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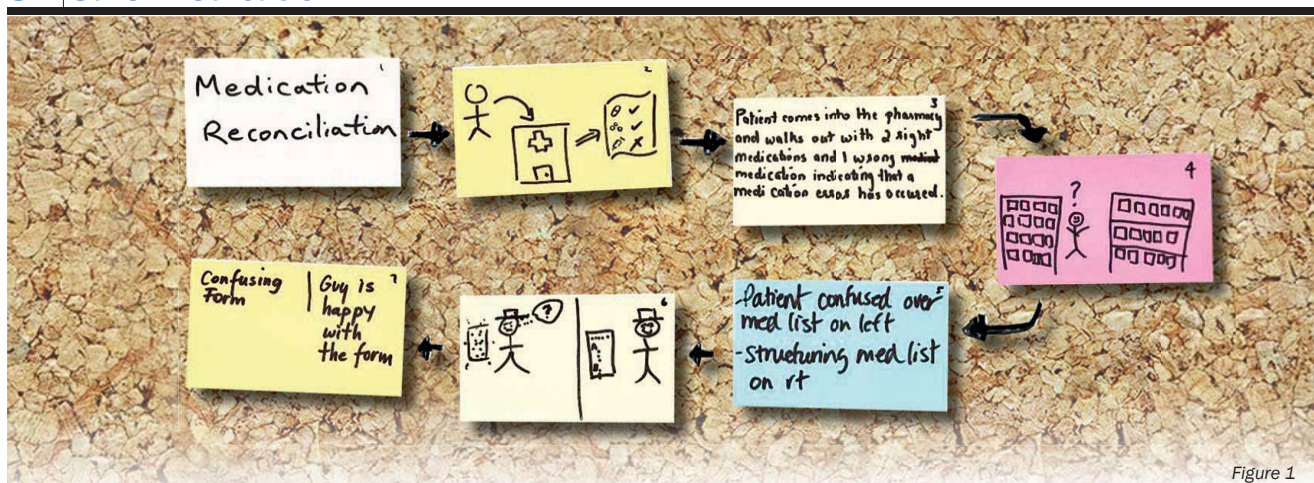


Figure 1

The broken telephone Pictionary during transition of care

By John Cao and Certina Ho

Broken Telephone Pictionary is basically a game where a person starts off drawing a topic and the next person interprets the drawing and writes it out in words. The next person then uses the new description to draw another picture, so on and so forth. I am sure this will generate a lot of laughter from the off tangent drawings and deviations from the initial topic. Yet, when faced with a similar situation with discharged patients experiencing harm due to miscommunication and errors on their prescriptions, should we take a step back to examine the causes and mitigate the errors?

The following is a case example of a medication incident reported to ISMP Canada's Community Pharmacy Incident Reporting (CPhIR) program.

The patient was hospitalized for two weeks. Nitro-dur® was not included on the discharge order brought to the community pharmacy. The patient's wife inquired the next day and upon calling the hospital, it was realized that Nitro-dur® was missed. The patient had suffered angina since coming home from the hospital.

The American Geriatric Society (AGS) defines Transitional Care as "a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location". The World Health Organization recognizes medication incidents at transition of care to be a major concern for patient safety globally.

Up to 23 per cent of hospital discharged patients experience at least one adverse

event; with 72 per cent being adverse drug events. In addition, patients with one or more medication discrepancies have higher rate of rehospitalization than patients without. Therefore, adverse medication events, hospital readmission, and death can be a result of suboptimal discharge.

Many of the incidents are results of miscommunication or prescription error, and medication reconciliation plays an important role in mitigating these errors. Medica-

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tion Reconciliation "is a formal process in which health care providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care". It involves gathering all the information (i.e. what has been added, changed or discontinued) about a patient's medication to enable appropriate prescribing decisions.

According to the 2014 Canadian Health Accreditation Report, the national compliance rate for medication reconciliation at transfer or discharge was at 61 per cent, an increase from 50 per cent in 2011. Therefore, this represents an area of patient safety which deserves more focus.

Figure 1 outlines the optimal patient transition through hospital admission to discharge. MedsCheck is a medication review program available in Ontario but the idea is similar to other medication review programs across Canada. Before admission, community pharmacies should conduct a medication review with the patient using the Best Possible Medication History (or BPMH) process and have the patient bring the BPMH into the hospital. Upon admission, medication reconciliation should be completed using the BPMH process again. During discharge, clinicians should reconcile discrepancies between hospital orders and the patient's BPMH to create a Best Possible Medication Discharge Plan. Within two weeks of discharge, i.e. when the patient returns to the community pharmacy, a follow-up medication review, again using the BPMH process, should be completed.

This ensures continuity of care and allows the opportunity for identification and resolution of medication discrepancies due to communication issues. Having access to all of the previous descriptions and drawings for reconciliation can certainly keep the telephone pictionary topic consistent throughout the game, but what is the fun in that?! **■**

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