



safer healthcare  
*now!*

The SHN-CAPHC Paediatric  
Medication Reconciliation Orientation  
and Training Workshop

Four Points Sheraton  
August 9-10, 2005  
Mississauga, Ontario

*Final Workshop Proceedings Paper*



## *Executive Summary*

Every year thousands of Canadian children will suffer unintentional complications and adverse events from medication errors. A number of children and youth will tragically lose their lives.

Safer Health Care Now! under the auspices of the Canadian Patient Safety Institute, is an ambitious Pan-Canadian campaign to implement six evidence-based patient care interventions aimed at reducing unintentional adverse events. This quality improvement initiative is part of a major international effort that builds upon the work of the Institute of Healthcare Improvement's (IHI) "100,000 Lives Campaign" in the United States.

Medication reconciliation in paediatric services presents special challenges. Most paediatric patients are too young to provide accurate reports of the medications they are using; for youth there are issues related to privacy and consent and for new Canadians, language barriers often prevent parents from assuming this role. These unique circumstances call upon the special knowledge and experience of the paediatric health care community to collectively lead the way.

The Canadian Association of Paediatric Health Centres (CAPHC) Medication Reconciliation Collaborative is a Safer Health Care Now! partner whose mission is to reduce medication errors through a national medication reconciliation strategy. The Collaborative represents over 25 Canadian health centres, including all children's hospitals in Canada and many more health care centres that provide services to children and youth.

Medication reconciliation, one of the six Safer Health Care Now! Campaign patient safety interventions, is used to prevent medication errors at all points of transitions of care. Medication reconciliation involves clearly and accurately documenting patient medication usage and reconciling discrepancies.

Its ultimate goal is to reduce adverse drug events (ADE's). Research has shown that 70% of medication errors can be eliminated when medication reconciliation is implemented.

On August 9-10, 2005, over seventy interdisciplinary child and youth health professionals from across Canada participated in CAPHC's Paediatric Medication Reconciliation Orientation and Training Workshop. Building upon the work and leadership of Canada's Institute of Safe Medication Practices (ISMP) in this area, this interdisciplinary national paediatric team came to consensus on the following timelines, strategies and procedures for the four stages of the Campaign:

1. **September to October 2005:** Getting started and launching a successful campaign within your Site; developing teams and engaging key stakeholders.
2. **November to December 2005:** Collecting baseline data; establishing the groundwork for monitoring and evaluating outcome.
3. **January to March 2006:** Implementing the pilot phase; understanding how processes can be changed to ensure successful implementation and integration.

4. **April to October 2006:** Implementing medication reconciliation as a regular quality improvement practice and evaluating the results.

At the close of the workshop, Elaine Orrbine, CEO of CAPHC, congratulated the group on their collective wisdom and collaboration in setting the stage for a national paediatric medication reconciliation strategy. Elaine reiterated that everyone, CEO's, senior administrators, managers and all front-line healthcare professionals have an important leadership role to play as part of this national paediatric team.

CAPHC is strongly committed to provide leadership and support to all participating healthcare organizations. Teams within each health care centre will not be working alone. All teams will be able to draw from each other's expertise and will have ongoing support from both CAPHC's Paediatric Medication Reconciliation National Coordinator, JoAnne Whittingham, and the National Safer Health Care Now! Campaign's communication, education and evaluation resource teams.

As the first Canadian paediatric community of practice to launch a national medication reconciliation quality improvement initiative, our Canadian paediatric community is breaking new ground and leading the way! The success of this Campaign will depend upon the commitment and collaboration of each of our participating organizations.

CAPHC would like to express its sincerest gratitude to all workshop participants and extend our sincerest appreciation to all the senior management teams at our participating organizations.

My sincerest appreciation to all!



Elaine Orrbine  
Chief Executive Officer  
Canadian Association of Paediatric Health Centres (CAPHC) [www.caphc.org](http://www.caphc.org)  
Association Canadienne Des Centres De Santé Pédiatriques (ACCSP)

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## ***Presentations***

### **Overview of CAPHC; The commitment to a national patient safety agenda**

*Elaine Orrbine, Chief Executive Officer, Canadian Association of Paediatric Health Centres (CAPHC)*

Elaine briefly described the Canadian Association of Paediatric Health Centres (CAPHC) and how this national network of paediatric health centres is well positioned to provide an established mechanism and support network to work as a partner of the Safer Healthcare Now! Campaign. CAPHC is committed to provide co-ordination and facilitation for this national paediatric implementation strategy focused on “Preventing Adverse Drug Events”. The unique and significant challenges presented by working within the paediatric population were described. The overview and timelines of the implementation strategy were outlined.

### **Snapshot of the CAPHC National Patient Safety Survey**

*Anne Matlow, Director, Infection Prevention & Control Program, The Hospital for Sick Children*

Anne described the purpose, methodology and results of the National Patient Safety Survey that was conducted by CAPHC in 2004. The purpose of this survey was to identify current patient safety practices at paediatric health centres and organizations across Canada. The questions included in the survey were divided into 8 categories and served to identify current practices and access to resources. 28 of 30 eligible CAPHC member centres participated and analysis of the data identified national patient safety priorities for the paediatric population. Highlights of the findings were:

- 64.3 % of the centres have established mechanisms for patients and families to report near misses but only 44.4% of the centres have established strategies in place to eliminate phrases in medication orders and prescriptions that could be misinterpreted
- Unanticipated medication errors were identified by a majority of centres (78.6%) as being a key area of concern.
- 92.9% of the participating centres indicated that there was a need for more national initiatives to improve paediatric health care safety.

These data are being used by CAPHC to establish future directions and research priorities in patient safety.

### **Introduction to the Institute for Healthcare Improvement (IHI) and the Saving 100,000 Lives Campaign**

*Jordan Bohnen, Institute for Health Care Improvement*

Jordan’s presentation served as an overview of the Saving 100,000 Lives Campaign in the United States that has provided the impetus to and support for the Canadian Safer Healthcare Now! Campaign. The IHI is a national healthcare quality improvement think-tank, led by Dr. Donald Berwick, which is dedicated to improving the quality of healthcare systems both in the United States and around the world. Research reveals the serious problems in providing safe healthcare that leads to up to 98,000 deaths annually in the United States. The basis of the IHI campaign is that the solutions to this problem lie with instituting broad-based system changes. The goal of the campaign is to build a national infrastructure for change that will see 1,600 hospitals enrolled in the campaign with the goal of saving 100,000 lives. The campaign structure, principles, reporting mechanisms and goals including the six evidence-based interventions that are part of the campaign were described.

## **Introduction to the Safer Healthcare Now! Campaign**

*Carolyn Hoffman, Director of Operations (ON to BC), Canadian Patient Safety Institute*

Carolyn described the Canadian Safer Healthcare Now! Campaign, a national grassroots patient safety initiative aimed at reducing preventable complications and deaths in Canadian hospitals. The campaign is patterned after and supported by the IHI 100,000 lives campaign with six, targeted, evidence-based interventions aimed at improving patient care. The six interventions and the structure of the campaign were described. The SHN campaign is targeted to wrap up the campaign by the end of 2006. The essence of the campaign is based on collaboration, sharing and support between the campaign leaders, the partner organizations providing support and the participating organizations. A total of 102 health care delivery organizations are enrolled to date with 238 teams working on one of the six targeted interventions. Carolyn wished all the teams great success in attaining their improvement objectives.

## **Keynote Address**

### **Medication Reconciliation: Making a Difference in the Safety of Children**

*Julie Morath, CEO of the Children's Hospitals and Clinics in Minneapolis/St. Paul*

Julie gave an inspirational address on creating a culture of paediatric patient safety with the vision of being the safest healthcare system in the world and then becoming even safer! She described the exponential growth in medicine that has resulted in effective treatments but potentially dangerous systems; systems that are too complex for well trained and well intentioned people to provide safe care and where "harm" has become a significant but not a well understood variable, especially in the paediatric population. In the USA 70,000 children are harmed each year in health care with neonates and adolescents are at the highest risk. Medication use is the most prevalent cause. Julie stressed that initiatives to implement system change are a call to action to move forward and implement best practices for patient safety. The audience was encouraged to focus on transfers and transitions of care, to identify the gaps that create communication breakdowns and to build a bridge to create a safety net by instituting effective and critical communication protocols. Medication Reconciliation is currently the weakest link, the biggest challenge and the largest opportunity to make healthcare safer.

### **Introduction to the Institute of Safe Medication Practices (ISMP) and the Canadian Medication Reconciliation Getting Started Kit**

*Margaret Colquhoun, Project Leader, ISMP Canada*

In this final presentation before the breakout sessions Margaret described ISMP Canada and the Canadian Getting Started Kit. The mission of ISMP Canada is the safe use of medication through improvement in drug distribution and delivery system design and provision of education about adverse drug events and their prevention. This is done, in collaboration with many organizations, through voluntary incident reporting, analysis and recommendation of prevention strategies, newsletter publication and various other educational and support programs. ISMP, in partnership with the Canadian Patient Safety Institute, has taken the lead in creating the Canadian version of the Medication Reconciliation Getting Started Kit. Margaret described the evolution and creation of the Kit and the contents. The definition of and the case for medication reconciliation as well as the potential impact were highlighted. Margaret then gave a brief overview of the conceptual framework, the definitions and the process of medication reconciliation and explained the differences between the IHI and the Canadian SHN Campaign Getting Started Kits.

## Workshop Objectives and Processes

Susan Pisterman, the workshop facilitator, gave an overview of the goals and objectives of the workshop and the SHN-CAPHC Paediatric Medication Reconciliation Collaborative campaign. It was pointed out the participants will be breaking new ground in their respective organizations and will serve as leaders and champions in helping people to save lives. Over the two days of the workshop the goals were to:

- Gather in break-out session groups to work through the Getting Started Kit (GSK) and determine what needs to be done to implement Medication Reconciliation.
- Four concurrent groups will address the topics of each session with the assistance of the session leaders and report back to the assembled group in the plenary sessions.
- Susan stressed that modifying the GSK was not the goal but rather the purpose is to decide on the implementation strategy and determine how this strategy will work in different paediatric settings.

## Getting Started; Leadership and Teamwork

After the first breakout session on Day 1, the session leaders reported and a number of issues were discussed with respect to facilitating the first steps in the implementation of paediatric medication reconciliation. The session groups made a number of suggestions for launching the implementation of medication reconciliation at all participating centres.

- Strategies to support the participation at all centres, on an interdisciplinary level, were suggested including identifying champions, keeping the process simple, explaining what benefits the project will have and the consequences of non-compliance.
  - It was noted that both senior executive and management as well as front-line people will need to be engaged.
  - The contribution of senior management was recognized as essential to the success of the implementation of paediatric medication reconciliation.
  - Some of the participants noted that their organizations had not yet finalized who the site leader of the initiative will be and acknowledged the importance of establishing this leadership to continue the momentum and build on the enthusiasm of the workshop.
  - Participants stressed the need for support and strategies to engage senior management support within their organizations.
- *CAPHC will develop an executive summary that will capture the key concepts of the SHN! Campaign, specifically Medication Reconciliation, including a clear picture of what medication reconciliation is all about and what needs to be done, emphasizing the improvement in patient care and the CCHSA mandate for accreditation.*
- *CAPHC will send a thank you letter to each organization's CEO with thanks for sending the participant to the workshop, explaining the project, and itemizing what CAPHC can do to help.*
- It was noted that, while the basic framework of implementing medication reconciliation will be the same for each organization, there was room for flexibility and customizing the basic framework to adapt to the needs of each organization.
  - It was also noted that it would be very useful if there was an opportunity to attend another training session, e.g. for anyone who would be joining the team who was not at this workshop
- *CAPHC will keep all centres and workshop participants informed with respect to upcoming workshops*

The make-up of the team that will be responsible for implementing the project within each participating centre was discussed and a number of suggestions were made.

- That the teams include all stakeholders including front line staff and senior management.
  - That continuity in the team make-up including senior management contacts will be important.
  - That families should be involved from the beginning, e.g. from family-centered care committees, including parents as well as a child, e.g. an adolescent.
  - That teams could also include members from the following areas;
    - Decision support or health information analysts
    - Data collection experts
    - Finance/budget specialists
    - Community relation teams
    - Quality improvement teams
  - The suggestion was also made that community pharmacists could also be involved in this project.
  - It was suggested that the size of the team would depend on the size of the organization.
    - Teams will include a core group and specific team members can be added depending on the organization.
    - Larger organizations could have a steering committee and a working group at the grassroots level, while smaller organizations may have only one group responsible for planning and implementation.
- *Each organization will form their team based on the criteria discussed and the suggestions in the Getting Started Kit.*

Issues with respect to competing priorities and financial constraints were discussed. It was noted that challenges including limited resources and possible additional cuts may make it difficult to maintain focus on this project. Strategies to maintain enthusiasm and commitment were suggested including the creation of a strong consistent communication plan to market the project in a way that will give it the attention and support that it needs.

- It was noted that, while details of how each centre will handle communication will differ, the communication plan used in all organizations will need to have a consistent message, as well as consistent tools available.
  - It was suggested that the communication plan should include a clear picture of what needs to be done
  - Multiple strategies were suggested including a common presentation, posters, newsletters, one page summaries and a list of FAQ's.
  - It was suggested that the creation of a common presentation, particularly including parts of Julie Morath's presentation, would be very useful to make presentations to senior management.
  - Tools such as newsletters would have all the appropriate logos with a spot for each organization to put their own logo.
- *CAPHC will provide the template for the communication plan including a common presentation as well as other tools and links to the SHN and CPSI communication plans to insure consistency.*

Other suggestions were discussed for maintaining focus and enthusiasm for the project

- That resources available at each site, that will allow success, are clearly quantified.
- That access to real time data and updated run charts be maintained.
- That teams have a small group to do the initial work of planning the process so that a majority of the work is done up front.

- That time savings be documented.
- That organizations ensure that there are no disincentives for people to come forward with concerns or information on adverse events/incidents.
- It was noted that teams should expect to have success and share success stories as publicly as possible with team members involved in presentations.
- That team members are recognized and rewarded; suggestions for rewards are included in the procedure manual.

## **Baseline and Pilot Data Collection**

The reports back from the second breakout session on Day 1 (Collecting Baseline Data) indicated that there were many questions and concerns about definitions underlying the data collection, data collection methods, which forms to use and data submission, including concerns with respect to privacy issues. There was much discussion on the various issues including data submission, sample selection, sample size (number of charts to review), the time frame for the project, how to collect the best possible medication history (BPMH), and the process for “reconciling” medications.

These discussions were continued on Day 2 of the workshop when the format of the workshop was structured to address all of the issues raised after the second breakout session on Day 1 and to work out logistical issues. Each section of the proposed procedure was discussed with the assembled participants in a plenary session rather than in breakout groups. This process allowed consensus to be reached. It was noted that, to some extent, it was necessary for the procedure to be consistent, however, success depends on each organization doing what works for them.

### ***Patient Sample Selection***

The issue of how to choose the patient population where the baseline data and pilot data are to be collected was discussed at length. The discussion centered on a number of issues including the criteria for choosing the admission point to begin data collection and whether teams would have the flexibility of choosing their own sample patient population or if the decision should be made as a collaborative. It was noted that if an area is chosen that has no problems it may be necessary to repeat the baseline data collection. The consensus was that it was important to clarify the criteria for patient selection.

It was decided that each site would decide on which patient populations would be targeted for baseline data collection and pilot implementation of medication reconciliation. It was noted that the population chosen for baseline data will be the same one used for pilot implementation.

➤ *The following criteria were proposed and accepted for selecting the patient population;*

- A patient population/admission point should be chosen where it is suspected a problem exists and where medication reconciliation can make a difference. This planning should be done ahead of time to avoid a situation where baseline data needs to be collected on a second population because there is little evidence of a problem with the first group. It was suggested that the planning phase could include such strategies as talking to colleagues and/or doing a pilot review of a small number of charts.
- A patient population/admission point should be chosen where there is a sufficient volume for data collection. One suggested strategy was to request that medical records provide data on admission volumes for a two-week period.

- An area should be chosen where there are staff who are enthusiastic and willing to participate for a period of several months. It was noted that skeptics will follow once success is demonstrated.

There was some discussion on whether particular patients within the chosen area should be excluded from data collection. In particular, there was discussion with respect to excluding patients where there is a significant difficulty obtaining a best possible medication history (BPMH). It was noted that such patients represent “real life” and that to exclude them is to exclude those patients at highest risk for medication errors. It was explained that for these patients the goal is to obtain the best history possible.

- *It was proposed and decided that the only criterion for exclusion of a patient was that the patient presents with no prescription medications.*

### ***Baseline Data Collection***

The method of data collection, the number of charts to be reviewed and the time frame were discussed. It was agreed that the concurrent method of data collection, as described in the GSK and the Procedure Manual, will be used throughout the baseline and pilot testing. The number of cases to be done for the baseline data collection phase was discussed. The point was made that it will be important to have enough data to track change and to create the case for change the sample would need to have adequate power (sample size).

- *It was agreed that 20 to 25 charts were reasonable for most organizations with some considerations based on the size of the organization.*
- It was noted that within sample size criteria, larger institutions would need to choose an appropriate number of charts for the size of the institution in order to feel comfortable that the data will provide a good picture of what is going on in their institution on basis of the baseline data collection, e.g. 20 charts for a 1500 bed institution would not be an adequate sample.
- However it was also noted that, if a high volume hospital chooses a unit that has lower volume than 20 to 25 charts would be a reasonable sample.
- Whether the smaller organizations would be able to meet the goal of 10 to 20 charts was discussed.
- It was suggested and agreed that low volume hospitals, once the process is set up, do all admissions until the end of November.
- *CAPHC will code and categorize the data for the size of the hospital (small, medium, large) allowing for analysis of how quickly change can occur depending on the size of the facility.*

A number of issues with respect to the time frame of the data collection were discussed.

- There were concerns expressed about the time frame to complete the prescribed number of charts.
- It was suggested that using a time frame of only one week might sample the practice of only one or two front line staff.
- Also noted was the possibility that having the same group of people collecting and aggregating the data over 18 months of the project may present some challenges.
- *It was agreed that baseline data collection is to be completed by the end of December, meaning that participating centres have 4 months to get their teams together, get people on board and*

*enthusiastic, work through the processes, understand the forms, practice using the forms and get the baseline data in.*

However it was noted that all centres are welcome to send in complete and send in their baseline data before this deadline

### ***Pilot (Early) Implementation and Data Collection***

A number of issues with respect to the collection of data after the baseline data collection is completed were discussed including the procedures for pilot data collection, the patient population to be targeted, the number of charts to be reviewed and time lines for data collection and submission.

- The pilot phase (early implementation) was described as a way of identifying areas that need improvement, training staff in best practices and imbedding processes and forms into daily practices.
  - The purpose of the pilot is to fine-tuning the process, to understand the forms and make changes.
  - The preferred method is to start small, e.g. PDSA cycles.
  - This process is to institute behaviour change and to make sure everyone is comfortable with the process and using the forms.
  - The pilot is to be conducted on the same unit/admission point as where the baseline data was collected since the purpose is to track changes over time.
- *It was proposed and agreed that once the pilot phase has begun and a goal is chosen, e.g. 75% reduction in unintentional discrepancies, improvement is be monitored by doing audits monthly*
- The audits should be made part of daily best practice and a maximum of 20 charts will need to be audited every month.
  - The monthly audit consists of 20 cases chosen randomly (if there is a high enough volume that random selection makes sense).
  - Random selection is the best practice, however, each centre will choose what is best for them.
  - Smaller institutions with low volumes will likely do all concurrent admissions, e.g. if there are 3 admissions in a month 3 patients should be reviewed.
  - It was also suggested that smaller institutions may want to use all admission points, if feasible.

The length of the pilot phase data collection and the timelines were discussed

- It was agreed that participating centres would start pilot implementation in January 2006 with the goal of completing this phase by the end of March 2006.
- It was noted that some organizations may be able to start the pilot earlier than January.
- It was also agreed that the medication reconciliation process, data collection and submission should continue after the chosen goal is achieved, e.g., continue to monitor with monthly audits and send in data to insure that success can be maintained.

## Implementation of Medication Reconciliation and Evaluation

The implementation of medication reconciliation past the pilot phase was discussed.

- It was agreed that once the chosen goal on the pilot unit is reached the process would be “*spread*” to other units by repeating the same cycle of baseline → pilot → implementation → goal.
- It was clarified that this would be sent as a different data set.
- It was noted that as organizations are adding more units they will be doing multiple charts and this may become an issue of resources.
- It was noted that some organization may add transfer points, e.g. once goal is reached on a group of patients they will move on to the next transfer point for the same group.

## Collecting the Best Possible Medication History (BPMH)

There was a good deal of discussion around the 5 steps to collecting the data and particularly the patient medication history.

- Some confusion about the steps of a PMH (Patient Medical History) and then a BPMH were noted, e.g. was the PMH used as information for the BPMH?
  - The practical issues and barriers to collecting a BPMH were noted including language barriers, parents who are not available, split families and foster families.
  - Other issues were discussed including determining compliance with prescribed medications, e.g. the child not being given the medication by the parent, who will take the PMH and the BPMH, training people to take a BPMH, what to do on weekends and what parts of the PMH and the BPMH would be part of the patient chart.
  - It was also stated that, as part of this project, only prescription medications would be considered.
  - However, it was also noted that while a patient is admitted OTC meds also become a prescription medication.
  - Children who are taking OTC meds and/or herbal remedies will need to be included at some point beyond this initiative.
  
  - It was suggested that it would most likely be a nurse and perhaps a physician that would take the PMH and a pharmacist would complete the BPMH.
  - It was noted that pharmacists do this as normal practice and there would be some need to frame the discussion with physicians with respect to the project.
  - It was noted that doing a PMH and a BPMH means asking families the same questions 2 or 3 times and this may become frustrating for them; It was suggested that the person doing the BPMH could frame the questions to reduce this effect, e.g. review the PMH and ask for clarification.
  - The importance of creating process maps for whom currently collects this type of data (e.g., baseline data) and having a form to enable them to do both at once was noted.
  - It was noted that who will take the history would depend on the organization and that it would be important to have a template for consistency.
  - It was suggested that a script for the BPMH would be a useful tool and would insure that the history was complete and that there was consistency across interviewers and sites.
  - It was noted that over 18 months it may be hard to have the same person collecting the baseline data and completing the audit forms and this may have issues for consistency.
- *Each implementation team will determine who take the medication history and do the chart audits and what training may be necessary*

- *CAPHC will consult the literature and create a suggested script for taking the BPMH*

## **Medication Reconciliation Procedures**

The forms and procedures for reconciling medications was reviewed and discussed

- The ability to reconcile was discussed, e.g. would the prescribing physician still be available to clarify the orders.
- One question was whether there should be a specific time frame or if a delegate should be consulted.
- What to do when the physician was not available for reconciliation was discussed.
- Weekends were noted as a possible complication.
- It was also noted that it may not be possible to reconcile if the patient does not stay.
- It was questioned whether PMH's that could not be reconciled should be excluded, however it was also noted that this may exclude the populations at highest risk.
- It was suggested that a column be added to the form indicating whether action was taken or not.

Margaret Colquhoun and Virginia Flintoff reviewed the medication reconciliation forms

- They noted that the forms in the GSK are intended to be samples reconciling tools only.
- The main features of the forms were reviewed and discussed.
- The point of the medication reconciliation form is for ordering physicians to clarify their thinking and the **essential features** are what leads staff through the physicians thought processes, e.g. **continue, add or hold or discontinue**, in addition to the features that are essential within each institution.
- It was noted that it is critical that the teams review their current processes and some of the samples and think about how this will work within their institution, e.g. will the form ask physicians to state why they are changing medications on the form itself or elsewhere in the chart.
- Margaret noted that this is where the teams will need to do a lot of work when starting the pilot.
- She suggested starting with the forms currently in use and comparing them to the examples in the GSK to find one that will fit with current processes; the point of the forms is to lead clinical staff to a reconciling thought process, e.g. get the thinking to be clear and the orders to be realistic and have fewer potential discrepancies.
- This piece cannot be scripted for organizations.
- Start small to test (e.g. one interested doctor, nurse and pharmacist), use PDSA cycles to test the form.
- Every institutions form will slightly different.

There was much discussion around the process and how to use the forms with current charting practices

- Virginia noted that the form is for medication admission history and that the medication orders will go on the doctor's orders
- One suggested process was for the medication reconciliation form to be used to collect the BPMH, e.g. to serve as a worksheet, then the AMO's would be checked against the form and any discrepancies noted
- What forms would be included on the patients chart was a topic of much discussion
- It was noted that the form that is used to collect the BPMH contains valid patient information and needs to be documented on the chart, e.g. discrepancies and resolutions have to be identified on the chart

- Virginia noted that this would be an internal issue that each organization would need to work out for themselves
- It was however, agreed that the audit tool would not become part of the chart
- *Each organization will develop a tool based on what is already in their system (paper or electronic).*
- *Each organization will determine which forms are to be part of the clinical record.*

## **Data submission**

Issues with respect to data collection, data submission and privacy issues were discussed.

- It was noted that these issues will vary by organization and province.
- The issue of how data was to be submitted and how individual patient privacy was to be protected was discussed and clarified in terms of which forms are to be used for submission of data.
- Teams will be aggregating data on their own site using the audit form in the GSK (details in the protocol manual).
- The audit form is to be used for monthly audits.
- From these forms, each centre aggregates their monthly data using the Measurement worksheets from the GSK.
- These forms would be submitted to the CAPHC national office.
- *CAPHC will include complete data submission instructions in the procedure manual to be sent to all participating centres*
- *CAPHC will create a national paediatric database that will aggregate everyone's data*
- *From this aggregated data CAPHC will send summary run charts for the paediatric data to each organization monthly*
- *CAPHC will submit the paediatric data to SHN on the behalf of the centres*
- *As well CAPHC will have access to the national reports so that all participants can see the paediatric and adult progress over time*
- Whether or not organizations would need REB approval was discussed and it was noted that some institutions required REB approval for QA projects, e.g. HSC
- Several participants noted that this would be an issue because of contact with patients and because the data is being published
- A template for REB questions was suggested
- Possible opportunities for each centre to separately publish the data were discussed.
- It was noted that there would be publication of many types including both the quantitative data and qualitative information on the lessons learned through the process.
- Virginia replied that the SHN group has the issue of publication, both nationally and by individual organizations on their agenda to discuss.
- There may be a requirement to manage this in a certain way.
- This came back to the question of what approval will be required within each organization.
- Different organizations have different criteria and processes and it is up to each team to determine what they need to do in this area.
- Michelle Lahey noted that a more detailed discussion with respect to this is necessary, she will bring it back to the collaborative and will discuss with the SHN group.
- *CAPHC will monitor this discussion and get back to all participants*

## Closing Remarks and Next Steps

During the past several years, CAPHC's Patient Safety Collaborative has been striving to implement and support a national agenda and framework for partnership and communication around patient safety issues. Among the six SHN! Campaign interventions, the Patient Safety Collaborative has identified Medication Reconciliation as their national priority.

Within a large geographical area, there is often only one children's health centre. This poses a significant challenge for system-wide quality improvement based on limited opportunity for relevant benchmarking, sharing of information and best practice. The ultimate goal of CAPHC and the Safer Healthcare Now! Campaign is to prevent ADE's by providing support for paediatric health care centres across Canada to implement medication reconciliation. Working as a paediatric patient safety collaborative will expedite change and quality improvement.

This workshop brought together interdisciplinary child and youth health professionals from across Canada who are committed to participating in this national initiative to make system wide changes to improve patient safety.

CAPHC extends its sincerest gratitude to all the participants for their participation in the workshop and their leadership role in the launch of this national child and youth health quality improvement initiative. Many thanks is also extended to the support and generosity of MEDBUY Corporation, as well as the Canadian Patient Safety Institute and the Safer Healthcare Now! Team. In addition, Margaret Colquhoun and Brenda Carthy of ISMP Canada and Virginia Flintoft of the University of Toronto provided tremendous expertise and leadership in this process.

CAPHC is strongly committed to providing leadership and support including access to resources and connections in order, to facilitate this important paediatric quality improvement initiative. CAPHC will, in the coming months;

- Create a procedure manual that builds on the Getting Started Kit and incorporates the strategies and procedures, specific to paediatric health care centres, that were agreed on at this workshop
- Develop education materials that will capture the key concepts of the SHN! Campaign, specifically Medication Reconciliation, including a clear picture of what medication reconciliation is all about and what needs to be done, emphasizing the improvement in patient care and the CCHSA mandate for accreditation.
- Provide a forum for communication between all teams at participating health care centres
- Provide a template for a communication plan including an education and information package, as well as other tools and links to the SHN! Campaign resources.
- Create a national paediatric database to collect and collate data, send summary run charts of the data to each organization monthly and submit the paediatric data to SHN on the behalf of the centres.
- Prepare and disseminate reports to all participating centres and the Safer Healthcare Now! Campaign