Welcome to the Medication Safety Community of Practice Webinar Series

Hosted by ISMP Canada

February, 2012

An Update from Accreditation Canada on Medication Reconciliation in Long-Term Care

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Medication Safety CoP Aim

- To improve Medication Safety within Long Term Care homes. It is a collaboration of three organizations HQO, QHN and ISMP Canada with support from SHRTN

Medication Safety CoP Team

- Doris Doidge, RN, MN, CoP Co-Lead
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  - QI Coach, Residents First
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  - Institute for Safe Medication Practices (ISMP) Canada
- Terry Kirkpatrick, B.A., R.L.C., M.Ed.
  - Knowledge Broker, SHRTN
- James Medd
  - Information Specialist, SHRTN
- Core Working Group

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For More Information & Upcoming Webinars, Go to:

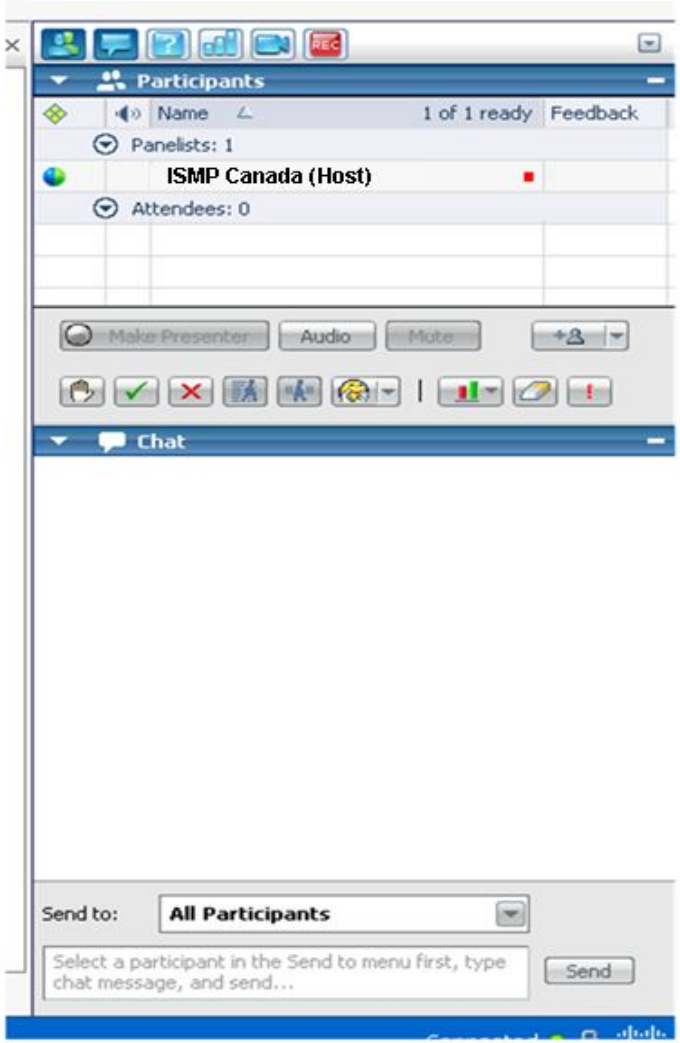
- WWW.SHRTN.ON.CA

Housekeeping

- Please make sure that you joined the call correctly. See the screen for information or your email that was sent to you with your connection information.
- You will be on Mute right now but we will open the lines later for questions so it's important that you joined the call correctly..
- There is a Chat box function that you can use.
- Hand raise.

Questions

1. Raise your hand. If you have a phone icon by your name we will un-mute your phone and you can ask your question



2. Type your question in the chat box

3. Email your question to webinars@ismp-canada.org

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An Update from Accreditation Canada on Medication Reconciliation in Long-Term Care

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Presenter

- Gregory Kennedy, MSc
  - Health Services Research Specialist
  - Accreditation Canada

Objectives

- to provide a detailed update on expectations for medication reconciliation in the Qmentum accreditation program, and
- to review recent improvements to the Medication Reconciliation at Transfer or Discharge ROP for long–term care

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An Update on Medication Reconciliation in Qmentum for Long-Term Care

Greg Kennedy

ISMP/HQO/QHN Webinar

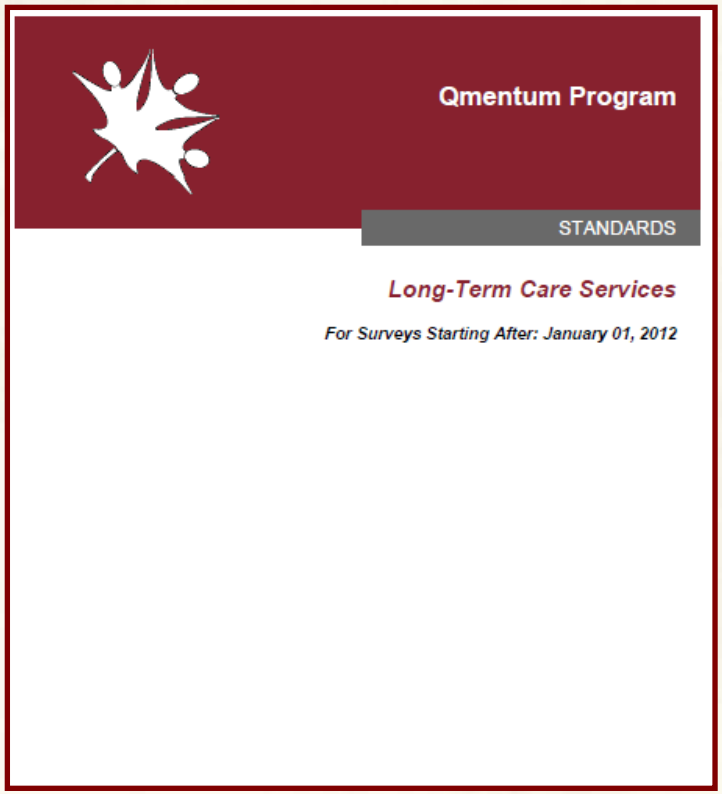
February 16, 2012

Overview

- Long-Term Care Services standards
- Medication reconciliation in Qmentum
- Expectations and program updates
  - Med rec at admission
  - Med rec at transfer or discharge
- During the On-Site Survey
- Questions

Long-Term Care Services

- Minor revisions released February 1st:
  - Enhancements to Guidelines
  - Simplified language
  - Deletions of n/a criteria and those lacking measurability
  - ★No new requirements



Crosswalk

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LONG TERM CARE SERVICES STANDARDS (APPLICABLE TO SURVEYS UNTIL THE END OF JANUARY 2012)	LONG-TERM CARE SERVICES STANDARDS (APPLICABLE TO SURVEYS BEGINNING IN FEBRUARY 2012)
1.1 The team collects information about its clients and the community. Guidelines: Information includes the types of clients served by the organization, their service needs, and trends that could have an impact on the community and its health service needs. Service needs are influenced by health status, capacities, risks, and determinants of health, such as lifestyle, education, and housing. Information can come from internal and external sources such as the Canadian Institute for Health Information (CIHI), census data, end of service planning reports, wait list data, client committees, and community needs assessments.	1.1 The organization collects information about its residents and the community. Guidelines: Information includes the types of residents served by the organization, their service needs, and trends that could have an impact on the community and its health service needs. Service needs are influenced by health status, capacities, risks, and determinants of health, such as lifestyle, education, and housing. Information can come from internal and external sources such as the Canadian Institute for Health Information (CIHI), census data, end-of-service planning reports, wait list data, resident committees, and community needs assessments.
1.2 The team uses the information it collects about clients and the community to define the scope of its services and set priorities when multiple service needs are identified. Guidelines: When defining the scope of its services, the team considers the resources that are currently available in the community and those that are still needed.	1.2 The organization uses the information it collects about residents and the community to identify appropriate service offerings and set priorities when multiple service needs are identified. Guidelines: When defining the scope of its services, the team considers the resources that are currently available in the community and those that are still needed.

REQUIRED ORGANIZATIONAL PRACTICES

Our objective of guiding our clients toward safe and quality health care is strengthened by the Required Organizational Practices.

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 as an organizational priority
- Medication reconciliation at admission
- Medication reconciliation at transfer or discharge
- Safe surgery checklist
- Two client identifiers
- Verification processes for high-risk activities

MEDICATION USE

- Antimicrobial stewardship ★
- Concentrated electrolytes
- Heparin safety
- Infusion pumps training
- Medication concentrations
- 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

★ **New in 2013**

♦ **New in 2013 for select acute care standard sets**

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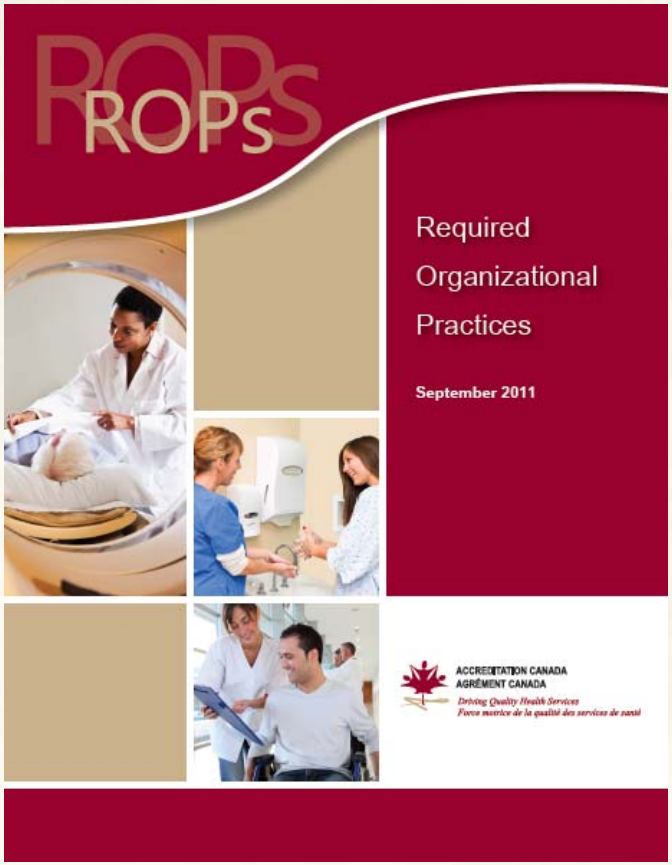
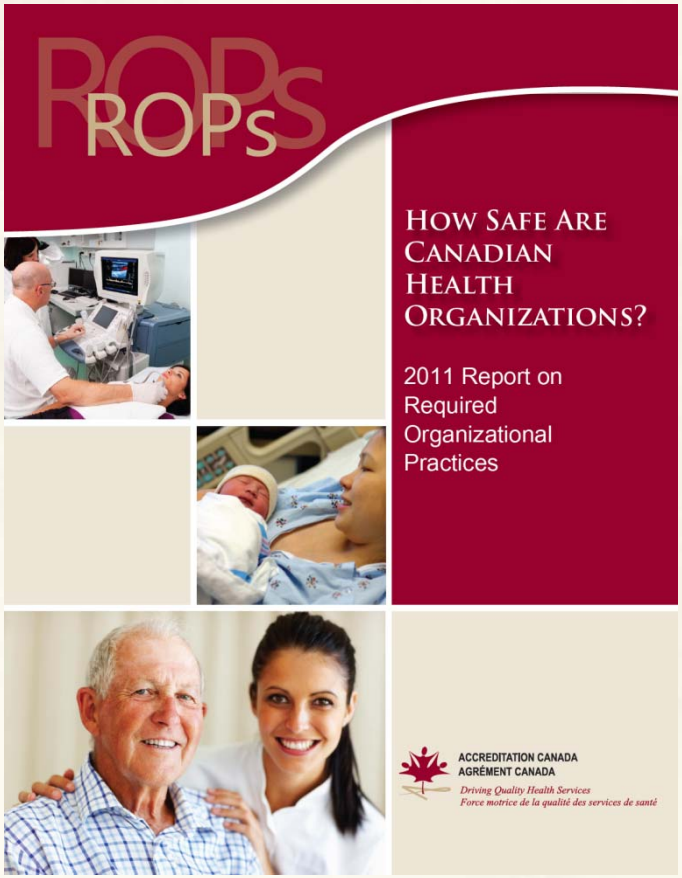
ROP Resources

- New ROP Handbook coming soon: www.accreditation.ca
  - Full listing of ROPs, including updated reference sections



2011 Report on ROPs

- Released during Patient Safety Week 2011: www.accreditation.ca



Med Rec in Qmentum

- An organization-wide approach to medication reconciliation
  - Leadership standards
    - ROP highlights expectations
  - Service standards
    - ROPs focus on having a formal process in place

Med Rec as an Organizational Priority

- Med rec is implemented in one client service area at admission.
- Med rec is implemented in one client service area at transfer or discharge.
- There is a documented plan to implement med rec throughout the organization.
- The plan includes locations and timelines for implementing med rec.

National Compliance – All Sectors

Table 2 – ROPs with national compliance rates of less than 75%

ROP	Patient Safety Goal Area	Compliance Rate (%)		
		2008	2009	2010
Evaluates compliance with hand-hygiene practices	Infection Control	n/a	72	73
Implements a falls prevention strategy	Risk Assessment	42	70	69
Identifies abbreviations, symbols, and dose designations that are not to be used	Communication	n/a	66	67
Develops and implements a plan for medication reconciliation throughout the organization*	Communication	n/a	n/a	61
Conducts medication reconciliation at admission	Communication	32	46	47
Conducts medication reconciliation at transfer	Communication	38	44	36

*The 2010 compliance rate for this ROP is based on the 103 organizations that had an on-site survey since September 2010.

n/a = ROP had not yet been introduced

Most notable improvements since 2008

National Compliance – Long-Term Care

ROP	Patient Safety Goal Area	Compliance Rate (%) 2010
Conducts medication reconciliation at admission	Communication	64%
Conducts medication reconciliation at transfer or discharge	Communication	57%

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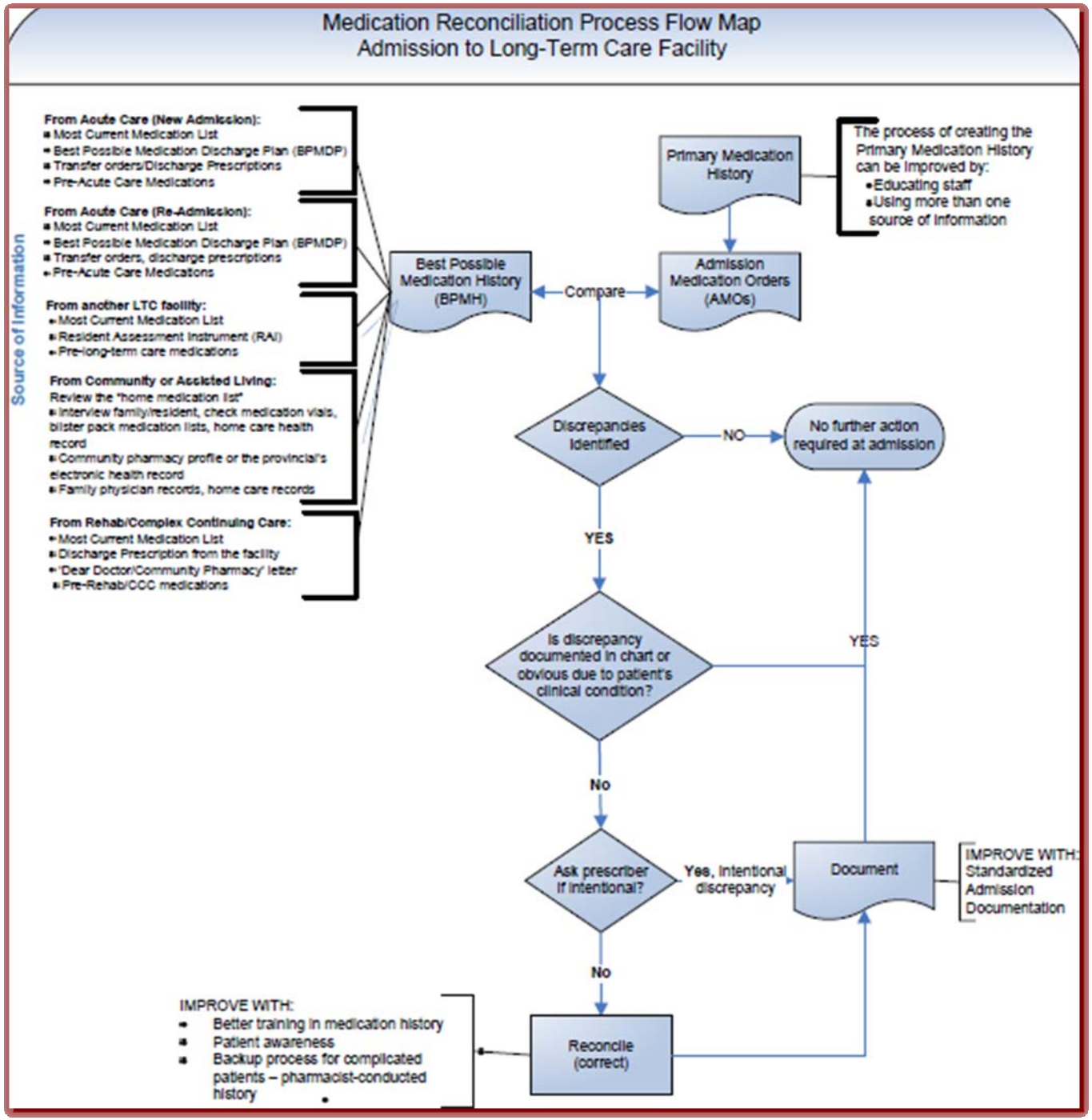
Medication Reconciliation at Admission

Med Rec at Admission

- ROP: The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.

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.


Medication Reconciliation Process Flow Map
Admission to Long-Term Care Facility
Source of Information
From Acute Care (New Admission):
Most Current Medication List
Best Possible Medication Discharge Plan (BPMDP)
Transfer orders/Discharge Prescriptions
Pre-Acute Care Medications
From Acute Care (Re-Admission):
Most Current Medication List
Best Possible Medication Discharge Plan (BPMDP)
Transfer orders, discharge prescriptions
Pre-Acute Care Medications
From another LTC facility:
Most Current Medication List
Resident Assessment Instrument (RAI)
Pre-long-term care medications
From Community or Assisted Living:
Review the "home medication list"
Interview family/resident, check medication vials, blister pack medication lists, home care health record
Community pharmacy profile or the provincial's electronic health record
Family physician records, home care records
From Rehab/Complex Continuing Care:
Most Current Medication List
Discharge Prescription from the facility
'Dear Doctor/Community Pharmacy' letter
Pre-Rehab/CCC medications
Best Possible Medication History (BPMH)
Compare
Primary Medication History
The process of creating the Primary Medication History can be improved by:
Educating staff
Using more than one source of information
Admission Medication Orders (AMOs)
Discrepancies Identified
NO
No further action required at admission
YES
Is discrepancy documented in chart or obvious due to patient's clinical condition?
YES
No
Ask prescriber if intentional?
Yes, intentional discrepancy
Document
IMPROVE WITH:
Standardized Admission Documentation
No
IMPROVE WITH:
Better training in medication history
Patient awareness
Backup process for compilcated patients – pharmacist-conducted history
Reconcile (correct)

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Medication Reconciliation at Transfer or Discharge

Med Rec at Transfer or Discharge

- In September 2011, revisions were made to:
  - Introduced sector specific versions (Acute, LTC)
  - Update language – e.g., Best Possible Medication Discharge Plan
  - Improve definitions for transition points – internal transfer, external transfer / discharge
  - Better reflect the proper process incorporating progress from the field

Med Rec at Transfer or Discharge

- ROP: The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).

Internal Transfer

- An interface of care within a facility where medication orders are changed or rewritten.
- Internal transfers where medication reconciliation should occur include:
  1) A change in responsible medical service
  2) A change in level of care
  3) And/or transfer between units when one of the previous two conditions is present.

Discharge

- A critical interface of care where clients are at risk of medication discrepancies as they transition out of a facility.
- Discharge includes external transfers to another service environment or community-based service provider, or the end of service.
  - E.g. long-term care to acute care; long-term care to self-care; and between long-term care facilities.

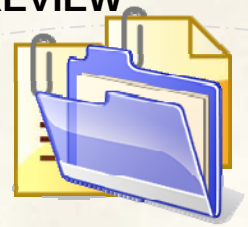
Tests for Compliance

- There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).
- The team makes a timely comparison of the up-to-date, complete medication list, and new medication orders or recent changes.
- The team documents that the up-to-date, complete medication list and new medication orders or recent changes have been reconciled; and appropriate modifications to medications have been made where necessary.
- Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), **or**, the up-to-date medication list is communicated to the next provider of care (discharge).
- The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.

Transfer and Discharge

During the On-Site Survey

REVIEW



TALK and LISTEN

OBSERVE

RECORD

Next Steps

- Long-Term Care Services in Qmentum
  - Strategic committee formed to assess how program components can be enhanced to better meet client's needs
- Med Rec in Qmentum
  - Ongoing consultation with national partners to determine med rec requirements moving forward

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Thank you!

Questions

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Wednesday, March 21, 2012	Psychotropic Medications	Carlos Rojas-Fernandes, BSc Pharm, Pharm D

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We encourage you to report medication incidents

Reporting and Prevention Systems
Medication Incident and Near Miss Reporting Programs

Practitioners

Healthcare Professional - (e.g., nurse, pharmacist, physician)

General Public

Preventing harm from medication incidents is not just a responsibility for health professionals - **consumers like you** can also play a vital role.

CPhIR - Community Pharmacy Incident Reporting Program

For participating community pharmacies.

Analyze-Err®

For participating healthcare facilities.

Evaluation of Webinar

- An Evaluation link will be sent to you
- Please complete

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Thank You