CAPHC-SHN Paediatric Medication Reconciliation Collaborative
Sixth Interactive Teleconference
Listen, Reflect and Move Forward
Thursday, Sep 6th, 2007

Speakers: Elaine Orrbine (Chair) – President & CEO, CAPHC
JoAnne Whittingham – CAPHC National Patient Safety Coordinator
Margaret Colquhoun – SHN! MedRec Lead, ISMP (Canada)
Virginia Flintoft – Lead, SHN! Central Measurement Team
Kim Streitenberger – Sick Kids, Faculty member for the MedRec

Participants: Members of the CAPHC-SHN! Paediatric Medication Reconciliation Collaborative

Introduction and Welcome

- Elaine Orrbine introduced the speakers and welcomed all participants to the sixth interactive teleconference
- Elaine noted that the call was intended to follow-up on the environmental scan of all teams conducted over the summer
- The main focus of the call was to explore the challenges of moving forward from implementation of MedRec to sustainability and spread, as well as some reflection on the current data from a system-wide perspective.

Overview of PMRC progress to date (Aug/05 to Sep/07)

- JoAnne gave a short presentation on the progress of the teams in reducing medication discrepancies (see attached)
- 16 teams have submitted early implementation data with audit data collected on a median of 50 patients per team (range 10 to 243 patients per team) and a total of 1360 patients have been reviewed
- Overall, for teams that have submitted early implementation data the overall rate of Type 3 (unintentional) discrepancies per patient has decreased from a baseline value of 0.55 to an early implementation value of 0.29
- The overall rate of Type 2 (undocumented) discrepancies per patient has decreased from a baseline value of 0.45 to an early implementation value of 0.29
- Both the audit data and the environmental scan of the teams over the summer have provided a picture on the progress of the teams
- While some teams are close to their goal (a 75% reduction in the baseline rate) not all teams consider these changes to be sustainable
- The main themes in barriers to sustainability include;
    - Engagement of medical and corporate leadership
    - Resistance to practice change
    - Limited resources to continue to educate staff and conduct audits
    - Competing priorities with other initiatives
    - Team fatigue and maintaining motivation

- Where teams feel they are sustaining improvements one of the key supports is internal Senior Leadership support, particularly from those with operational responsibility for patient safety.
- Other enabling factors include clear management support, staff with dedicated time to manage the project and engagement of front-line colleagues

Q&A

- Margaret Colquhoun noted that the paediatric collaborative is providing leadership to MedRec teams in many of the adult healthcare sites
- The input of the paediatric community has provided an understanding of how complex MedRec is - what is working, as well as challenges and barriers
- Virginia Flintoft agreed that the experiences of the paediatric teams are common across the adult care community

Central Measurement Team (CMT) Recommendations re spreading MedRec

- Virginia noted that the CMT does not encourage teams to spread until they have reached their goal and maintained it for 3 to 4 months – it is believed that once the audit data demonstrate that the goal rate is being maintained that is clear evidence that all staff are on board
- Margaret Colquhoun noted that the SHN! Education Resource Committee has set as a standard, across all interventions, that the improvement in rates should be maintained at goal for 3 to 4 months before beginning spread
- Kim Streitenberger commented that variability in the audit results is to be expected since the process itself, as well as the environment in which it is being implemented, is variable
- She noted that it is important for teams to understand and analyse the patterns in the variability in terms of what is happening with respect to the implementation team, the patient population, etc.
- This will allow teams to understand how to get the discrepancy rates down and sustain the change
- Kim agreed with the goal of sustaining the lower discrepancy rates before attempting to spread the changes.

Paediatric Team Experience with Spread

- Carolyn Johnston, IWK, noted that they are preparing to take on a fourth team although they still have variability in the three teams that are currently active
- Part of the reasoning behind their strategy is that they are gearing up for accreditation and teams are anxious to be part of the initiative - she feels they are on the right track because they have learned different lessons from each team
- Virginia cautioned that to apply the same strategies on a new team, they need to know that the strategies are working – if the rates are not yet at goal this indicates that the process is not yet working as it should – the team needs to analyze the data and determine what the barriers are
- Marg suggested that they could apply the lessons from the existing teams, understanding that the system is not yet completely changed

- Kim Streitenberger noted the MedRec team at Sick Kids is in a similar situation with respect to accreditation – they have one pilot unit up and running, but don't yet feel they are sustaining their process, therefore are not ready to spread the process to another unit.
- However they have teams that want to get started in response to accreditation requirements.
- Their strategy is to bring one of these teams on board as a second pilot to help the implementation teams sort out some of the issues and tweak the process – they are setting this up as an internal collaborative so the teams can learn from each other
- Elaine noted that it is very positive that accreditation is motivating centres to get engaged with the MedRec process – there is a danger in holding teams back when they are keen to get started
- Elaine suggested that the Sick Kids strategy may work for other sites
- Virginia agreed that the pilot approach is OK, however, she cautioned that this is contingent on size of the institution – if the settings are very different it will be important to solve problems in the first pilot before spreading
- It was noted that it is critical to maintain good communication between the teams
- Janice Seeley, Saskatoon Health Region was curious to know what other teams are doing in terms of sample size for audits, sharing that, in her Region, they have maintained 10 charts per audit.
- JoAnne Whittingham noted that most teams had variable sample size from audit to audit – depending on the patient mix
- Kim Streitenberger noted that their team has kept their sample size consistent – she feels this is important to track improvement since it allows the rates to reflect a change in process
- Janice Seeley also noted that it is important to choose a sample size that will be sustainable from audit to audit
- Carolyn Johnston, IWK, noted that within their 3 teams the sample size can vary depending on patient admissions and it is not always the same from team to team
- Virginia Flintoft reiterated that it is important within each team to maintain the same sample size.

Sharing Successes and Challenges – rapid fire presentations

Joel Lamoure, London Health Sciences Centre

- The Children's Hospital of Western Ontario is a hospital within a hospital, with the responsibility of implementing MedRec in both paediatric and adult venues
- Joel noted that one of the keys to successful implementation has been the collaborative effort
- MedRec was started as a one person exercise – it was quickly determined that it was not possible for one person to do
- The process of implementation has been a winding road with a number of dead ends and detours - Joel noted that it has been very important to stay fluid
- The team has had some amazing champions with very supportive leadership
- A number of committees are supporting the project including Risk Management, Pharmacy and Therapeutics (P&T), Director of Pharmacy and the professional practice leaders in nursing.
- He noted that their audit sample size is up and down for reasons including staff changes and new physicians

- They have conducted PDSA cycles in various areas across the hospital including Paediatrics - allowing the sharing of successes between areas
- One PDSA cycle was to front-load a pharmacist together with nursing on the pre-admit unit
- This proved to be valuable – there was large increase (>30%) in the value of the success index at admission and this carried through to discharge
- Lessons with respect to allocation of pharmacy resources will be presented to senior leadership
- The MedRec form has been co-authored by nursing, who do the BPMH – pharmacy validates and performs reconciliation
- Joel is currently doing a cost analysis and has kindly agreed to share this information with the CAPHC PMRC Collaborative

Kim Streitenberger with Lynn Mack, Sick Kids

- They have faced all 5 challenges on their pilot unit that were listed in JoAnne's presentation
- The audit data show when their MedRec process is used as designed, discrepancies are reduced – undocumented intentional discrepancies are reduced and unintentional discrepancies are down to zero – at this point the team is holding these gains
- Part of solution has been to engage front line staff with additional education – MedRec is a standing agenda item at weekly staff meetings
- The team is also more actively sharing the audit results – getting staff to "own" the results and the improvement
- Kim also noted that anecdotal stories of "good catches" were a tipping point
- Understanding of the process has been somewhat of a challenge – resulting in inconsistencies in conducting the BPMH and reconciliation itself.
- To resolve this problem they have backtracked and redesigned their form as well as revamped the staff education process
- They have made the form very intuitive, (e.g. this is step one and this is who is responsible for completing it and this is what they need to do)
- They have put together an advisory team of medical and senior leadership in the organization including the VP of Quality and Patient Safety, the Chief Nursing Executive, the Director of the Learning Institute etc.,
- The team is reporting their results and the challenges to this advisory group in very plain language, very frank from the front lines
- They feel that this places MedRec on the radar of the Directors who have operational responsibility for patient safety and provides them with some direct accountability for the results, while looking for more systemic solutions

Carol Cooke, Children's Hospital of Eastern Ontario

- From the beginning the team had commitment from the Executive Team, Director of Pharmacy and the Chief of Staff who heads the clinical risk and patient safety committee
- The baseline collection phase went well on the pilot unit
- At the beginning, staff shortages and the lack of a dedicated pharmacist stalled the process
- Despite the significant senior leadership support, one of the most significant issues with implementing the changes was staff resistance – mainly due to the fact that there are so many changes happening in the organization, MedRec became one more practice change that staff were not ready to adopt, particularly the physician group

- The team continued with the initiative and made a presentation to the clinical risk and patient safety committee identifying some of the issues
- As a result of this meeting, Pharmacy is currently putting together a proposal – they will backtrack and put the process into the ER (63% of admissions) preferably with a dedicated pharmacist
- The team is hoping to overcome practice resistance by imbedding the process
- Overall, there are many changes for the staff to cope with – a severe nursing shortage this summer, potential pharmacy shortages, an unknown effect of having a new chief of staff, as well as moving to an electronic health record and to a new interdisciplinary practice model hospital-wide
- Carol noted that it was her opinion that if MedRec is to be is to be imbedded successfully, teams can't go one step at a time – it is important to accept that units need to stop doing business in the old way and start doing business in the new way.

Simone Falconer and Yuen Low, North York General Hospital

- Yuen noted that, as the MedRec practice change evolves, they are moving towards a more collaborative effort involving the unit coordinators and the unit administrator – Yuen noted that she agrees that a collaborative effort is vital
- Initially they were concentrating more on data collection rather than on the processes that would determine how they can implement and sustain changes in practice
- Regular meetings and communications between team members, with unit front line staff and with the physicians has been very important - the pharmacy director and the paediatric program director sit in on these meetings
- She noted some challenges with practice change – they have developed a self training package for the front line nurses for doing the BPMH
- Unit coordinators remind the physicians to complete the reconciliation piece when they write the admission orders
- She notes that new pharmacy staff and new hospitalists that come on board are open to education with respect to MedRec

Q & A - Sharing and Learning from Each Other

- Marg Colquhoun noted that she very interested in the BPMH training tool from North York – the faculty is working on creating a training tool for BPMH that can be used across the country on a technology platform and are seeking input from teams who have developed tools
- Virginia Flintoft noted how important the comments about collaborative efforts were – MedRec will not work with only one person
- Elaine asked the rapid-fire presenters to comment on their experiences with using the "reality check" of accreditation, in overcoming practice change resistance
- Joel noted that they have had better luck approaching MedRec from the impact on patient safety aspect
- Kim agreed and noted that they have also used the patient safety approach and presented it to staff as a learning opportunity
- She did however note that accreditation serves as a motivator at the senior leadership level

- Elaine noted that senior leadership buy-in and accountability has been a issue raised as a barrier by many teams but that there seems to be some resolutions to this challenge noted in the call today
- Simone Falconer noted that it is important to educate senior leaders – an increased understanding that the process is not simple and needs support will be very beneficial
- Simone also noted that it is very helpful to have directors at the management level who understand change management and PDSA cycles

Final Comments

- Leslie Galloway noted that they always learn from the rapid fire presentations – she really appreciated Carol Cooke's comment regarding how important it is to accept that units need to stop doing business in the old way and start doing business in the new way
- This is the approach their team in Winnipeg took – while they have not had the resources to do monthly audits, they have really focused their energies on making the practice changes - when they spread to two additional units they had not yet reached goal but had created a sense of urgency that MedRec needed to be implemented
- They had very good leadership support and a physician champion who advocated to keep the process moving forward
- Marg Colquhoun also followed up on Carole's comments and noted that the data shows changes need to be made - there is now lots of experience on how to change, and despite the complexities, it has to be done – she suggests that this would make a good basis for a national call – the status quo is no longer acceptable
- Joel Lamoure noted that at the end of the day you have to do the impossible with nothing extra (e.g. with the resources that are in place); the London team has demonstrated, on a small scale to date, that an effective BPMH procedure only added a few minutes of time
- It is necessary to set a cost for prevention of morbidity and mortality, and use this to argue for the necessary resources to change standards of practice
- Elaine wrapped up the call noting that CAPHC is developing a senior leadership engagement strategy– she invited all participants to provide any additional comments with respect to challenges and barriers that will be important to bring to senior leadership colleagues
- Feedback on this strategy will be provided on the next scheduled interactive call
- It was noted that there is a paediatric patient safety workshop being planned in conjunction with the next SHN! Learning Series to be held in Winnipeg on March 31 to April 2 2008. Additional information will be sent to all CAPHC PMRC Collaborative members in the coming weeks

Elaine thanked everyone for their participation and contributions to our sixth interactive teleconference!

The teleconference was adjourned at 2 pm EST

The date of the seventh national interactive teleconference will be confirmed in the New Year