **Olavo Fernandes**, Director of Pharmacy - Clinical, University Health Network
1130 - 1200	**Towards Safer Care Using Health Information Solutions**	**Jennifer Zelmer**, Senior Vice President, Clinical Adoption and Innovation Canada Health Infoway

1200 – 1230	**Lunch**	
1230 – 1345	**Facilitated Panel discussion** ➢ *Experiences with medication reconciliation* ➢ *Key strategic issues* ➢ *What needs to be done*	**Steven Lewis - *Moderator*** **Wendy Nicklin**, President and CEO Accreditation Canada **Judith Shamian**, President, Canadian Nurses Association (CNA) and President and CEO, VON Canada **Vickie Kaminski**, President and CEO Eastern Health, Newfoundland and Labrador **Janice Munroe**, President-Elect, Canadian Society of Hospital Pharmacists; Regional Medication Safety Coordinator, Fraser Health **Dr. Ed Etchells**, Associate SGS Member, Department of Medicine, University of Toronto; Staff Physician, Division of General Internal Medicine; Director of Patient Safety Improvement Research, Centre for Health Services Sciences; Associate Director, University of Toronto Centre for Patient Safety
1345 – 1445	**Making the MedRec Challenge a Reality! Working Groups**	**Steven Lewis** - ***Facilitator***
1445 - 1500	**Break**	
1500 – 1600	**Plenary discussion (Action Plan) – The National Challenge** *To result in The Challenge and actionable plans to move forward in Canada*	**Steven Lewis** - ***Facilitator***
1600 – 1630	**Hitting it out of the park!**	**Hugh MacLeod**

Attendance List - Optimizing Medication Safety at Care Transitions - *Creating a National Challenge*

Name	Title	Organization
Wendy Nicklin	President and CEO	Accreditation Canada
Bernadette MacDonald	Vice President Programs and Services	Accreditation Canada
Carolyn Hoffman	Vice President of Quality	Alberta Health Services
Dave Bilan	Director, Clinical Workforce Support from HPSP	Alberta Health Services
Karen Horon	Pharmacy Services Medication Reconciliation Program Lead	Alberta Health Services
Susan Mumme	Senior Vice President, Quality Practice & Partnerships / Quality Performance Improvement	Alberta Health Services
Mary Lou Lester	Medication Safety Leader for British Columbia	BC Patient Safety & Quality Council
Dr. Jeffrey Schnipper	Director of Clinical Research Brigham and Women's Hospital (BWH); Academic Hospitalist Service Associate Physician in the Division of General Medicine at BWH; Assistant Professor of Medicine at Harvard Medical School	Brigham and Women's Hospital; Harvard Medical School
Maureen Charlebois	Chief Nursing Executive & Group Director, Clinical Adoption	Canada Health Infoway
Jennifer Zelmer	Senior Vice President, Clinical Adoption and Innovation	Canada Health Infoway
Lak Parmar	Group Director, DIS, Telehealth & PHS Programs	Canada Health Infoway
Larisa Szyrajew	Clinical Adoption - Project Coordinator	Canada Health Infoway
Nadine Saby	President & CEO, and Board Liaison	Canadian Association of Chain Drug Stores
Justin Bates	Director for e-Health	Canadian Association of Chain Drug Stores
Dr. Todd Watkins	Director, Professional Affairs and Strategic Health Alliances	Canadian Medical Association
Dr Kathryn Reducka	Physician Risk Manager, Education Department	Canadian Medical Protective Association
Norma Freeman	Nurse Consultant	Canadian Nurses Association
Chantal Leonard	Chief Executive Officer	Canadian Nurses Protective Society
Marie Owen	Director of Operations	Canadian Patient Safety Institute (CPSI)
Hugh MacLeod	President and CEO	Canadian Patient Safety Institute (CPSI)
Anne MacLaurin	Project Manager	Canadian Patient Safety Institute (CPSI)
Cecilia Bloxom	Director of Communications	Canadian Patient Safety Institute (CPSI)
Janet Cooper	Senior Director, Professional and Membership Affairs	Canadian Pharmacists Association
Janice Munroe	President-Elect, Canadian Society of Hospital Pharmacists; Regional Medication Safety Coordinator, Fraser Health	Canadian Society of Hospital Pharmacists
Jeremy Veillard	Vice President, Research and Analysis	CIHI
Michael Hunt	Director, Pharmaceuticals and Health Workforce Information Services	CIHI
Dr. John Maxted	Family Physician	College of Family Physicians
Cathy Szabo	Executive Director	Community Care Access Centres
Renee Claire Fox	Risk Management Coordinator Health and Social Services Center	CSSS Jeanne-Mance
Iris Krawchenko	Chair, Board of Directors, Dell Pharmacy Ltd.; Pharmacist Manager, Certified Geriatric Pharmacist, Dell Pharmacy	Dell Pharmacy, Hamilton ON

Attendance List - Optimizing Medication Safety at Care Transitions - *Creating a National Challenge*

Name	Title	Organization
Vickie Kaminski	President and Chief Executive Officer	Eastern Health, Newfoundland and Labrador
Joanne Donahoe	Director of Quality and Access	Health PEI
Polly Stevens	Vice President, Healthcare Risk Management	Healthcare Insurance Reciprocal of Canada
Alice Watt	Medication Safety Specialist, ISMP Canada; Medication Reconciliation Specialist, *Safer Healthcare Now!*	ISMP Canada
Brenda Carthy	Project and Event Coordinator, ISMP Canada; National Medication Reconciliation Intervention Coordinator, *Safer Healthcare Now!*	ISMP Canada
Kimindra Tiwana	Medication Safety Specialist	ISMP Canada
David U	President and CEO	ISMP Canada
Sylvia Hyland	Vice President and COO	ISMP Canada
Marg Colquhoun	Project Leader, ISMP Canada; National Medication Reconciliation Intervention Lead, *Safer Healthcare Now!*	ISMP Canada; *Safer Healthcare Now!*
Anne McGuire	President and CEO	IWK Health Centre
Nancy Winslade	Assistant Professor, Department of Medicine, Medical Office of the 21st Century Research Project, Faculty of Medicine	McGill University
Micheline Ste Marie	Associate Director, Professional Services	Montreal Children's Hospital, McGill University Health Centre
Karen Sequeira	Consultant, Patient Safety	Ontario Hospital Association
Nancy Cooper	Director of Policy & Professional Development	Ontario Long Term Care Association
Paula Neves	Director Health Planning and Research	Ontario Long Term Care Association
Christina Bisanz	CEO	Ontario Long Term Care Association
Emily O'Sullivan	Performance Improvement Implementation Manager Health System Accountability and Performance Division	Ontario Ministry of Health and Long-Term Care
Diane Vermilyea	Sr Policy Advisor, Health System Strategy Division	Ontario Ministry of Health and Long-Term Care
Debbie Gibson	Health Analytics Branch, Health System Information Management and Investment Division (HSIMI)	Ontario Ministry of Health and Long-Term Care
Donna Denison		Patient Advocate
Carol Kushner		Patients for Patient Safety
Dr. Nick Kates	Provincial Lead	Quality Improvement & Innovation Partnership
Sandra Dudziak	National Director of Clinical Services/Nurse Practitioner	Revera
Marlies van Dijk	SHN Western Canada Node Leader	Safer Healthcare Now!
Markirit Armutlu	Québec Campaign Node Leader	Safer Healthcare Now!
Theresa Fillatre	Atlantic Canada Leader	Safer Healthcare Now!

Attendance List - Optimizing Medication Safety at Care Transitions - *Creating a National Challenge*

Name	Title	Organization
Caroline Robitaille	Québec Campaign Safety Improvement Advisor	Safety Improvement Advisor - Quebec Node *Safer Healthcare Now!*
Maura Davies	President and Chief Executive Officer	Saskatoon Health Region
Myra Parcher	Manager Operations – Home Care	Saskatoon Health Region
Dr. Chaim Bell	Assistant Professor of Medicine and Health Policy, Management, & Evaluation, University of Toronto; Staff General Internist, St. Michaels Hospital; Safer Healthcare Now! National Medication Reconciliation Faculty	St. Michael's Hospital
Ken Balderson	Medical Director, InPatient Mental Health Unit	St. Michaels Hospital, Toronto
Dr. Susan VanDeVelde-Coke	Executive Vice President	Sunnybrook Health Sciences Centre
Dr. Ed Etchells	Associate Director, University of Toronto Centre for Patient Safety; Medical Director, Information Services and Staff Physician, Division of General Internal Medicine, Sunnybrook Health Sciences Centre; Associate Professor of Medicine, University of Toronto; Safer Healthcare Now! National Medication Reconciliation Faculty	Sunnybrook Health Sciences Centre; University of Toronto
Carmine Stumpo	Executive Lead, Pharmacy, Emergency Services & Corporate Projects	Toronto East General Hospital
Olavo Fernandes	Director of Pharmacy-Clinical, University Health Network: Assistant Professor, Leslie Dan Faculty of Pharmacy, University of Toronto; Core Faculty Member, University of Toronto Centre for Patient Safety; *Safer Healthcare Now!* National Medication Reconciliation Faculty	University Health Network
Dr Michael Baker	Physician-in-Chief of the University Health Network; Professor of Medicine at the University of Toronto	University Health Network; University of Toronto
Steven Lewis	President Access Consulting Ltd., and Adjunct Professor at the Centre for Health and Policy Studies, University of Health Policy	University of Calgary and Simon Fraser University
Virginia Flintoft	Project Manager, Central Measurement Team *Safer Healthcare Now!;* Department of Health Policy, Management and Evaluation Faculty of Medicine, University of Toronto; Safer Healthcare Now! National Medication Reconciliation Faculty	University of Toronto; *Safer Healthcare Now!*
Fruzsina Pataky	Medication Safety Coordinator; Safer Healthcare Now! National Medication Reconciliation Faculty	Vancouver Coastal Health - Providence Health Care
Susan Wannamaker	Chief Operating Officer Vancouver Coastal Health – Richmond; Chief Nursing Officer and Executive Lead Professional Practice – Vancouver Coastal Health	Vancouver Coastal Hospital
Judith Shamian	President and CEO, VON Canada; President, Canadian Nurses Association	VON Canada
Kaaren Neufeld	Chief Quality Officer	Winnipeg Regional Health Authority
Doris Nessim	Medication Reconciliation Consultant	

Draft A Call to Action:
Implementation of Medication Reconciliation across the Canadian Healthcare System

Executive Summary

Achieving accurate communication about medications at care transitions (medication reconciliation) is proving to be complex and more difficult to implement then expected. Discrepancies in patients' medication(s) and the potential to result in adverse drug events (ADE's) pose a significant patient safety risk to consumers of healthcare. In Canada, published studies have demonstrated that 40–50% of patients experience unintentional medication discrepancies upon admission to acute care hospitals and 40% of patients experience discrepancies at hospital discharge. (ref) To date the focus has been on improving ADEs within the acute care setting but it is clear the focus must expand across the Canadian healthcare system.

Given the importance of accurate and complete transfer of medication information for patient safety, Canada Health Infoway *(Infoway)*, the Canadian Patient Safety Institute (CPSI) and the Institute for Safe Medication Practices Canada (ISMP Canada) convened a national multidisciplinary summit of senior leaders, national associations, provincial quality councils, physicians, nurses, and pharmacists from across Canada on February 10, 2011 in Toronto, Ontario, Canada.

The purpose of this Canadian senior leader's summit was to identify and reduce medication reconciliation barriers and create a plan to accelerate adoption across the Canadian healthcare system. The goal of this day is to create a national challenge to optimize medication safety at care transitions.

The compelling start to the summit was a story by a consumer who experienced multiple medication reconciliation failures while receiving care within the Canadian healthcare system. These failures resulted in significant harm to the patient leading to avoidable pain and suffering, prolonged hospitalization and ultimately death. The discussion throughout the day verified that this was indeed not an isolated incident but rather a failure to provide safe care that plays out over and over again in our healthcare system.

> "If hospitals could provide menus for lunch, then surely hospitals can provide printed lists of medications as a way to check these on admission and provide to the patient on hospital discharge."
> Donna Dennison

The summit raised a call to action to implement a strategy to accelerate and optimize medication reconciliation across the continuum of care. Open communication among summit leaders supported the idea that medication reconciliation is complex but worthy of a national strategy to support implementation. Emergent themes arising from the summit were:

A. Culture and Human Systems
B. Leadership Accountability
C. Systems approach
D. Infrastructure and Tools spanning the continuum of care
E. Skills and Training
F. Multi-sector Engagement
G. Public Engagement and Empowerment
H. Leveraged Action for Sustainability

Despite the complexity of medication reconciliation the consensus was that we need to *turn up the heat* and *move* medication reconciliation forward in Canada. We need leadership within the system to step up and champion the cause; encourage our healthcare practitioners that medication reconciliation is doable, possible and it is about improving care, access and productivity. This is an urgent call for action. We need to move now! We need to turn up the heat. If we believe this is a system we need to open up and have a new conversation. We need to think and act like a system. Let's work strategically together as a pan-Canadian nation and start the medication reconciliation movement.

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