Outstanding Issues in Medication Reconciliation

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About ISMP Canada

ISMP Canada is an independent not-for-profit organization dedicated to reducing preventable harm from medications.

Our aim is to heighten awareness of system vulnerabilities and facilitate system improvements.

www.ismp-canada.org

Patient Story

- Mr. J 78 y.o man
- Citalopram 40 mg po daily and lorazepam 0.5mg po q4-6h prn for anxiety
- Went to see ortho for ongoing leg cramps
- Ortho prescribed quinine
- Pt took Rx to regular pharmacy
- Not covered by provincial formulary

Patient Story

- Called prescriber and switched med to chlordiazepoxide 25mg po qhs
- Pt took med for 2 days
- Feeling ++ somnolent during the day
- Called daughter who is pharmacist
- Daughter / pharmacist said “are you kidding me?”

Scope of the Issue

- **16%** of physicians say hospitals send them information needed for follow-up care within 48 hours of a patient being discharged
- **26%** say they always receive a comprehensive report from specialists who have seen their patients, and 11% of them say these reports are timely
- **43%** of physicians say they can easily generate a list of any patient's medications

How do Canadian primary care physicians rate the health system?

Health Council of Canada, 2013

Scope of the Issue

- A comparison between patients electronic medical record (EMR) lists and pharmacy medication fill histories found:
  - an **average of 6 discrepancies** per patient
  - **41%** of patients having an inactive medication recorded on their EMR profile (Johnson, 2010)
- A family health team in Ontario found that only **1 in 86** charts accurately reflected what the patient was actually taking

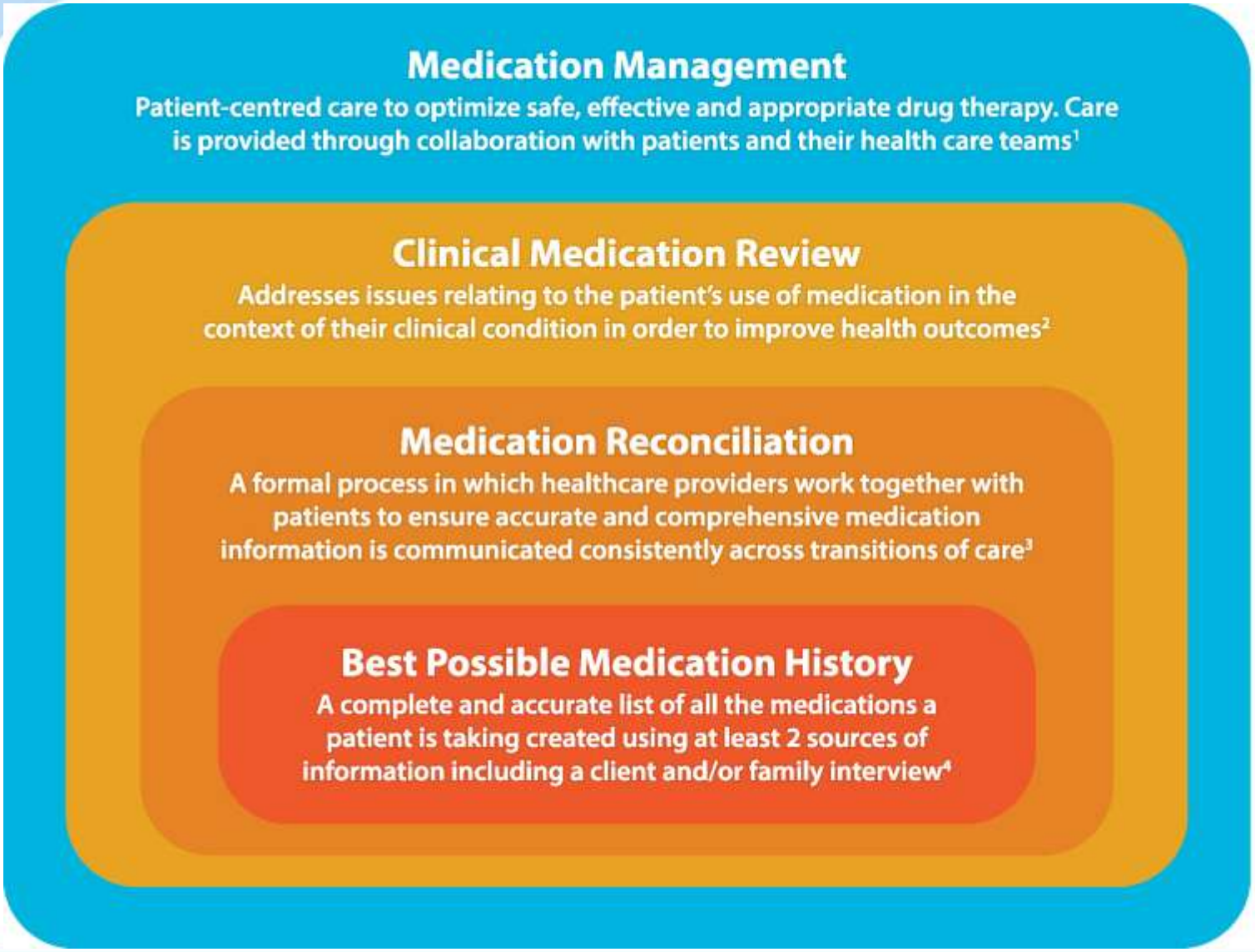
Medication Management

Patient-centred care to optimize safe, effective and appropriate drug therapy.

Care is provided through collaboration with patients and their health care teams.

Developed collaboratively by the Canadian Pharmacists Association, Canadian Society of Hospital Pharmacists, Institute for Safe Medication Practices Canada, and University of Toronto Faculty of Pharmacy, 2012.

You cannot evaluate and optimize what you do not know and you cannot start off with wrong information



1. Developed collaboratively by the Canadian Pharmacists Association, Canadian Society o Hospital Pharmacists, Institute for Safe Medication Practices Canada, and University of Toronto Faculty of Pharmacy, 2012
2. www.health.gov.bc.ca/pharmacare
3. ISMP Canada. Medication Reconciliation in Acute Care: Getting Started Kit. 2011
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Adapted from
Fraser Health, Providence Health Care, Provincial Health Services Authority, Vancouver Coastal Health

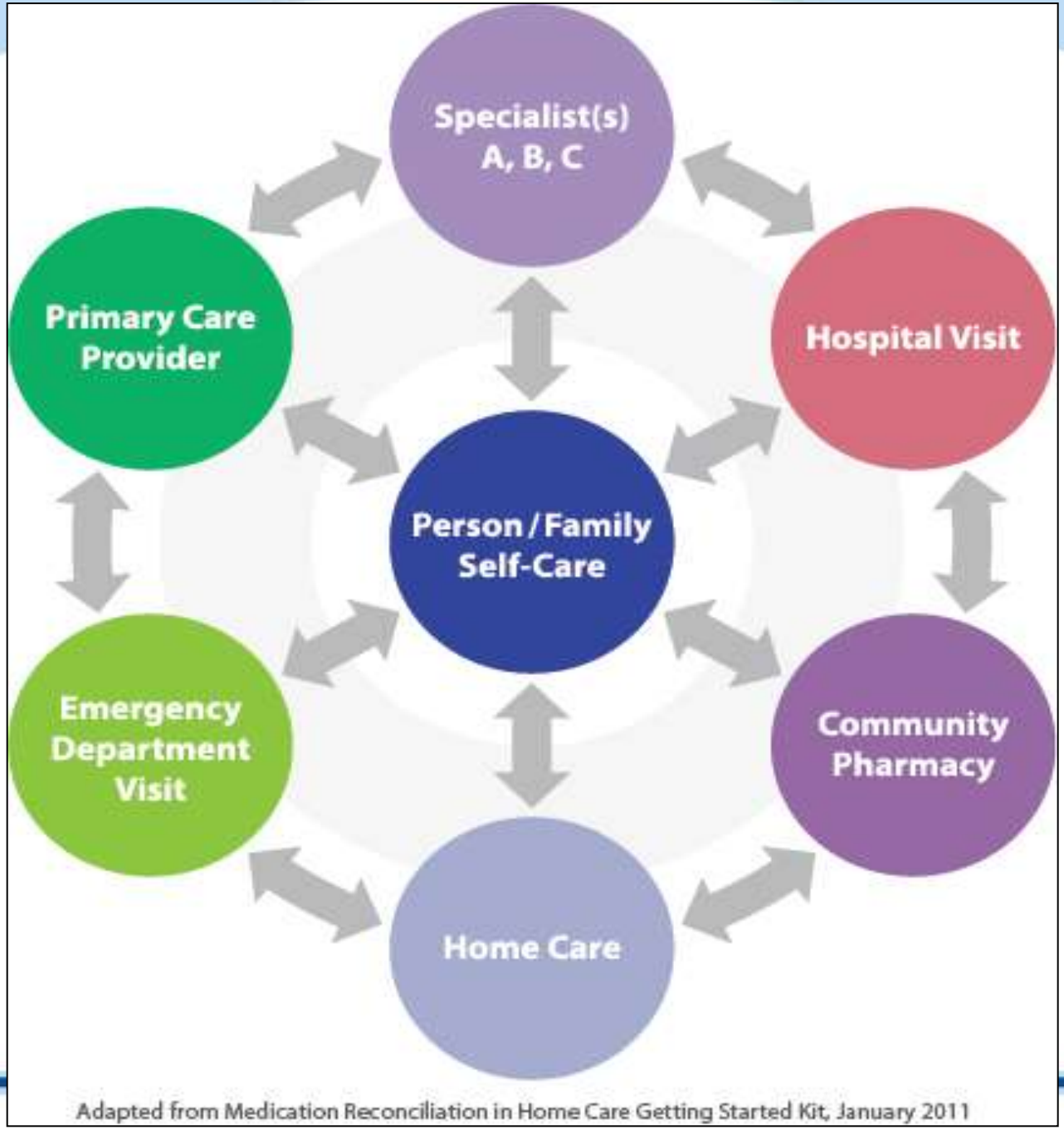
Medication Reconciliation

- MedRec is a **formal** process in which health care professionals **partner with patients** to ensure **accurate and complete** medication information is **communicated** consistently at **transitions of care**

- It requires a **systematic and comprehensive review of all the medications** a patient is taking (known as a **BPMH**) to ensure that medications being added, changed or discontinued are carefully evaluated

In other words:

….making sure the right information is communicated about a patient's medications each time the patient moves throughout the healthcare system



Adapted from Medication Reconciliation in Home Care Getting Started Kit, January 2011

Medication Communication Failures Impact EVERYONE!

PATIENT & FAMILY

- loss of life
- prolonged disability
- temporary harm
- complicated recovery
- loss of income
- confusion about treatment plan

HEALTHCARE SYSTEM

- prolonged recovery time
- increased cost and staff time due to rework
- avoidable readmissions and Emergency department visits
- reduced access to health services

SOCIETY

- loss of productivity
- workplace absenteeism
- increased cost
- loss of public confidence in the healthcare system

Medication Safety: We all have a role to play.

Safe patient care depends on accurate information. Patients benefit when clinicians work with patients, families, and their colleagues to collect and share current and comprehensive medication information. Medication reconciliation is a formal process to do this at care transitions, such as when patients enter the hospital, are transferred or go home. We all have a role to play.

Accreditation Canada, Canada Health Infoway, the Canadian Medical Association, the Canadian Nurses Association, the Canadian Pharmacists Association, the Canadian Society of Hospital Pharmacists, Patients for Patient Safety Canada, the Royal College of Physicians and Surgeons of Canada, The College of Family Physicians of Canada, Canadian Patient Safety Institute and the Institute for Safe Medication Practices Canada **actively support strategies to improve medication safety and call on all healthcare professionals to contribute to effective communication about medications at all transitions of care to improve the quality and safety of our Canadian healthcare system.**

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

Canada Health Infoway / Inforoute Santé du Canada

ASSOCIATION MÉDICALE CANADIENNE / CANADIAN MEDICAL ASSOCIATION

CANADIAN NURSES ASSOCIATION / ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

cpsi icsp

CANADIAN PHARMACISTS ASSOCIATION / ASSOCIATION DES PHARMACIENS DU CANADA

Canadian Society of Hospital Pharmacists / Société canadienne des pharmaciens d'hôpitaux

ismp CANADA

PATIENTS FOR PATIENT SAFETY CANADA / PATIENTS POUR LA SÉCURITÉ DES PATIENTS CANADA

ROYAL COLLEGE / COLLÈGE ROYAL

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA / LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

PATIENT & FAMILY

- loss of life
- prolonged disability
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MedRec in Primary Care

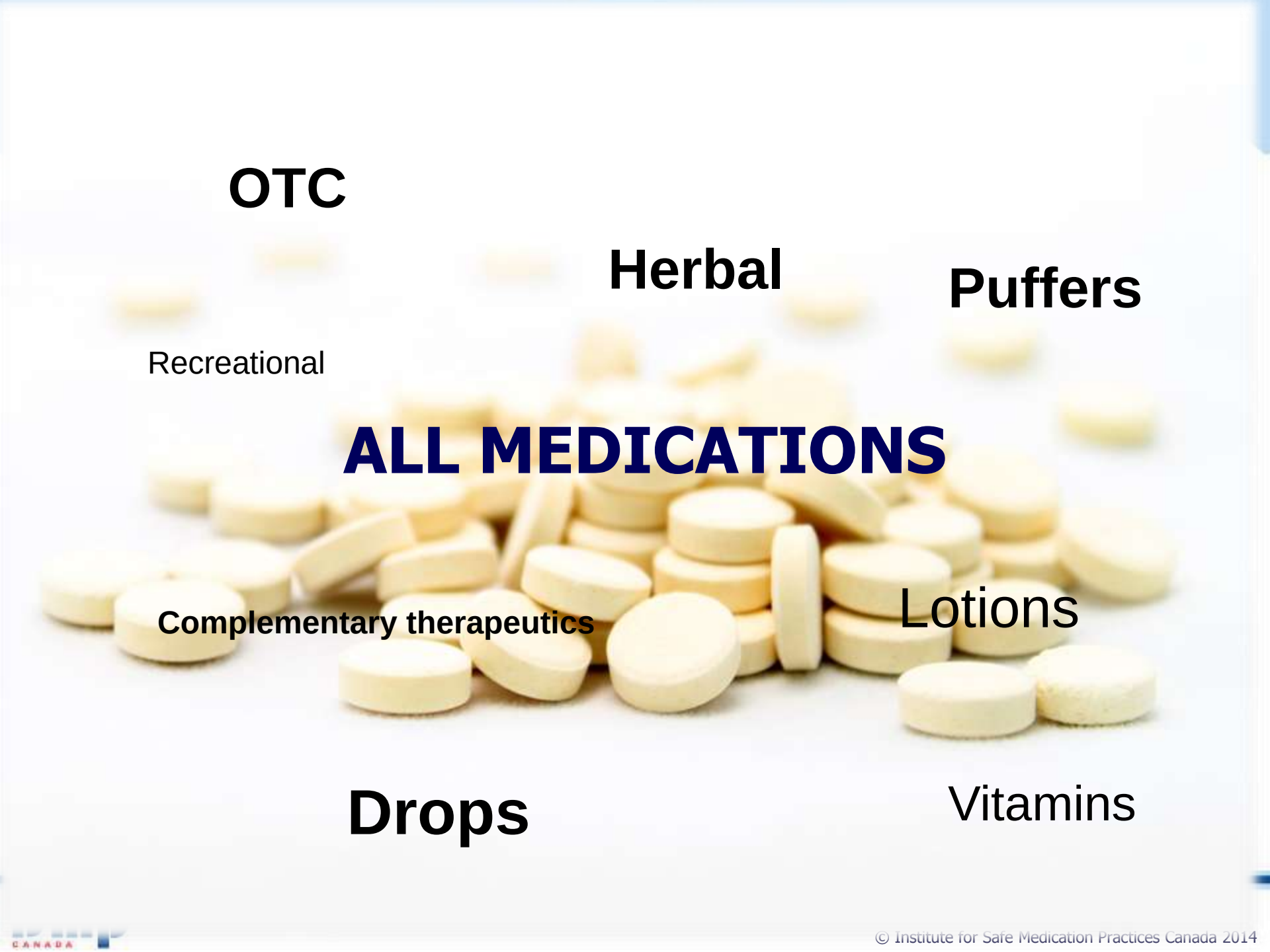
- Create a BPMH
- Identify and resolve discrepancies
- Communicate current list
- Update(reconcile) the current list at each patient visit – even if during the visit no medication changes were made

The Best Possible Medication History

A complete and accurate list of how the patient takes all of his or her therapeutics

NOT JUST how they were prescribed

NOT JUST prescribed medications



We open the vial with the patient and say "tell me how you use/take these".

Sharon Sobol, Pharmacist, Cape Breton

I don't

When my wife reminds me

Nightly

After I have a headache

Wednesdays

How the patient takes them

I take them all at once

Two or three times a day

When I feel "funny"

I stopped taking them when my blood felt too thin

What drugs?

Reconcile

- What is reconciled today is un-reconciled at the next visit
- Reconciling at each visit is crucial
- Build MedRec into each visit
- Change the process

How do we do it?
How do we make it easier?

- Ownership of the problem
  - Take charge, be a champion for MedRec
- Ownership of the list
  - Shared with patient
- Build MedRec into each visit

Barriers

- Time
- Human resources
- Technology
- Variability in processes
- Constant need for updating
- Still highly dependent upon humans

MedRec Resource Guide: Primary Care – *Coming Soon!*

In the mean time….

www.ismp-canada.org/medrec

www.hqontario.ca/qualitycompass

www.medscheck.ca

MedsCheck

SafeMedicationUse.ca

SUPPORTED BY HEALTH CANADA

Help Prevent Medication Incidents

A component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS).

Volume 3, Issue 1 — **Newsletter** — January 11, 2012

Medication Reconciliation Can Help to Reduce the Chance of Errors with Medicines!

SafeMedicationUse.ca has received a report from a consumer who noticed potential problems on two occasions while receiving care in an emergency department. Each time, the consumer spoke up after noticing that healthcare providers had incomplete information about a medicine the consumer was taking at home. On one occasion, information that was obtained from a computer system did not include the current dose of the consumer's medicine warfarin. On another occasion, the computer system did not have current information on the consumer's dose of candesartan cilexetil (brand name Atacand). Warfarin is a blood thinner. Candesartan can be used to treat high blood pressure or heart failure. A mistake with either of these medicines could cause harm. Fortunately, the consumer spoke up and made sure that the healthcare providers got the right information. Read more about speaking out when you have concerns

(www.safemedicationuse.ca/newsletter/newsletter_speakout.html)

Whenever you receive healthcare, it is important that you and your healthcare provider have complete information about all your medicines. Healthcare providers may use more than one source of information to prepare a complete list of your medicines. This list is sometimes called a "best possible medication history" or BPMH. Making a BPMH is the key step in a process known as "medication reconciliation". When a BPMH is being created, it is ideal for you or your family to participate.

You can help your healthcare providers to prepare the BPMH by bringing your own list of medicines and all of your medicine bottles with you whenever you receive healthcare. These steps can be a big help because it may be difficult for you to remember the information yourself, especially if you are feeling sick. Ideally, you should include all types of medicine that you take at home, including over-the-counter drugs and herbal medicines. Tell your healthcare provider how you take each medicine. These details are important because healthcare providers may not always be able to get complete information by looking at your medicine bottles or computer reports. For example, a doctor may have changed the dose of one of your medicines without writing a new prescription.

What is Medication Reconciliation?

Medication reconciliation is a way to make sure that information about your medicines is passed on when you move from one setting of care to another. During medication reconciliation, a healthcare provider makes a list called the "best possible medication history". This list contains information about your medicines that is as complete and correct as possible. All of your healthcare providers can use this list when they are making decisions about your medicines and other types of care. Medication reconciliation works best when patients and families are partners in the process.

Medication reconciliation may happen when you are admitted to hospital, when you are transferred from one area to another while you are in hospital, and when you are discharged from hospital. Medication reconciliation can also happen in nursing homes, in the community with your family healthcare team, and in other healthcare settings.

After the BPMH is prepared, your healthcare provider should review the entire list with you to be sure it is accurate. Healthcare providers should also tell you about any changes that are made to your medicines and should help you to update your list of medicines. Read more about keeping a list of medicines

(www.safemedicationuse.ca/newsletter/newsletter_minerals.html)

Medication reconciliation helps to ensure you get the medicines you need. It can also prevent you from receiving the wrong medicine or the wrong dose of a medicine. Be involved, and help prevent errors with your medicines!

Brought to you by ismp CANADA

ismp CANADA

How could communication about Mr. J's medications have helped?

- Family doc  Specialist
- Specialist  Mr. J
- Pharmacist  Mr. J
- Pharmacist  Specialist
- Pharmacist  Mr. J

Thank You