



*The CAPHC-SHN Paediatric Medication
Reconciliation Collaborative*



**CAPHC-SHN Paediatric Medication Reconciliation Collaborative
Third Interactive Teleconference
Implementing Changes: short and long term solutions
Thursday, May 25, 2006
12:00 – 2:00 PM (EST)**

Speakers: Elaine Orrbine (Chair), CEO, Canadian Association of Paediatric Health Centres
JoAnne Whittingham, National Project Coordinator, PMRC
Margaret Colquhoun, ISMP Canada
Dr. Anne Matlow, Hospital for Sick Children
Dr. Trey Coffey, Hospital for Sick Children

1. Introduction and Welcome

- Elaine Orrbine introduced the speakers and welcomed all participants to the third interactive teleconference

2. Adoption of Agenda and Approval of the February 23rd Teleconference Summary

- The agenda for today's interactive teleconference and the minutes from the February 23rd teleconference had been sent to all participants
- Elaine noted that any additional information with respect to the agenda could be brought forward in the Q & A sessions during the call
- The business arising from the summary of the Feb 23rd call will be reviewed during this call and feedback provided
- If anyone has noted any errors and omissions in the summary they were invited to let JoAnne know so that the changes can be made

3. Business Arising (see attached summary)

- Elaine provided a summary of the issues arising from the Feb 23rd call, referring to the update documents that were sent out with the teleconference agenda

Update on inclusion of OTCs (final recommendations attached)

- Elaine noted that there was a very rich discussion with respect to the inclusion of OTCs at the February 23rd teleconference after which a small working group was established
- Elaine thanked all the members of this sub-committee for all their time and effort in finding a workable resolution
- The final recommendation was reviewed; OTCs and herbal medications should be included as part of our paediatric "Best Possible Medication History" however the data that CAPHC, for the members of the PMRC, submits to the Central Measurement Team at SHN will not, for the time being, include OTC and herbal medications
- The additional data collected will have added benefit for the PMRC in that data that includes OTCs can be analysed and provide all of our members with additional knowledge about OTCs and herbal medications

Coding discrepancies and understanding the measures

- Elaine invited Margaret Colquhoun to review the issues around understanding the measures and coding discrepancies, particularly with respect to new medications ordered on admission
- Margaret referred to page 12-16 of the GSK and noted that the intention was to have the normal process of taking a primary medication history take place, the admission medication orders (AMOs) completed and subsequently compared to the “Best Possible Medication History”
- During this process anything different from what the patient was taking at home should be clear and should be an intentional and documented discrepancy
- If teams find medications on the AMOs, that the patient was not on at home, and for which there is no clearly documented reason for ordering based on the history, then these may be a discrepancy as defined in the GSK, page 16

- Margaret also spoke about the fourth measure developed by the team at London Health Sciences and complemented the team on the development of this measure
- The MedRec Faculty group will be having a meeting in June to review what is missing in the GSK and what needs clarifying, e.g. further explanation of the MedRec process and collection of data at discharge
- At this meeting the clarification of existing measures and the addition of any new measures, including the measure from London Health Sciences, will be on the table
- Because the revised GSK will be ready in October their recommendation is that teams wait until then to put any changes in place so that all teams are putting the changes in place at the same time

Route of administration of medications

- Third point under business arising was the route of administration of medication
- EO reviewed the recommendation; if the route of administration of medication has been changed on admission and there is not apparent clinical reason than this may be coded as an unintentional discrepancy.

4. Paediatric Medication Reconciliation Collaborative (PMRC) Milestones to Date *(congratulations to all teams!)*

- Elaine Orrbine briefly reviewed the summary of baseline data
- Currently data from 15 of our participating centres has been submitted and it is expected that data from the remaining centres will be submitted shortly
- Elaine noted that this summary and subsequent summaries that will be provided are intended to provide ongoing snapshots of what is going on across the country
- She pointed out that this is very preliminary and captures the total baseline data submission
- A more detailed report will be provided as the initiative moves forward

Q&A

There were no questions or comments from the participants

5. Making change: sharing and learning from each other; rapid fire presentations

Pat Overholt, from the Credit Valley Hospital, noted a number of key points from their experience

- Pat noted that there has been so much information made available, that what has worked best for their team is to focus on the 7-step framework of the GSK, both to keep the team on track and for education of the unit staff
 - Their strategy is to post the framework visually and check off the steps as they work through the process
 - Securing the leadership commitment was the most important step for their team
 - All the teams working on SHN interventions at Credit Valley are responsible for reporting to senior leadership (the Board and the Quality Care Committee) once a month, this has helped to keep her focused
 - Pat also noted that the true leadership commitment is the team and in order to make change it is important to grow leaders from this perspective
 - Her strategies to support the team include developing a resource and communication binder that is available to all staff on the floor, taking front line staff to conferences and staying late to help them with the project tasks
 - The resource and communication binder includes tools, articles and the run charts
 - She also attends the paediatrician's business meeting once per month to update them and answer questions, this helps with buy-in
 - Other strategies include poster boards on patient care units, participation in corporate patient safety expos, articles in community and staff newsletters
 - Their number one underlying principle for everything they do is to keep it simple by using or modifying available tools
 - The primary lesson learned that brought them forward was shock and dismay at the baseline data that illustrated that there is a problem
 - They have process-mapped their system in order to eliminate redundancies and to use the MedRec process to build on existing nursing practices
 - They are creating written standards so that everyone understands their role in MedRec
- Elaine Orrbine noted the importance of the accountability to senior leadership for all teams in that this solidifies the engagement and promotes patient safety culture

Q&A

Ruth Lee, Hamilton Health Sciences asked if there were any extra resources committed to initiative.

- Pat explained that there were not no added resources and noted that her strategy is to sell the initiative as something that staff are already doing and that will eliminate redundancies in the system
- She noted it was important to change the language to *improving the process* of obtaining the home medication history in order to insure what patients are taking in the hospital is correct
- Margaret Colquhoun commented on the resources issue and noted that other sites are finding that when they review their processes that there is a lot of redundancy in the history taking and are applying MedRec both to solve this problem and to meet the new CCHSA standards for proactive risk assessment
- People that she has met with believe that they are saving time and resources with MedRec

Ruth Lee also noted that they have had concerns expressed by nurses who are wondering what the college standards are that fit with the responsibilities around medication histories

- Pat noted that she feels this fits well with the standard of safe medication practices and Ruth agreed
- Pat also noted that she be willing to share the written standards and tools that their team has developed; she will send these documents to JoAnne

Carole Cook, Children's Hospital of Eastern Ontario (also on the line were Tracy Wrong, Chris Sorfleet and Carolyn Stewart) reviewed their progress

- She reiterated a previous comment about leadership commitment in that their new director of pharmacy had come with his own goals of imbedding MedRec in the organization, as well as many other projects aligned with pharmacy changes
- Currently there are numerous pharmacy and practice changes underway and, as a result, MedRec is being presented as one of these practice initiatives rather than there being a lot of specific hype around this particular initiative
- The team had initially targeted oncology however practice changes in this area were successfully implemented quickly with the result that this unit could not be used for baseline data collection, therefore they are focusing on the general medicine population
- Clinical educators are used to brief nursing staff about the initiative and there are two pharmacists assigned to collect the data
- The director of pharmacy has been reporting to the Clinical Risk and Patient Safety Committee on a monthly basis
- They also will be developing a newsletter with a pharmacy corner
- The team has started to discuss the documentation issue; the goal is to get all the information in one place so that it becomes the orders that people are working from
- They are making initial movement toward electronic records

Q&A

- There were no questions or comments from the participants
- Elaine Orrbine noted that senior leadership and accountability was a recurring important point
- She noted that team newsletters could go on the CoP and on the CAPHC website

Barb Evans, Saskatoon Health Region, provided an update for their region

- They are not exclusively a paediatric site, there are five pilot areas of which one is paediatric
- They have great administrative support and a steering team
- The form that they are developing will also be used as the physician order form
- The team is working through PDSA cycles and are currently completing the second PDSA
- They have found that one on one meetings with the residents is very useful for obtaining buy-in
- They have had some interesting results in that the number of undocumented intentional discrepancies have decreased, indicating that the form is working, however the number of unintentional discrepancies has increased
- The team will focus on touching base the physician and nursing groups to reinforce the purpose and importance of MedRec
- As well the team is concentrating on improving education on how to do a BPMH

- They are developing laminated posters on MedRec and on doing a successful medication history and are hoping to have these ready for the third PDSA cycle in June
- As well the team is working on the link with electronic government pharmacy records and hope, in the long run, to be able to eventually download this to the form so that physicians have a record of what the patient was taking at home
- The initiative has no extra resources and this is a challenge,
- There are some concerns with respect to the summer period and it is recognized that they will need to be inventive to continue with the process

Elaine Orrbine noted that the summer holidays would be an issue for all teams and that it is extremely important that teams try to maintain the momentum during the time of summer holidays

Q&A

There were no questions or comments from the participants

6. Physician Engagement

Elaine Orrbine noted that the issue of physician engagement has come up in previous calls and introduced Anne Matlow and Trey Coffey, physicians from The Hospital for Sick Children who have hands-on experience with this issue

Trey Coffey introduced herself as a paediatrician and hospitalist on the unit where MedRec is being piloted and described her experience with physician engagement

- In the setting where MedRec is being piloted at HSC, the patient population is all general paediatric and respiratory medicine patients and the average census is 6 to 10 admits per day over 3 wards
- Trey described her efforts in enlisting support of the larger physician group
- Her initial strategy was to work in one on one meetings, e.g. with the director of clinical unit, using a one page handout with relevant graphs and charts
- The initial response from the clinical director was that she should not spend too much time on this project, as it would not be viewed as a legitimate academic pursuit; she noted that this was an issue that should be explored at some point
- As well as one on one meetings, she also presented the case for MedRec at a number of existing meetings and conferences
- Trey noted that she used a lot of charts and graphs from the literature however actual examples from the patient population proved to be more compelling
- Implementation of MedRec has been planned to take place in two phases
- The first phase is intended to get physicians comfortable in using the form after which reconciliation will be introduced including a double check by pharmacy and nursing
- When they started to use the MedRec form they did a lot of “just in time” training at morning and evening hand-over to show residents how to use the form
- The initial reaction from the residents was the perception that using the form was extra work
- The team has had a difficult time convincing the residents and physicians that using the form is more accurate and safer up front and that it will save time and rework later
- In the process of introducing the form they have learned a lot about the profound difficulty in introducing practice change into their environment with two different teams, frequent turnovers on the unit and a lot of the staff working night shift

- They have found that “just in time training” is not possible to maintain with the constant turnover and the shift work
- They have found that generally the physicians are supportive but have not really embraced the concept to become champions within the individual teams
- They are currently at about 30% (of admissions done during the period) use of the form
- She noted that while the physicians have bought into the concept of MedRec, the main problem is that there is not mechanism for immediate feedback or consequences of not using the form which makes it easy to forget to do
- The team is hoping that the reconciliation phase will highlight the benefits of using of the form and provide more accountability and feedback

Anne Matlow, in her presentation, covered a number of areas including the challenges of physician engagement, what to be aware of in terms of getting physicians involved, and suggestions on ways to frame initiative.

- One of the main challenges to physician engagement is the culture in which physicians have been used to functioning wherein they are trained to be autonomous and doing things their way
- This is a culture where, as a rule, physicians have been valued for their independence and are not willing to admit that they are doing things wrong
- This culture is a deterrent to working as part of a team
- The second challenge is involves the currency under which they will be valued, e.g., research publications or being acknowledged to be a good educator
- The expectation that that if physicians are going to go out of their way to do extra work, there needs to be something in it for them, e.g., if it is not part of their initial job description, why add it to their plate
- In general, quality improvement projects are not acknowledged to have a currency for academic promotion or “brownie points”
- Another challenge is that it can be difficult for a physician who is a champion for a particular initiative to approach their colleagues and ask them to change their ways
- It needs to be recognised that this may not be easy for physicians
- An additional deterrent is that MedRec is competing with the main tasks of patient care
- Physicians and residents are already overworked with the primary clinical responsibilities of taking care of patients as well as any academic responsibilities they may have

Anne suggested that it was important to recognise these challenges, realise that they can be resolved and to accept that it will be difficult to bring physicians on board

- She suggested that there are two potential ways to frame the initiative that may help to engage physicians
- One way is to describe quality improvement initiatives as a chance for health care workers to lead the way, e.g. recognise that health care workers don't want everything to be dictated by management
- Such initiatives allow health care workers, including physicians, to lead the way and to be proactive
- The second way to frame the initiative is to make the focus the patient; how can we get the job done to improve patient care?

Anne also reviewed the nuts and bolts of getting started

- She noted that the key step was assemble a committed team; team members need to have knowledge, skills, status and expertise

- As well as team members need to be accountable such that the end result is bettering patient care
- She stressed that it is important for team members to have a context, the current context is the Safer Healthcare Now! Campaign
- She noted that a burning platform context works, use an example of a close call due to a medication ordering error is a good way to engage physicians
- The next step is for the team to agree why change is necessary and what small improvement they are going to test using PDSA cycles
- She noted that it is important that everyone on the team understand their individual role and responsibilities
- In terms of roles and responsibilities, Anne noted that, while a physician champion may be willing to be part of the initial work of the team, most physicians would much rather work with a draft form that has been developed and make corrections rather than starting from scratch
- Physicians need to know that the ultimate product will be better, easier, straight forward and uncomplicated to use and that it will make a positive difference in patient care
- Anne stressed that it is important to keep the team informed, including the physicians and share the data, particularly incidents of close calls
- Where physicians are resisting, she suggests the physician champion or executive sponsor or opinion leader to meet one on one to determine what the problem might be

On a going forward basis, Anne hopes to see a new currency being developed where being involved in initiatives improving patient care and safety will have a value in promoting the careers of physicians both in terms of acknowledgement for engaging in these types of projects and in terms of “citizenship” within the hospital

Q&A

Ruth Lee, Hamilton Health Sciences complimented Anne and Trey on the presentation

- She wondering if there were concerns about medico-legal ramifications of signing the forms
- Trey noted that no one has raised this concern
- She did note however that use of the form is highlighting how much families don't know about dosages and other details of the medications therefore there is a lot of frustration that amounts can't be noted on the form
- Who is encouraged to use the form depends on the team

Margaret Colquhoun noted that Peter Norton has spoken on physician engagement and suggests building on what appeals to them, e.g., local patient stories work well as well as demonstrating that the process will save them time. She also agreed that it is not necessary to have physicians attend all the meetings and that doing so is not necessarily a sign of engagement

Elaine Orrbine suggested that there was time for Anne and Trey to open the discussion to a bigger perspective

- Trey explained that they would like to explore the variability in the sites, different types of physician champions and the different barriers
- She noted that there are likely different expectations of physicians at different sites
- They propose starting off by better understanding each site and where they are, in the context of MedRec

- It is expected that this information can be used to better strategize around the issue of physician engagement
- Anne noted it would also be useful to have demographics of an optimal team, e.g. experience vs. personality
- Margaret Colquhoun noted that this is a good question because there is not enough experience yet to know what is the best makeup for a team
- She will be attending a Western Collaborative learning session and will be happy to share feedback from these sessions

- Anne Matlow wondered if teams would be interested in completing a short questionnaire while they are working on the project
- Elaine suggested that, as well, once this initiative is wrapping up, it would be very interesting for sites to describe their teams and compare to the success in changing practice, this could lead to recommendations for the optimal team make-up
- Pat Overholt noted that it would be important to know how many teams have a member with quality training
- Elaine thanked all for the rich discussion and noted that there are seeds for the fourth interactive call

7. Reviewing the Timelines and scheduling for the next PMRC interactive teleconference

Elaine noted that it was important to recognise the milestones in the timelines

1. **September to December 2005:** Getting started and launching a successful campaign within your Site; developing teams and engaging key stakeholders.
 2. **January to February 2006:** Collecting baseline data; beginning to implement change.
 3. **March to April 2006:** Moving into the pilot implementation stage and determining how processes can be changed to ensure successful implementation and integration of medication reconciliation.
 4. **May 2006:** Baseline data will be evaluated and reports submitted to all participating centres and the *SHN! Campaign* Steering Committee.
 5. **May to October 2006:** Full implementation of medication reconciliation
 6. **October to December 2006:** Evaluation of the results, dissemination and exploration of new QI models for care
 7. **The campaign beyond December 2006**
- She noted that Items 1 to 3 are almost completed with just a few sites left to submit baseline data
 - CAPHC will be providing a report on the baseline data and as well the data will also be submitted to the Central Measurement Team at SHN
 - Over the summer and into the fall teams will be moving into full implementation phase
 - After October the focus will be on evaluation, dissemination and exploring next steps including new quality improvement models of care
 - Elaine also provided feedback from the SHN! Steering Committee meeting in April
 - The committee has planned for the current phase to continue into June 2007
 - She stressed however that this doesn't mean that teams don't have to submit data now; it is important to keep the momentum going in order to impact on change at a system wide level
 - Elaine also noted and stressed the importance of measurement which is critical to the success of the campaign, therefore it is vital to maintain the data submission deadlines



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- Elaine informed all that, at the CAPHC annual meeting in Vancouver, there is a patient safety symposium being planned on Oct 15th; it is hoped that some of the MedRec data will be shared at this symposium
- Elaine thanked everyone for their participation and contributions to our third interactive teleconference and congratulated everyone on their tremendous accomplishments to date!
- The fourth interactive call is for planned for Sept 14th

The teleconference was adjourned at 2 pm EST

The fourth interactive teleconference will be held September 21st, 2006