Advancing Safe Medication Practices

Medication Safety at Transitions of Care

Alice Watt R.Ph

March 4th, 2016

PPL Network, TEGH

Objectives

1. Discuss how we learn from medication adverse events
2. Share strategies to enhance medication safety at transitions in care
    - Medication Reconciliation
    - Hospital to Home Facilitating Medication Safety at Transitions – A Toolkit for Healthcare Providers
    - National Medication Safety Checklist - 5 Questions to Ask about your medications

About ISMP Canada

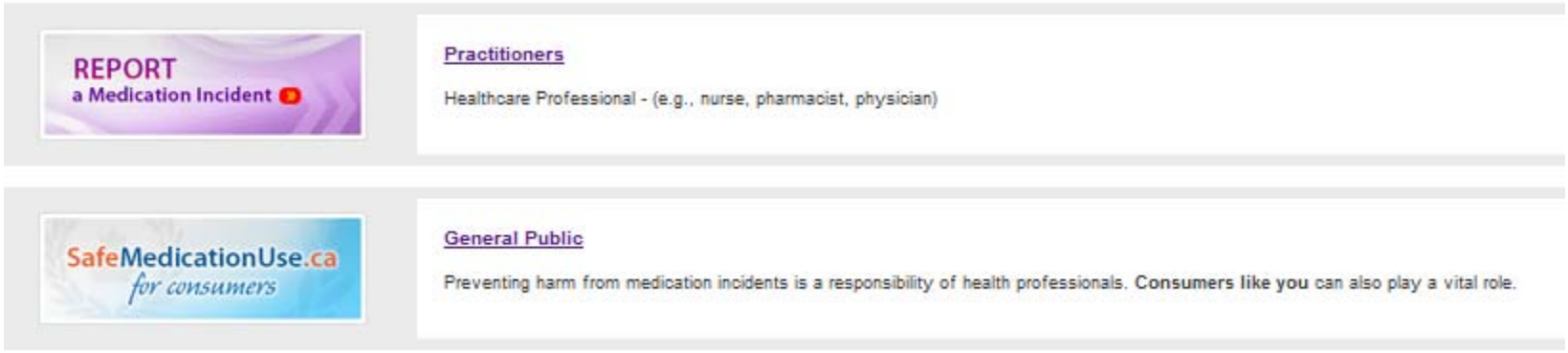
- Independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings.

- Incorporated in 2000 for the purpose of analysis of medication incidents, sharing learnings, and making recommendations for medication system safeguards.

- Our goal is the creation of safe and reliable **systems** for managing medications.

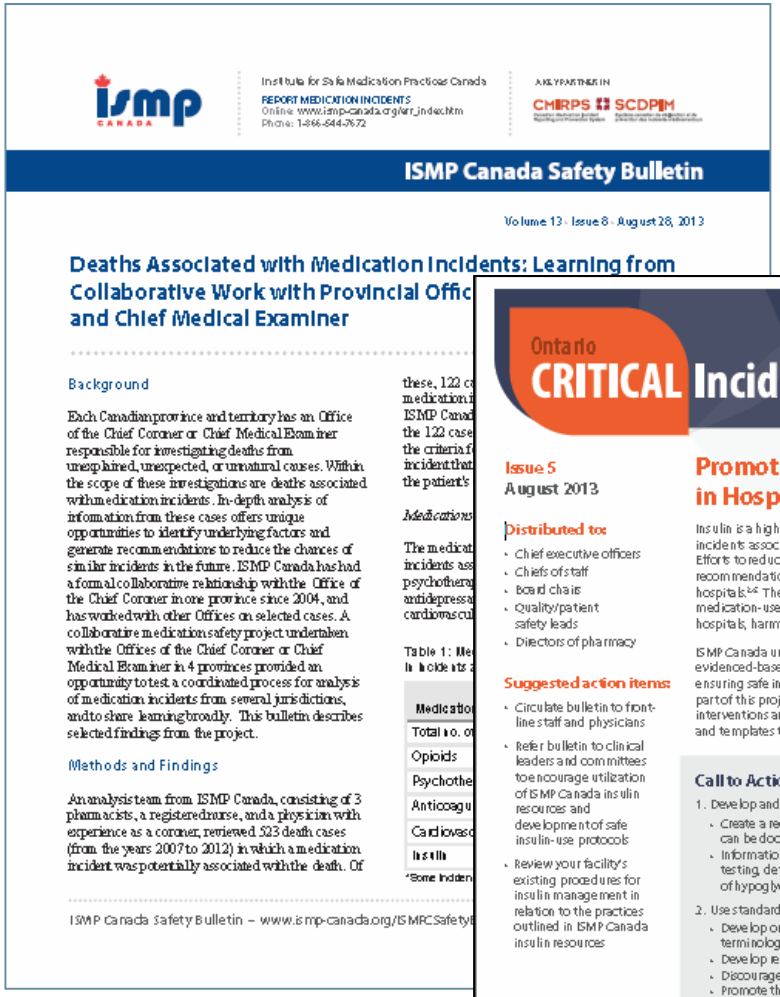
Medication Incident Reporting

- Incidents voluntarily reported



- Incidents discussed by interdisciplinary team of analysts (nurses, pharmacists, physician)

ISMP Canada Safety Bulletins



ISMP CANADA

Institute for Safe Medication Practices Canada

REPORT MEDICATION INCIDENTS
Online: www.ismp-canada.org/err_index.htm
Phone: 1-866-544-7672

ISMP Canada Safety Bulletin

Volume 13 • Issue 8 • August 28, 2013

Deaths Associated with Medication Incidents: Learning from Collaborative Work with Provincial Offic and Chief Medical Examiner

Background

Each Canadian province and territory has an Office of the Chief Coroner or Chief Medical Examiner responsible for investigating deaths from unexplained, unexpected, or unnatural causes. Within the scope of these investigations are deaths associated with medication incidents. In-depth analysis of information from these cases offers unique opportunities to identify underlying factors and generate recommendations to reduce the chances of similar incidents in the future. ISMP Canada has had a formal collaborative relationship with the Office of the Chief Coroner in one province since 2004, and has worked with other Offices on selected cases. A collaborative medication safety project undertaken with the Offices of the Chief Coroner or Chief Medical Examiner in 4 provinces provided an opportunity to test a coordinated process for analysis of medication incidents from several jurisdictions, and to share learning broadly. This bulletin describes selected findings from the project.

Methods and Findings

An analysis team from ISMP Canada, consisting of 3 pharmacists, a registered nurse, and a physician with experience as a coroner, reviewed 523 death cases (from the years 2007 to 2012) in which a medication incident was potentially associated with the death. Of

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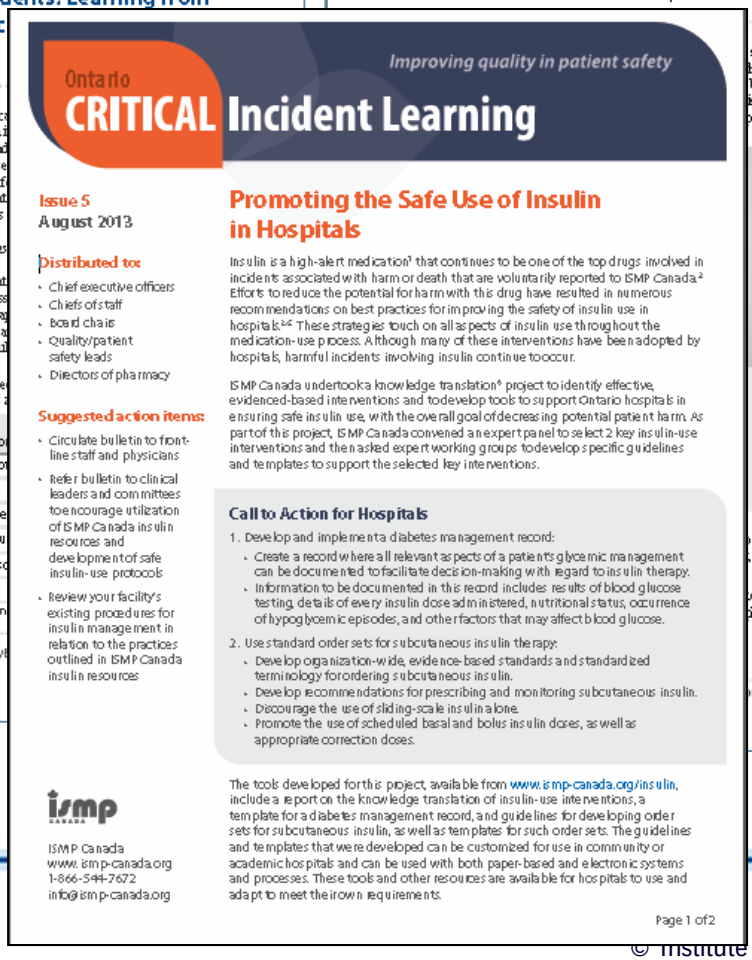
ISMP Canada Safety Bulletin – www.ismp-canada.org/ISMPCSafetyB



Ontario
CRITICAL Incident Learning

Improving quality in patient safety

Issue 5
August 2013

Distributed to:

- Chief executive officers
- Chiefs of staff
- Board chairs
- Quality/patient safety leads
- Directors of pharmacy

Suggested action items:

- Circulate bulletin to front-line staff and physicians
- Refer bulletin to clinical leaders and committees to encourage utilization of ISMP Canada insulin resources and development of safe insulin-use protocols
- Review your facility's existing procedures for insulin management in relation to the practices outlined in ISMP Canada insulin resources

Promoting the Safe Use of Insulin in Hospitals

Insulin is a high-alert medication[1] that continues to be one of the top drugs involved in incidents associated with harm or death that are voluntarily reported to ISMP Canada.[2] Efforts to reduce the potential for harm with this drug have resulted in numerous recommendations on best practices for improving the safety of insulin use in hospitals.[3-5] These strategies touch on all aspects of insulin use throughout the medication-use process. Although many of these interventions have been adopted by hospitals, harmful incidents involving insulin continue to occur.

ISMP Canada undertook a knowledge translation[6] project to identify effective, evidenced-based interventions and to develop tools to support Ontario hospitals in ensuring safe insulin use, with the overall goal of decreasing potential patient harm. As part of this project, ISMP Canada convened an expert panel to select 2 key insulin-use interventions and then asked expert working groups to develop specific guidelines and templates to support the selected key interventions.

Call to Action for Hospitals

1. Develop and implement a diabetes management record:
   - Create a record where all relevant aspects of a patient's glycemic management can be documented to facilitate decision-making with regard to insulin therapy.
   - Information to be documented in this record includes results of blood glucose testing, details of every insulin dose administered, nutritional status, occurrence of hypoglycemic episodes, and other factors that may affect blood glucose.
2. Use standard order sets for subcutaneous insulin therapy:
   - Develop organization-wide, evidence-based standards and standardized terminology for ordering subcutaneous insulin.
   - Develop recommendations for prescribing and monitoring subcutaneous insulin.
   - Discourage the use of sliding-scale insulin alone.
   - Promote the use of scheduled basal and bolus insulin doses, as well as appropriate correction doses.

The tools developed for this project, available from www.ismp-canada.org/insulin, include a report on the knowledge translation of insulin-use interventions, a template for a diabetes management record, and guidelines for developing order sets for subcutaneous insulin, as well as templates for such order sets. The guidelines and templates that were developed can be customized for use in community or academic hospitals and can be used with both paper-based and electronic systems and processes. These tools and other resources are available for hospitals to use and adapt to meet their own requirements.

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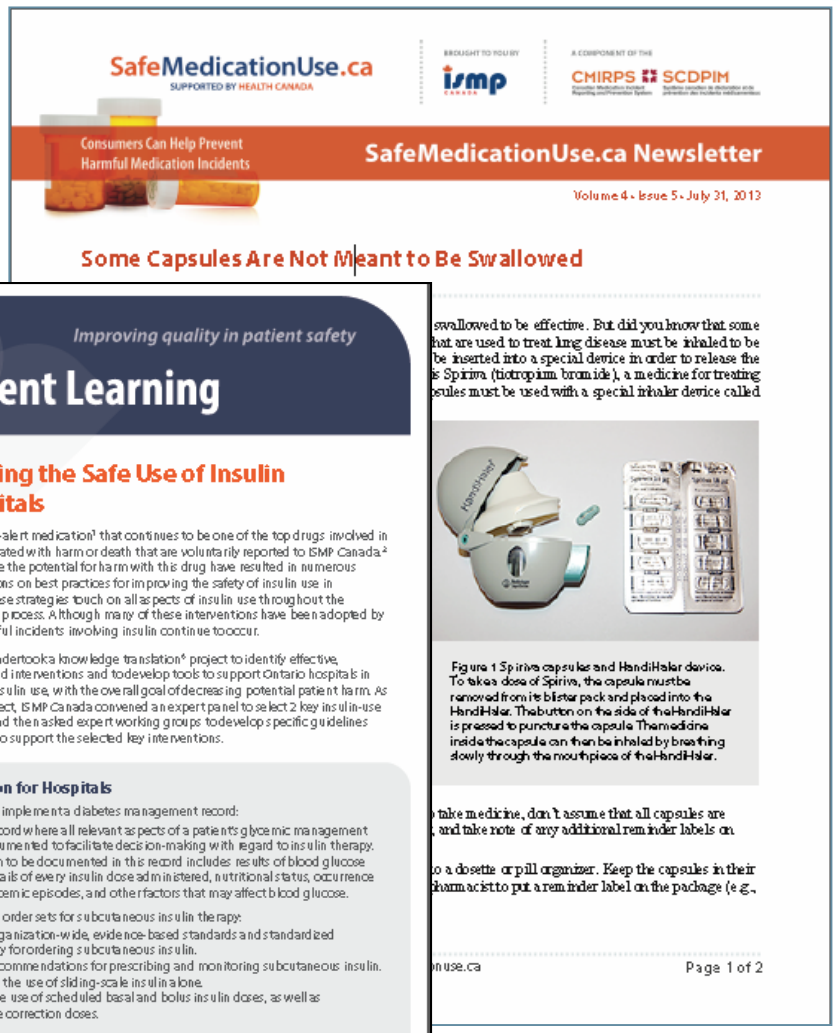

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Consumers Can Help Prevent Harmful Medication Incidents

SafeMedicationUse.ca Newsletter

Volume 4 • Issue 5 • July 31, 2013

Some Capsules Are Not Meant to Be Swallowed

swallowed to be effective. But did you know that some
hat are used to treat lung disease must be inhaled to be
be inserted into a special device in order to release the
is Spiriva (tiotropium bromide), a medicine for treating
sules must be used with a special inhaler device called

Figure 1 Spiriva capsules and HandiHaler device. To take a dose of Spiriva, the capsule must be removed from its blister pack and placed into the HandiHaler. The button on the side of the HandiHaler is pressed to puncture the capsule. The medicine inside the capsule can then be inhaled by breathing slowly through the mouthpiece of the HandiHaler.

take medicine, don't assume that all capsules are
and take note of any additional reminder labels on

o a dosette or pill organizer. Keep the capsules in their
harmacist to put a reminder label on the package (e.g.,

nuse.ca

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Medication Adverse Events at Transitions

- 54% of patients had at least one unintended discrepancy on admission to hospital; most common was omission. 39% had potential to cause moderate to severe harm or deterioration

Cornish PL et al., Arch Intern Med. 2005

- 62% of patients had at least 1 unintentional discrepancy at transfer; most common was omission (56%)

Lee JY et al., Ann Pharmacother. 2010

- 72% of adverse events at discharge are medication related; the majority are preventable

Forster HD et al., Can Med Assoc. 2004

Aggregate Analysis of Medication Incidents in Home Care

- 68% of the incidents reviewed were due to medication transition failure and involved a problematic transition of the patient and his/her medications from the hospital back home.

Reference: http://ismp-canada.org/download/safetyBulletins/2014/ISMPCSB2014-8_MedicationIncidentsHomeCare.pdf

“Poor communication at transitions can undo a lot of effort and compromise otherwise excellent care.”

Dr. M. Hamilton

SHN! November 2015 Teleconference Your discharge is someone’s admission

Medication Reconciliation

Where are you at with MedRec?

We have a lot of work to do

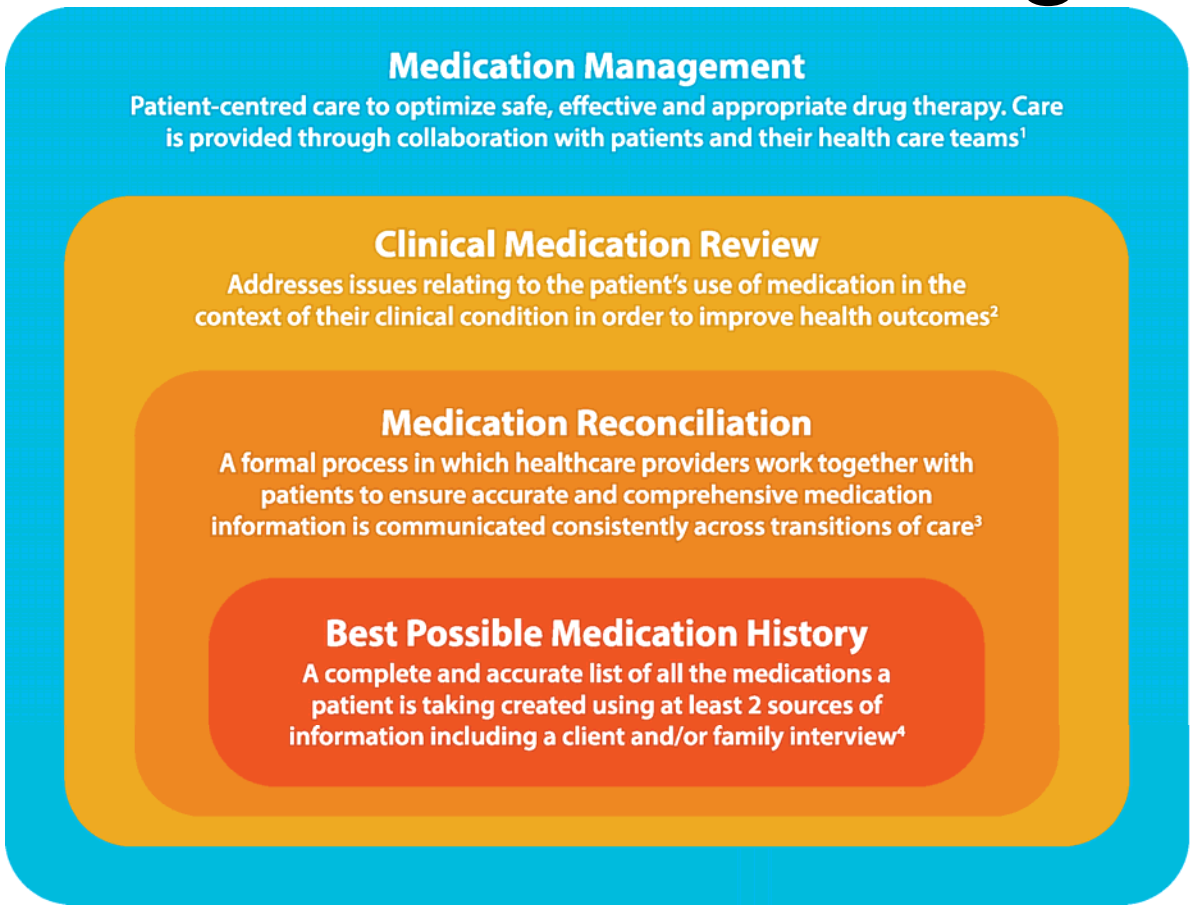
We are doing alright

We are doing great

Summary of MedRec Evidence

- Research has shifted from admission MedRec to discharge and strategies to reduce readmissions
- MedRec, amongst a suite of interventions has been shown to reduce re-admissions
- Pharmacy-led and pharmacist involvement in MedRec have showed substantial reduction in the rate of all-cause readmissions (19%), all-cause ED visits (28%) and ADE-related hospital revisits (67%).

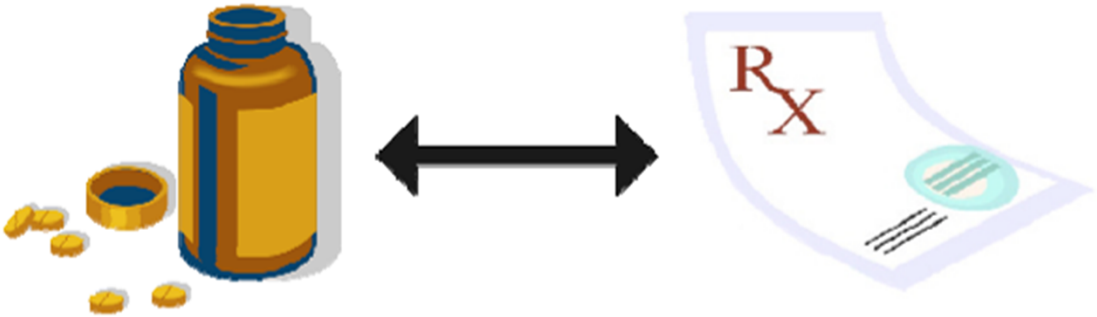
MedRec - One Component of Medication Management



1. 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
2. www.health.gov.bc.ca/pharmacare
3. ISMP Canada. Medication Reconciliation in Acute Care: Getting Started Kit. 2011
4. ISMP Canada. Medication Reconciliation in Acute Care: Getting Started Kit. 2011

Adapted from
Fraser Health, Providence Health Care, Provincial Health Services Authority, Vancouver Coastal Health

What Is Medication Reconciliation?



It is a formal process comparing:

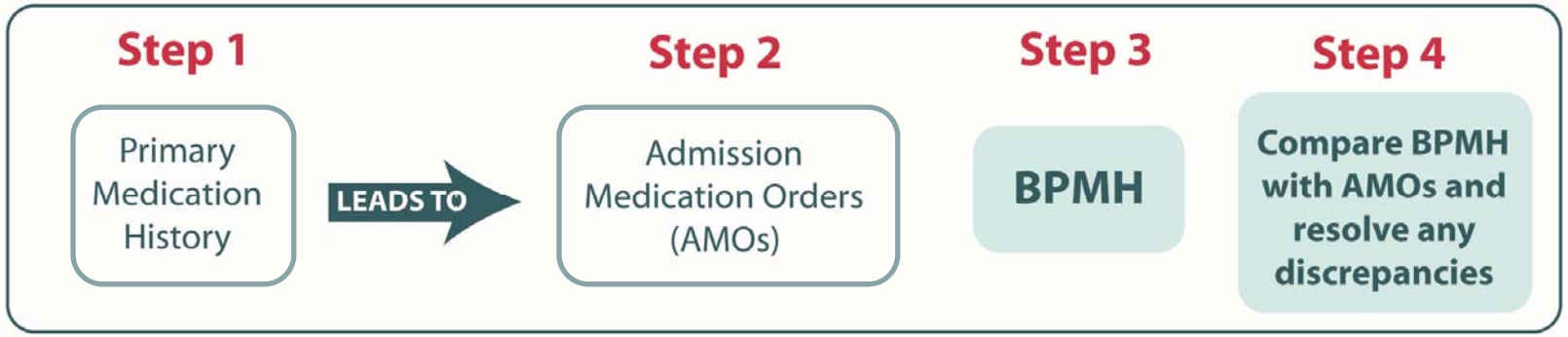
A patient's accurate and comprehensive medication history (Best Possible Medication History)

Medications prescribed at Admission, Transfer and Discharge

Discrepancies are identified and brought to the attention of the healthcare team.

Retroactive MedRec Model

Occurs when the BPMH is conducted after admission medication orders are written



Proactive MedRec Model

Occurs when the BPMH is conducted before admission medication orders are written

Hybrid MedRec Model

- Where proactive/retroactive models co-exist
- Hybrid models exist because of:
  - Inadequate staffing to perform a BPMH proactively
  - Complex patients with extensive medication histories, or
  - Incomplete information available to complete a BPMH prior to admission orders

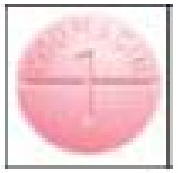
How the Patient's Truth can be a MedWrecker

Patient Story shared by:
Colleen Cameron, RPh, Pharm.D.
Grand River Hospital, Kitchener ON

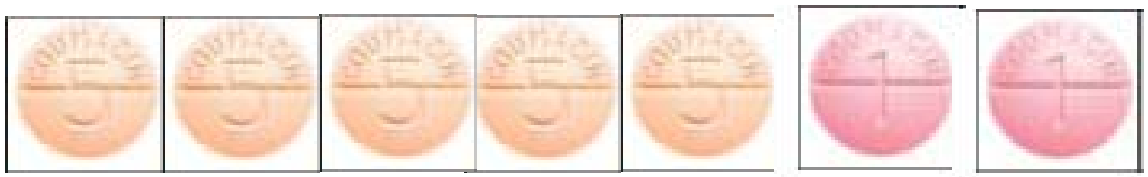
(SHN teleconference 2015 – Your discharge is someone's admission)

Ms. C, 72 years old

- Admitted to hospital for **acute delirium**, UTI, new onset diabetes, new onset atrial fibrillation.
- **PMH** – HTN, seizures, recurrent DVTs on warfarin
- **Social Hx**: widowed, lives alone in home, Gr. 8 education, manages meds & ADLs independently
- **Meds –** phenobarbital, carbamazepine, telmisartan/HCTZ, warfarin
- **Warfarin history** – on between 7-8 mg/day for > 15 years. Has always had 5mg and 1mg tablets dispensed. INRs pre-admission – consistently stable for years between 2.3-3.0



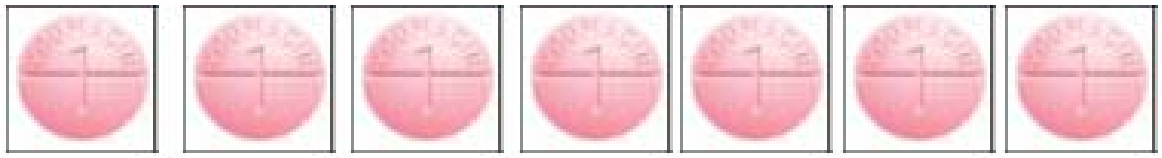
On discharge – delirium clearing and getting close to baseline, I took the home warfarin bottles out of her bag. "Can you please show me how you would take 7mg of warfarin?"



= 27mg

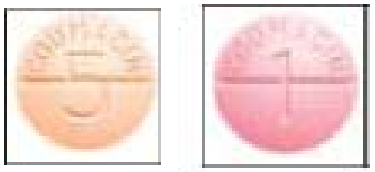
I confirmed with her "Is that 7mg?" → "Yes"

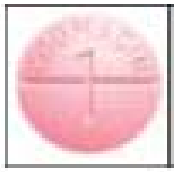
I put the 5mg vial behind my back and again asked her to put 7 mg in her hand using only 1 mg tablets.



= 7mg

Why the confusion?

Taking 7mg using  is MATH

Taking 7mg using  is COUNTING

What would the next admission look like if this hadn't been caught?

In the next admission for hematuria pulmonary hemorrhage, GI bleed and an INR > 10, when we ask her what her warfarin dose is for her BPMH: "I take 7 mg of warfarin every day."

The Patient's Truth

Outcome

Ms. C has been back in her home for 6 months.

She is independent with her ADLs and is managing her medications using warfarin 1 mg tablets

Morals of the story…

1. What we tell the patient is often very different than what their truth ends up being.

2. A medication history or list is simply a hint of what the patient may actually be doing.

Morals of the story…

3. The only hope we have of finding out the patient's truth
   - Talk and listen
   - Dialogue
   - Demonstrate (us and them)
   - Keep sleuthing...

4. The patient's truth is often cause for someone else's admission.

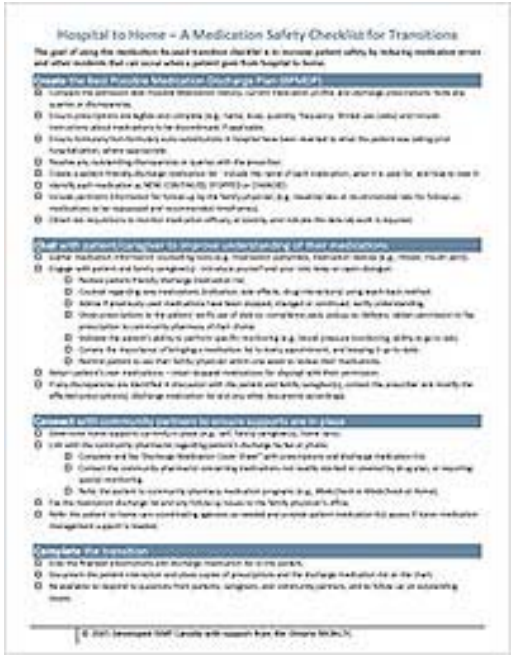
Measuring Your MedRec Process

"If you can't measure it, you can't improve it"

- **Was it done?**
  - Percentage of Patients Reconciled
- **How well was it done?**
  - BPMH > 1 source
  - Actual med use verified with patient/family
  - Each drug includes name, dose, strength, route, frequency
  - Every med is accounted for on orders
  - Prescriber has documented rationale for held or discontinued meds
  - Discrepancies communicated, resolved, documented

Hospital to Home - Facilitating Safe Medications at Transitions

A Toolkit and Checklist for Healthcare Providers

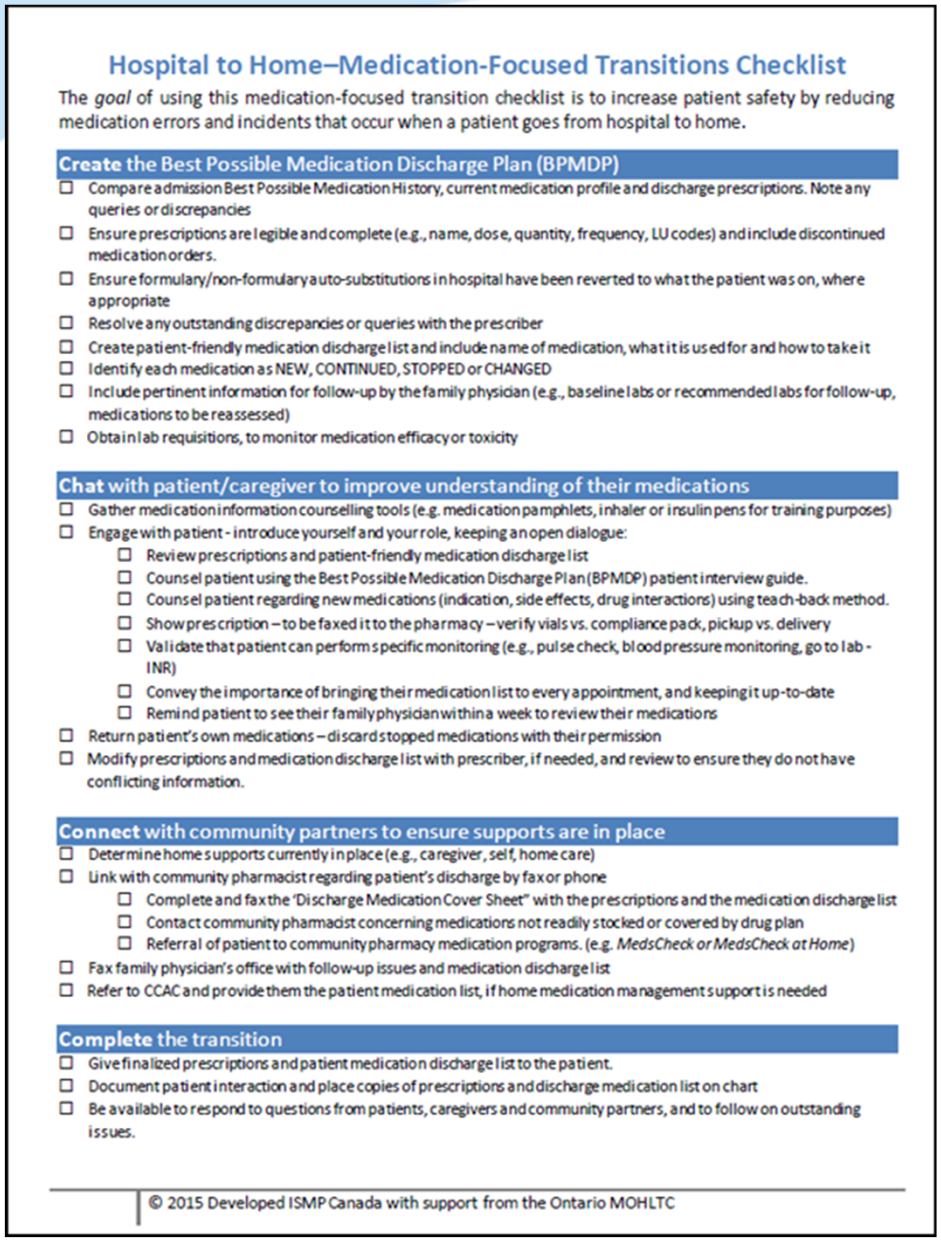

Hospital to Home – A Medication Safety Checklist for Transitions

Rationale for a Medication Focused Transition checklist

- Hospital discharge is a critical interface of care.
- Patients at high risk of fragmented care and adverse events
- Goal of using the checklist is to increase patient safety especially when a patient goes home from hospital.

Contents of the Toolkit

- Patient story
- How this will benefit the patient experience
- Rationale for developing a toolkit and checklist
- Identify your target population
- Define key players- roles and responsibilities
- Home support for medication follow-up
- Pharmacists – a good return on investment
- Change ideas, overcoming barriers



Hospital to Home–Medication-Focused Transitions Checklist

The *goal* of using this medication-focused transition checklist is to increase patient safety by reducing medication errors and incidents that occur when a patient goes from hospital to home.

Create the Best Possible Medication Discharge Plan (BPMDP)

- ☐ Compare admission Best Possible Medication History, current medication profile and discharge prescriptions. Note any queries or discrepancies
- ☐ Ensure prescriptions are legible and complete (e.g., name, dose, quantity, frequency, LU codes) and include discontinued medication orders.
- ☐ Ensure formulary/non-formulary auto-substitutions in hospital have been reverted to what the patient was on, where appropriate
- ☐ Resolve any outstanding discrepancies or queries with the prescriber
- ☐ Create patient-friendly medication discharge list and include name of medication, what it is used for and how to take it
- ☐ Identify each medication as NEW, CONTINUED, STOPPED or CHANGED
- ☐ Include pertinent information for follow-up by the family physician (e.g., baseline labs or recommended labs for follow-up, medications to be reassessed)
- ☐ Obtain lab requisitions, to monitor medication efficacy or toxicity

Chat with patient/caregiver to improve understanding of their medications

- ☐ Gather medication information counselling tools (e.g. medication pamphlets, inhaler or insulin pens for training purposes)
- ☐ Engage with patient - introduce yourself and your role, keeping an open dialogue:
  - ☐ Review prescriptions and patient-friendly medication discharge list
  - ☐ Counsel patient using the Best Possible Medication Discharge Plan (BPMDP) patient interview guide.
  - ☐ Counsel patient regarding new medications (indication, side effects, drug interactions) using teach-back method.
  - ☐ Show prescription – to be faxed it to the pharmacy – verify vials vs. compliance pack, pickup vs. delivery
  - ☐ Validate that patient can perform specific monitoring (e.g., pulse check, blood pressure monitoring, go to lab - INR)
  - ☐ Convey the importance of bringing their medication list to every appointment, and keeping it up-to-date
  - ☐ Remind patient to see their family physician within a week to review their medications
- ☐ Return patient's own medications – discard stopped medications with their permission
- ☐ Modify prescriptions and medication discharge list with prescriber, if needed, and review to ensure they do not have conflicting information.

Connect with community partners to ensure supports are in place

- ☐ Determine home supports currently in place (e.g., caregiver, self, home care)
- ☐ Link with community pharmacist regarding patient's discharge by fax or phone
  - ☐ Complete and fax the 'Discharge Medication Cover Sheet" with the prescriptions and the medication discharge list
  - ☐ Contact community pharmacist concerning medications not readily stocked or covered by drug plan
  - ☐ Referral of patient to community pharmacy medication programs. (e.g. *MedsCheck or MedsCheck at Home*)
- ☐ Fax family physician's office with follow-up issues and medication discharge list
- ☐ Refer to CCAC and provide them the patient medication list, if home medication management support is needed

Complete the transition

- ☐ Give finalized prescriptions and patient medication discharge list to the patient.
- ☐ Document patient interaction and place copies of prescriptions and discharge medication list on chart
- ☐ Be available to respond to questions from patients, caregivers and community partners, and to follow on outstanding issues.

And the Checklist….

Interventions to reduce medication errors when a patient goes from hospital to home

Create the Best Possible Medication Discharge Plan (BPMDP)

- Compare BPMH (home list), current medication profile (MAR) and discharge prescriptions.
- Identify each medication as new, continued, stopped or changed and if possible the reason for the changes.
- Ensure scripts are legible, complete and formulary auto-substitutions reverted where appropriate

Chat with the patient/caregiver

- Gather medication info counselling tools
- Engage patient, keeping open dialogue
  - Review patient friendly medication discharge list and prescriptions (show them)
  - Counsel patient on new medications using teach back method
- Return patient's own meds
- Make changes to scripts/discharge lists as needed.

Connect with community partners

- Determine home supports in place
- Link with community pharmacist via fax or phone (Fax cover letter template)
- Fax follow-up issues and medication discharge list to family physician's office
- Refer to CCAC and provide them with discharge medication info
- Cross-continuum team collaboration

Complete the transition

- Give finalized scripts and discharge medication information to patient/caregiver
- Document patient interaction
- Be available to respond to questions from patients, caregivers, community partners and to follow on outstanding issues

Alignment with Accreditation Canada Required Organizational Practices (ROPs)

- Medication reconciliation as a strategic priority
- Medication reconciliation at care transitions
- Information transfer at care transitions

Ref: Accreditation Canada Required Organizational Practices Handbook 2015; available from: http://www.accreditation.ca/sites/default/files/rop-handbook-2015-en.pdf

MedRec at Care Transitions ROP (acute care version)

TESTS FOR COMPLIANCE

Major	Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented, in partnership with clients, families, caregivers, and others, as appropriate.
Major	The BPMH is used to generate admission medication orders OR the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.
Major	A current medication list is retained in the client record.
Major	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.
Major	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.

2016 ROP Handbook

Partnering with our Patients

National Medication Safety Checklist

5 questions to ask about your medications

Background

- 2014 National Medication Safety Summit
  - Goal: Improving communication about medication among providers and patients and families at transitions of care
  - Action: Create and disseminate a national medication safety checklist for patients and families at transitions in care.

Collaborative Process

- Completed environmental scan
- Working group developed draft checklist
- Feedback obtained from patients, clinicians, advisory panel and external stakeholder groups
  - Electronic survey
  - Email
- Checklist revised based on feedback received

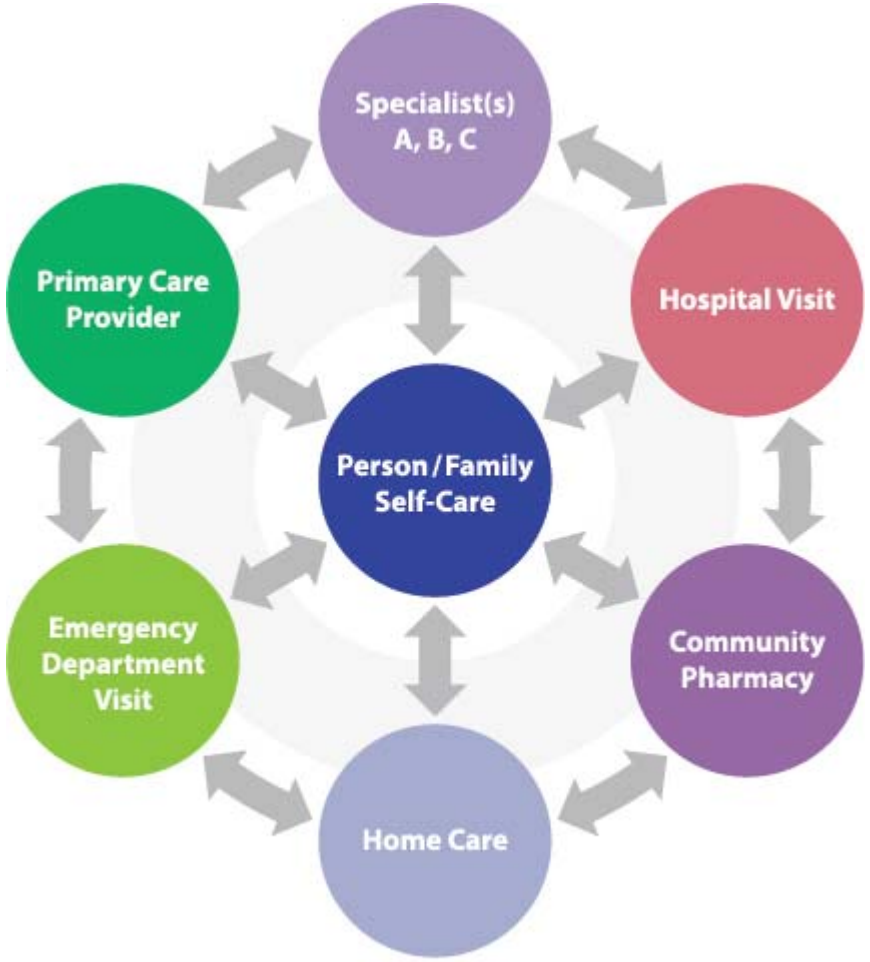
- Available in EN & FR
- Media campaign planned for March 9th, 2016

It's about starting a conversation

- "...initiates 2 way communication and encourages everyone to be more involved with their personal health care – take more accountability and responsibility"

How can it be used

- Patients
  - Before they leave the hospital
  - Bring it to every appointment
- Healthcare providers
  - Guide their discussion



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

Communication and Dissemination Plan

- National webinar
- Social media e.g. MedRec Facebook page, Twitter
- Disseminate to key stakeholder organizations
- Post on websites (www.safemedicationuse.ca)
- Safe Medication Use bulletin
- Word of mouth
- Media Launch March 9th,2016

Medication Safety Resources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A Key Partner in the Canadian Medication Incident Reporting and Prevention System (CMIRPS)
Advancing safe medication use
The Institute for Safe Medication Practices Canada is an independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings. ISMP Canada works collaboratively with the healthcare community, regulatory agencies and policy makers, provincial, national and international patient safety organizations, the pharmaceutical industry and the public to promote safe medication practices. ISMP Canada's mandate includes analyzing medication incidents, making recommendations for the prevention of harmful medication incidents, and facilitating quality improvement initiatives.
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Opioid Stewardship
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Upcoming ISMP Canada Events
Workshops
Wednesday, June 10, 2015
Resolving Drug-Drug Interactions: A Guide for Community Pharmacies to Reduce Potential Hospitalizations - Toronto, ON - All Sessions are FULL
June 11-12, 2015
Medication Safety for Pharmacy Practice: Incident Analysis and Prospective Risk Assessment - Toronto, ON

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Medication Reconciliation (MedRec)

SHARE

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Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medicati information is communicated consistently across transitions of care. Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taki (known as a BPMH) to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enabl prescribers to make the most appropriate prescribing decisions for the patient.

> *"[Medication Reconciliation] is definitely the right thing to do. We have certainly caught errors that could have caused harm to patients, which helps staff and physicians better understand the importance of MedRec."*
>
> *Winnipeg Regional Health Authority, MB*

A **Best Possible Medication History (BPMH)** is a history created using 1) a systematic process of interviewing the patient/family; and 2) a review of at least one other reliable sourc information to obtain and verify all of a patient's medication use (prescribed and non-prescribed). Complete documentation includes drug name, dosage, route and frequency. The BPM more comprehensive than a routine primary medication history which is often a quick preliminary medication history which may not include multiple sources of information.

The BPMH is a 'snapshot' of the patient's actual medication use, which may be different from what is contained in their records. This is why the patient involvement is vital.

ISMP Canada supports Medication Reconciliation provincially, nationally and internationally

ISMP Canada created Getting Started Kits for Medication Reconciliation in Acute Care, Long Term Care, Home Care for the Canadian *Safer Healthcare Now!* campaign and for the World Health Organization High 5's initiative and provides ongoing support to teams around the world.

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To Keep Up-to-Date with the Latest News on Medication Safety

Follow Us:

@SafeMedUse **@CanMedRec**

MedRec Ontario Network

- **Join the conversation!**
- **MedRec Ontario Network** a pan-Ontario network for community healthcare providers
- A discussion forum for sharing information, questions and resources about medication reconciliation in the community
- Email medrec@ismp-canada.org to join
- Supported by Health Quality Ontario

SafeMedicationUse.ca

SUPPORTED BY HEALTH CANADA

Help Prevent Harmful Medication Incidents

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

Preventing harm from medication incidents is a responsibility of health professionals. **Consumers like you** can also play a vital role.

Reporting Medication Incidents benefits all Canadians.

REPORT NOW

Tell Us How We're Doing:

TAKE THE SURVEY

Latest News and Resources

- Similar Patient Names Leads to Pregnant Woman Getting Wrong Prescription
- Safe Practices for Medication Use (Take Charge of Your Medicines!)
- "Take as Directed: Your Prescription for Safe Health Care in Canada" is now available in Canadian bookstores!
  "The authors provide helpful information that can guide Canadians on how to manage their health care, including safe medication use" says Sylvia Hyland, Vice President and Chief Operating Officer of ISMP Canada.
- Health Canada is reminding Canadians about using acetaminophen safely.
  - Read Health Canada's Information Update on Acetaminophen
  - Read the SafeMedicationUse article "Spotlight on Acetaminophen"
- Angeliq Drug Samples Mistakenly Provided as Birth Control - Newsletter - PDF
- Working with Consumers and Patients to Prevent Medication Incidents: Early Learning from ISMP Canada's Consumer Reporting and Learning Program, *www.SafeMedicationUse.ca* - Webinar - February 23, 2011
- Epinephrine Auto-Injectors - Know How to Use EpiPen and Twinject Properly

Medications: More Than Just Pills

Prescription Medicines

These include anything you can only obtain with a doctor's order such as heart pills, inhalers, sleeping pills.

Over-The-Counter Medicines

These include non-prescription items that can be purchased at a pharmacy without an order from the doctor such as aspirin, acetaminophen, laxatives, other bowel care products, **herbs** like garlic and Echinacea or **vitamins** and **minerals** like calcium, B12 or iron.

DON'T FORGET THESE TYPES OF MEDICATIONS

Eye/Ear Drops

Inhalers

Nasal Spray

Patches

Liquids

Injections

Ointments/Cream

Prompt the patient to include medicines they take **every day** and also ones taken **sometimes** such as for a cold, stomachache or headache.

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ismp CANADA

Adapted from Vancouver Island Health Authority

www.SaferHealthcareNow.ca

Best Possible Medication History Interview Guide

safer healthcare now!

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Prevent Adverse Drug Events through Medication Reconciliation

www.SaferHealthcareNow.ca

Introduction

- Introduce self and profession.
- I would like to take some time to review the medications you take at home.
- I have a list of medications from your chart/file and want to make sure it is accurate and up to date.
- Would it be possible to discuss your medications with you (or a family member) at this time?
  - Is this a convenient time for you? Do you have a family member who knows your medications that you think should join us? How can we contact them?

Medication Allergies

- Are you allergic to any medications? If yes, what happens when you take (allergy medication name)?

Information Gathering

- Do you have your medication list or pill bottles (vials) with you?
- *Use show and tell technique when they have brought the medication vials with them*
  - How do you take (medication name)?
  - How often or When do you take (medication name)?
- *Collect information about dose, route and frequency for each drug. If the patient is taking a medication differently than prescribed, record what the patient is actually taking and note the discrepancy.*
- Are there any prescription medications you (or your physician) have recently stopped or changed?
- What was the reason for this change?

Community Pharmacy

- What is the name and location of the pharmacy you normally go to? *(Anticipate more than one).*
  - May we call your pharmacy to clarify your medications if needed?

Over the Counter (OTC) Medications

- Do you take any medications that you buy without a doctor's prescription? *(Give examples, i.e., Aspirin)*. If yes, how do you take (OTC medication name)?

Vitamins/Minerals/Supplements

- Do you take any vitamins (e.g. multivitamin)? If yes, how do you take (vitamins name(s))?
- Do you take any minerals (e.g. calcium, iron)? If yes, how do you take (minerals name(s))?
- Do you use any supplements (e.g. glucosamine, St. John's Wort)? If yes, how do you take (supplements name(s))?

Eye/Ear/Nose Drops

- Do you use any eye drops? If yes, what are the names? How many drops do you use? How often? In which eye?
- Do you use ear drops? If yes, what are the names? How many drops do you use? How often? In which ear?
- Do you use nose drops/nose sprays? If yes, what are the names? How do you use them? How often?

Inhalers/Patches/Creams/Ointments/Injectables/Samples

- Do you use inhalers?, medicated patches?, medicated creams or ointments?, injectable medications (e.g. insulin)? For each, if yes, how do you take (medication name)? *Include name, strength, how often.*
- Did your doctor give you any medication samples to try in the last few months? If yes, what are the names?

Antibiotics

- Have you used any antibiotics in the past 3 months? If so, what are they?

Closing

This concludes our interview. Thank you for your time. Do you have any questions?

If you remember anything after our discussion please contact me to update the information.

Note: Medical and Social History, if not specifically described in the chart/file, may need to be clarified with patient.

Adapted from University Health Network

Excellent Resources

- STAAR - IHI - How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Re-hospitalizations

  http://www.ihi.org/resources/pages/tools/howtoguideimprovingtransitionstoreduceavoidablerehospitalizations.asp

- Project RED "Project RED (Re-Engineered Discharge)" – (Boston University) http://www.bu.edu/fammed/projectred/
- "Project BOOST" (Society of Hospital Medicine) – Dr. Jeffrey Schnipper http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=27659

Quality at St. Michael's: Medication Reconciliation

https://www.youtube.com/watch?v=LnOecYXw_UE

It's our job to ensure we know as much as possible about the medications our patients are taking – how many, how much and how often.

Learn how St. Michael's is improving the process that best tracks this information.

“It made a difference to that one”

Starfish story:
http://www.esc16.net/users/0020/FACES/Starfish%20Story.pdf

DISCUSSION/QUESTIONS

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