

Seventh Interactive Teleconference
MedRec Reality Check
Moving from intervention to practice
Thursday, Jun 12, 2008
12:00– 2:00 PM (EDT)

Speakers: Elaine Orrbine (Chair), President & CEO, CAPHC
JoAnne Whittingham, CAPHC National Patient Safety Coordinator
Theresa Fillatre, SHN! Atlantic Node Leader & Accreditation Canada Surveyor

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

Introduction and Welcome

Elaine Orrbine welcomed everyone to the teleconference. She reflected that Safer Healthcare Now! Phase 1 is in the final stretches and for the purposes of the CAPHC-SHN Paediatric Medication Reconciliation Collaborative, the group is coming up to the end of the intervention phase but entering a ***new beginning of uptake, practice change and sustainability***. She recognized the 3 years of hard work in implementation and the milestones in data collection both within the paediatric group and at the national level.

Medication Reconciliation & Accreditation Canada Standards

Theresa Fillatre, SHN! Atlantic Node Leader & Accreditation Canada Surveyor

- Theresa explained that there is a renewed focus, as part of the new Q-mentum program at Accreditation Canada, on medication management through three key elements of the program including standards focused on quality and safety, required organizational practices (ROPs) imbedded with the standards, and performance measures.
- Theresa explained that through the self-evaluation process, organizations can define upfront who their high risk clients are and provide explanations of how they are dealing with improvement. Compliance evaluation is built into the self – assessment. Sites shape their processes through the evaluation and to ensure the ROPs are fully integrated into a standard process.
- To evaluate compliance, surveyors will use tracer methodology that begins with a patient and an explicit priority process. Surveyors follow the steps of the patient throughout the system process, with no knowledge of the organizations self assessment information. Through dialogue and exploration with open-ended questions, surveyors validate the clinical protocols followed for that particular patient with staff at each point of care as well as with the clinical documentation, standard order sets, policies and procedures, etc.
- She reviewed the key areas of safe medication administration including;
 - The education of patients and families - Theresa stressed that education of clients is imperative; providing the tools and opportunity for the patients, parents, or caregivers to help the healthcare providers in gathering current medication histories and any other required information.
 - Encouraging monitoring of self-administration of medications by patients/caregivers, particularly in the home setting, focusing on side effects and benefits. Pharmacy and nursing department managers have a strong influence on how these processes are implemented and managed.
 - Clear, safe and accurate medication administration processes must be in place.

- Education and competency maintenance of staff in areas of medication delivery and medical devices is an emphasis.
- Monitoring clients following medication administration and understanding the flags that would indicate a potential adverse effect is important for both the healthcare provider and the client/caregiver.
- The Q-mentum program contains an explicit focus on having an established and coordinated risk management program which should address the reduction of medication errors and sentinel events.
 - Surveyors will review the protocols that are in place for organization to monitor their trends and will review what is done with the monitoring systems data. Their interest lies less in the numbers than in the processes themselves.
 - Theresa noted that creating a streamlined process that will allow for feedback to staff and provide the basis for good change ideas in the process of care is essential. Having electronic medication error reporting systems in place is only helpful if the data is used to evaluate medication management, work with improvement models and analyse outcomes.
 - Surveyors will be evaluating how well organizations understand and use their reporting system data to make improvements; a prime example is the MedRec run charts
- The second patient safety area in the ROPs is communication – how well is information provided to the patient/caregiver and how well they understand their role in maintaining medication safety?
 - The communication standards also include the importance of communication through all levels of service and transition points. The transfer of information at interface points of care, including to the community, must be clear. Within this standard is the clear expectation that there is a process for medication reconciliation at admission with the involvement of the patient/caregiver.
 - 2008 requirements specify that organizations will be asked to collect and report data on a single performance measure relating to medication management - Medication Reconciliation at Admission.
- With respect to MedRec, as a surveyor Theresa has observed that most organizations have at least begun MedRec at admission with pilot teams.
- The challenge, however, is that the BPMH is often still seen merely as a list, with the result that teams don't work towards developing new and improved clinical assessment protocols.
- The BPMH has to be recognized as a fundamental touchstone for reconciliation at future transition points, including transfer and discharge.
- Most organizations have not yet fully adopted standardized processes because the tests of change ideas and improvements to the system are not fully developed, even though the commitment exists. Using small tests of change is vital to the development of this process where patients, family and caregivers are equal partners with the healthcare professionals.
- While sites are working towards standardization of MedRec tools and processes, developing standardized education for staff can not yet be fully implemented because standardized education will be difficult until the process of tests of change has been completed - *it is not sufficient to educate to a BPMH and not educate to how the process is applied in the work area*
- MedRec is still seen as an add-on at some sites and role clarification is still an ongoing issue.
- The professional practice point of view is that pharmacists are the experts but the system is not set up for them to be available all the time for this role – clinical pharmacist resources are scarce and need to be used appropriately
- If collaborative professional models are not in place for collecting the BPMH, e.g. with nursing, there may be a delay of 24 to 36 hours before reconciliation and clarification of admission orders.

- *There is a responsibility to sort out the balance between professional practice standards and the process of good medication management*
- The lessons learned from accreditation include;
 - There is collective responsibility to assist with the education of senior leaders and clinical managers related to what the MedRec Process entails and the reasoning that underpins the process.
 - The need to share tools and exchange ideas between teams and organizations to ease start up of small tests of change
 - The recognition that one size does not fit all in terms of how the methodology is applied - but the basic MedRec tenets are constant and apply to all organizations.
 - Professional counsels have an important role in regulatory considerations and tolerance of new processes and practices.
 - Sites need to work with what they have...no one has extra resources. The process has to be approached as what is best for the patient.

Nurses, Physicians and Patients love and will engage in MedRec processes that are intelligent, simple to use and supported by pharmacists

Q&A

- In response to a question from Caroline Johnson, IWK, there was a discussion about the role of the senior leader in this initiative.
 - Theresa noted that the key role of the senior leaders would be in the development of an improvement charter. The executive sponsor must take the responsibility for setting expectations, providing parameters, and providing the resources for the improvement team to do its work and address system issues. They should also serve as the go-to person for major system barriers that are beyond the level of the team. Senior leaders are accountable to their board for monitoring quality and performance measures. They broker the relationships in the external environment to assist in the continuum of care.
- Marita Tomkin, Hamilton Health Sciences asked about best practices with respect to linking the MedRec process to the medication orders.
 - Theresa explained that there are two possible ways to do MedRec. The first is the reactive model where the BPMH is done after the initial history is taken and is then used to correct discrepancies in AMOs – this is seen as adding work to the system and maintaining poor processes
 - The more efficient method would be a proactive BPMH at the beginning of admission process and the physician generates admit orders from the BPMH admission form. Physicians can check off if medications are to be continued, discontinued, replaced, or a new medication added. It was noted that hold orders are not used by most institutions as they can be confusing.
 - As part of this process, pharmacy resources can be managed by having a standardized risk assessment determining when pharmacy needs to be involved.
 - Theresa also noted that when the BPMH is at the front of the process it is essential that compliance and skill level need to be monitored through performance management and education. If the BPMH is not done as intended there is no improvement in medication management safety

- She also suggested that if the process is lacking consistency, e.g. when the pharmacist is on vacation no MedRec is occurring, then there needs to be an examination of how this process can be improved – it was suggested that teams map the gaps with the patient as the centre and develop a different process thru the use of short PDSA cycles to regroup team players

Update on Paediatric Implementation Data – moving from intervention to practice

JoAnne Whittingham, Project Coordinator, Patient Safety

Using your data to improve your MedRec process – determining “Tests of Change”

Theresa Fillatre and JoAnne Whittingham

- JoAnne Whittingham shared that across the paediatric system, while collecting the audit data has been a significant resource challenge, the data submission is significant with almost 3,000 patients reviewed.
- Today’s presentation focussed on the SHN Central Measurement Team goals for audit data – by CMT definition teams are considered at full implementation if the discrepancy rates have been sustained close to goal for 6 consecutive months.
- This is the point at which the data shows that the process is working, the staff are on board and the team is ready to spread the process to other units
- The paediatric system-wide results were reviewed for Type 3 (unintentional) and Type 2 (undocumented) discrepancies
- The run chart for paediatric implementation data as well as for national averages, shows that there is still a lot of variability from month to month suggesting that there needs to be an exploration of what is causing the variability and how the processes can be modified.
- However, JoAnne recognized that the system-wide decrease in the rates is substantial at a more than 50% from baseline.
- Three examples of run charts from different sites were shared and Theresa commented on the results; offering an interpretation of what might be happening and suggestions for improved sustainability of the goal rates.

- Theresa commented that Team 1 appeared challenged by practice change because there were no real trends in the graphs.
- She suggested that this team map out their high level processes with respect to MedRec – the review of the process and the roles with all disciplines will help to address practice change resistance.
- They need to continue on with change ideas in short PDSA cycles ensuring real tests of change, in a rapid cycle way – this way the system process can be changed in weeks and hardwire the changes.
- She questioned whether there were new people or system changes that caused the variability.

- Theresa noted that Team 2 indicated they are identifying what their problems are and can manage those issues using small test of change.
- She suggesting annotating the run charts so there would be a better understanding of the issues; whether they were system issues or one patient with multiple issues. She referred to examples of run charts on the AMI CoP showing how to use annotation to benefit the team and use the data more effectively.
- The team representative shared that the value of utilizing the run charts and clarified the reasons for the variability
 - Feb 2006 to Jan 2007 nursing doing the BPMH

- Jan 2007 started with hospitalists only doing the BPMH Mon to Fri
- Beginning in May 2007 all paediatricians doing BPMH 7 days a week
- Dec 2007 blip was caused by an absence of hospitalists for two weeks and lots of vacation time
- The run chart of Team 3 illustrates that baseline data was collected, after which the team took a year to plan implementation, working with physicians and pharmacists, before more data was collected. Theresa noted that although the year was important, they could have been performing tests of change over the same time and would be further ahead in their process.
 - The team representative commented on their run chart and noted that a lot of work was done with the physicians after the baseline data was collected
 - Additional data was not collected until the nursing staff became involved in the process – the go-live date.
 - The team shared that the project manager was collecting feedback from staff as they spread, using the lessons learned to adapt to the spread units.
 - Patients admitted through the ER need to have BPMH at the time of admission to the holding unit. Residents from the unit are responsible for doing the BPMH in the ER and clinical pharmacists associated with the teaching teams are used at that point to work with the high risk patients.
- Theresa concluded with the value of annotating run charts. The information gathered from the annotated charts is valuable as MedRec is spread through to other units. It is a history of the tests of change and variability is then more easily explained so you come out with a clear story of your implementation process. The run chart data is also useful for explaining normal variances which are going to happen.

The BPMH – *Not just better paperwork – rapid fire presentations*

Joel Lamoure, Children's Hospital, London Health Sciences Centre

- Joel reiterated the value of the run charts in analysing what is happening with the process
- Their site has moved from the retrospective process, which they ran for 25 months – he noted that this made a lot of work
- They had the courage to admit that this was not working well for them –the process has been changed to a interdisciplinary dynamic with a prospective focus - AMOs are written after the BPMH
- The process is inter-professional and owned by all staff
- From their experience it was noted the using shorter PDSA cycles would have been more efficient in tracking problems and facilitating the appropriate changes.
- They are providing education with pharmacy and the nursing educator working together to educate all disciplines and will be starting train the trainer sessions
- He noted it can not be assumed that people know everything - education needs to be constant and inter-professional.
- There is a focus on changing behaviours with an environment that allows the team to admit errors and start process over again.

Caroline Johnson, IWK

- Carolyn described the IWK teams, each of the care teams are unique and differ in the processes used for MedRec, depending on the availability of pharmacy resources
- On some units where there is no pharmacist or inconsistent coverage, the BPMH is done by nursing staff.

- Nursing has embraced this role on some units; however they have been challenged, in some areas, with some pushback from nursing where MedRec is viewed as a pharmacy duty.
- With the different challenges in each care team, Carolyn noted the importance of having consistent membership on the implementation team across the units
- They have good tools and education set up – the need for continual education, at orientation and beyond was noted
- There was some discussion about creating a paediatric video for BPMH training – Elaine Orrbine noted that CAPHC can broker this process (e.g. engaging BPMH stars who can demonstrate their techniques)

- Theresa commented on the value the change ideas of from different areas and the use of short PDSA cycles both noted by Joel and Carolyn
- The notion of regrouping the team leaders is critical especially as spread starts
- Theresa suggested when there is push back from the teams that can't be managed there are resources to help facilitate, e.g. from the Nodes
- She also stressed that the goal of MedRec is a reliable process within a 24 hour window and if the pharmacy role can not be consistent then it is necessary to explore a more interdisciplinary model – map out gaps and explore solutions within the resource base – e.g. using nursing
- A model where the patient is at the centre of MedRec is the best approach - map out from the patient and determine what the resources are and how best to use them.
- If pharmacists are not readily available to take a BPMH then another discipline must be educated to fill that role and pharmacy resources can be used at another point in the process.

Margot Follett-Rowe, Hospital for Sick Children

- Margot described their education model with a wide variety of learning methods including:
 - A learning package for nurses included a background on the purpose and basis of MedRec, specific tips on taking the BPMH and specific case examples to work through.
 - Team members are clearly identified to offer resources and support.
 - Mentors observe the first BPMH taken and offers encouragement and advice on how to improve the process.
 - Learning stations are set up on education days and at orientation to provide opportunity to role play with other staff members.
 - Taking a BPMH has also been integrated as part of the practical OSCI exam.
 - Residents have bought into the process and will facilitate the education of first-year residents on MedRec
- Currently they have noted some variability in their compliance rate – this has been attributed to the fact that they had lost resource of a nurse doing daily front-line support.
- They have also started to involve families - In a pilot project in ER, 24 families participated by filling out a trial “Family Medication Worksheet” and were given an education package on the importance of their participation. The emphasis was placed on medication safety and the response was very good; families felt as though they were part of the process and understood the value of the end product.

Shirley Godward, North York General Hospital

- Many similar tactics have been used at NYGH, including the recognition that nursing has to be involved in the BPMH
- Nurses are educated in small groups by the unit clinical pharmacist
- They did numerous PDSA cycles on the BPMH form itself, with feedback from nursing

- Daily audits helped to identify barriers in completed the BPMH
- The unit coordinator has been instrumental in daily support of the process
- The better quality BPMH has replaced the previous nursing medication history - nurses saw the value of the BPMH once the duplication of efforts ended
- Tips are provided on the back of BPMH forms and are perceived as very helpful.

In conclusion, Theresa noted that issues surrounding MedRec are the same across the continuum of care. The value of having front line staff generating the change ideas is paramount

Elaine Orrbine noted the plans to create a paediatric patient safety business model. Standards for building a business case were identified as curriculum and family engagement. In addition, there is a suggestion to build paediatric standardized MedRec education package from the best practices of the paediatric teams. Everyone was encouraged to share their forms and ideas through the Communities of Practice on the SHN! website.

What's next?

- High Risk Medication Delivery in Paediatrics - A National Project
An Update
- PMRC Teleconference 8
The Business Case for Patient Safety Initiatives
- CAPHC 2008 Annual Conference • Edmonton, Alberta • **October 19 - 22, 2008.**
Transforming Services for Children and Youth - Turning our Thinking Inside Out!
Day 1 - CAPHC Annual Patient Safety Symposium - Sunday, October 19th, 10 am to 1 pm