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# Implementing Medication Reconciliation: *Easier said than done*



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*Implementing patient safety practices in paediatrics and adult health care*

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# Project Overview

- Four year project funded by the Canadian Health Services Research Foundation (CHSRF) and CPSI
- Canada wide multidisciplinary team
  - partners include CAPHC, CCHSA, ISMP Canada
- Purpose: to examine barriers and facilitators to 3 widely recommended patient safety practices
  - Safe handling and storage of concentrated potassium chloride (KCl)
  - Medication reconciliation (MedRec)
  - Computerized provider order entry (CPOE)

# Project Methodology

For each of the 3 safety practices we have (or will):

- Conduct a systematic review of the relevant literature
- Do a national survey to assess level of implementation
- Conduct interviews with hospital personnel to explore the barriers and facilitators encountered during the implementation process

Analysis:

- For each practice we hope to come up with an implementation 'guide'
- We will also conduct a comparative cross-analysis and use this to develop a guide to implementing patient safety practices more generally

## Current progress

- We are well underway with each of the three systematic reviews
- An electronic survey was administered through ISMP Canada's website to assess the level of implementation of KCI practices and CPOE at hospitals across Canada
- We have not yet started the KCI interviews
- The CPOE interviews have just started
  - We are currently conducting interviews with representatives from the 10 hospitals identified by the survey as having CPOE implemented on at least one clinical unit

# Medication Reconciliation project

- CAPHC agreed that participation in this research would be valuable to further explore the challenges of implementing practice change reported by facilities in Medication Reconciliation Collaborative
- After several discussions with the CAPHC Patient Safety Collaborative we initiated contact with 15 of the 18 Medication Reconciliation Collaborative centres
  - We will interview ~5 implementation team members at each centre:
    - Team leader, pharmacist, nurse, physician, quality/safety officer, senior administrator
- Semi-structured 30-minute interviews
  - ~25 interviews conducted so far

# Interview questions

1. Can you tell me about the factors that led to the decision to implement medication reconciliation (MedRec)?
2. Were major process or system changes required in order to implement MedRec at your site?
3. Can you describe the MedRec process as it works at your institution? In other words, what are the nuts and bolts of the process at your institution?
4. What were the major barriers and facilitators encountered during the implementation process?
5. How was the impact of the MedRec process evaluated?
6. Has anything significantly helped or hindered sustainability of your hospital's MedRec process?
7. If you had a chance to do it over again, is there anything that you would do differently with respect to the way in which your institution implemented MedRec?

# Barriers and facilitators

## Barriers:

- Expectations
- Added work
- Money/resources
- Fatigue
- Physician buy-in

## Facilitators:

- Executive support
- External support

## Barriers/Facilitators:

- Pharmacy
- Accreditation
- Choice of pilot unit
- Data

# Barriers: Expectations

- The implementation process was much more complex and time and resource intensive than expected
- More realistic expectations (perhaps learned from other institutions further along in the process) would have allowed allocation of necessary resources
- *“prior to the start of this project, the impacts on available resources should have been anticipated and maybe some support put in place”*

## Barriers: Added work, Money/resources

- MedRec is very resource intensive
- Very few institutions were given added resources for the project
- Participants all viewed MedRec as an important priority, but also as one of many projects
- At many institutions the added work fell mainly in Pharmacy's lap
- *"...most of us are doing this as an addendum to our existing work"*

# Barriers: Sustainability/Fatigue

- Almost all participants were initially excited
- But work was added to already packed schedules
- Teams often experienced fatigue after ~1 yr leading to decreased enthusiasm
- These issues were presented to senior management but often no added resources were provided to sustain project momentum
- *“I think that this is so very important because when we all started we were all very passionate. Because we all believe in it, we believe in the principle of it. We believe that this is part...of good care. But then passion sometimes is not enough. You really need to have dedicated resources to move forward”*

# Barriers: Physician buy-in

- Physician buy-in is a common problem
- Many physicians didn't see the value of MedRec
- Physicians felt they didn't have the time and/or that it was responsibility of Pharmacy
- *“One of the biggest barriers for us has been physician engagement...it's a challenge getting them to the meetings and getting them truly engaged”*
- *“I think there's resistance by some physicians to change their practice.”*

# Facilitators: Executive support

- Executive support allowed for needed resources, and acknowledgement of time/resource commitment
- Also helped in gaining buy-in from users (something that *has* to be done)
- “[*Senior executives*] came in right at the beginning and have always been very supportive throughout that process”

# Facilitators: External support

- All institutions appreciated external support from agencies such as CAPHC, ISMP Canada and SHN
- In particular:
  - The SHN Getting Started kit
  - The SHN-CAPHC Paediatric Medication Reconciliation Orientation and Training Workshop (August 2005)
- *“I think the facilitators [are] the Safer Healthcare Now, the CAPHC collaboratives...”*
- *“In August of 2005 we went to the CAPHC and MEDBUY and ISMP collaborative informational meetings to discuss the process of medication reconciliation and was introduced to the process”*

# Barriers/Facilitators: Pharmacy

- Pharmacy played a major role in MedRec at most centres
- Sometimes this created the perception that MedRec is the responsibility of Pharmacy  
→ decreased buy-in from nurses, physicians
- Representatives from such institutions stressed presenting MedRec as a responsibility to be shared across disciplines
- *“...now trying to change that into a shared responsibility. It’s getting a lot of pushback. It’s seen as pharmacists now trying to download their work to others because pharmacists have been doing it for two years and now we’re saying it is a shared responsibility”*
- *“...one of the sustainable pieces is having it a shared responsibility”*

## Barriers/facilitators: Accreditation

- Often a factor in the decision to implement
- Sometimes led to rushed implementation process with emphasis on CCHSA requirements rather than specific needs of institution
- Some institutions experienced a drop in enthusiasm/participation after accreditation
- *“...the way I’m looking at this is that we have to, instead of doing it for the wrong reasons, the way accreditation tells us we have to, we want to make sure we’ve got the right support, the right mechanism, the right process...”*

# Barriers/facilitators: Pilot unit

- Appropriate choice of pilot unit essential to success
- Problems can arise due to type of patients, number of patients and characteristics of patients and staff
- Fine balance between starting small, and starting too small
- *“...we want to be really inclusive, but we want to keep it manageable and rapid”*
- *“...we also did a very gradual inclusion process...we thought that would be just a little bit easier...but the only problem was that made it difficult for us to recognize which patients are going to be medication reconciliation and which aren't...that did cause a bit of confusion and frustration”*

# Barriers/facilitators: Data

- Audit data and 'good catch' stories helped gain user buy-in
  - But data collection very time consuming
  - Raw data doesn't always reflect the whole picture of what's happening on the unit
  - This can be discouraging for users
- *"I think showing them their baseline data [was a facilitator]...there is no argument once they see the data"*
  - *"... [physicians] were questioning us always why aren't the numbers going down, why are we doing this?... "Wait a minute... our numbers should improve.""*

# Conclusions

- This is a brief overview of the barriers and facilitators that teams are encountering
  - A complete analysis will be presented at this year's annual CAPHC meeting
- Implementing MedRec is not easy
  - challenges seem to be shared across institutions
- However there are also many facilitators to the process
- Teams are working on developing strategies to overcome these challenges
  - You will hear more about these strategies during the next segment of today's workshop