



Advances in Paediatric Patient Safety in Canada

Paediatric Medication Reconciliation
~Strategies for Sustainability and Spread~





Critical Factors

- Senior Leadership Commitment
- Implementation Team
- Front-line staff buy in
- Models and Processes
- Resource Issues
- Spread



IWK Teams Participating in Medication Reconciliation

- Inpatient Nephrology –baseline November 2005
- Inpatient Mental Health-baseline April 2006
- Adult Inpatient Gynaecology-baseline August 2006
- Inpatient Med Surgical-baseline November 2007

#1 Senior leadership

- flow of information to ELT /Directors (informed /visible lines of authority)
- promoting a culture that emphasizes the value of improvement work
- organizational responsibility and accountability

Executive Director of
Quality ,Patient Safety & Decision Support

Member of Executive Leadership Team,
Reports to CEO & Board
Receives reports from Director
Meets with Quality group



Director Quality of & Patient Safety
Director of Pharmacy
Program Directors

Quality &Patient Safety and
Pharmacy Directors provide
direction re initiative /are
available for consultation
Program Director may attend
operations committee meetings

#2 Implementation team

- interdisciplinary /collaborative / shared
- bridging gaps /feedback /visible support

Quality Improvement Coordinators

provide education & do “walkabouts”

troubleshoot monthly data with the Pharmacist

arrange team meetings /provide quarter reports /monthly updates

submit to & connect with SHN data team (teleconferences & COP)

update senior leadership

Pharmacists

support team at unit level

troubleshoot monthly data with Quality

obtain BPMH &/or reconcile (team specific)

identify & record discrepancies



Check the charts
.....check the
data!

Implementation Team (cont)

Nurses

- assist with on unit education
- obtain BPMH &/or reconcile (team specific)
- attend team meetings & provide feedback

Educator

Clinical resource nurse/ PDC can support front –line team

Physician

- review BMPH/reconcile/sign
- provide feedback to staff / lead
- promote with physician group

#3 Front Line -Buy in

- education about and interest in improvement work
- awareness of their outcomes success

staff and care team education....train the trainers

teams have input into the process ,the tools & trial designs

shared responsibility is promoted but are roles understood?

champions may or may not exist

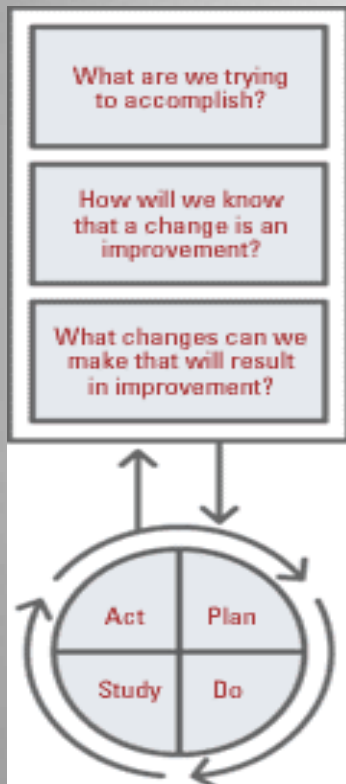
teams understanding of data -in relation to their practice

staying connected (quality council /interdisciplinary committees)



#4 Models and Processes

- practice improvement
- an understanding of interdisciplinary roles
- a sharing of responsibility



Improvement Model

- What are we trying to accomplish?

Define the population & use time specific, measurable aims

- How will we know that a change is an improvement?
Quantitative measures

- What changes can we make that will result in improvement?
• Not all changes bring improvement-be selective

Models and Processes

Medication History and Order Sheet (2006)

~ implemented on Nephrology

~revised 2006 /2007 for teams /shared responsibility

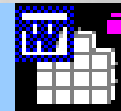


Medication History
and Order sheet

Pharmacy data collection sheet (2006)

~ implemented on Nephrology

~ revised 2006/2007 by pharmacists (discrepancy tracking ;OTC & RX)



Pharmacy data
collection sheet

Getting Your Best Medication History- Family Letter (2005)

~revised 2007 for teams /cross program use



Family Letter

▪Despite consistent tools ,compliance & process variables
exist across teams

Success Indexes

Team & Success Index-SI	SI October 07	SI November	SI December	SI January 08	SI February
IP Nephrology	86%	98%	100%	80%	85%
IP Mental Health	100%	100%	100%	100%	X
IP Med Surgical	54% baseline	80%	78%	71%	64%
IP Adult Gynaecology	91%	93%	86%	86%	84%

Inpatient Paediatric Mental Health

Month	# of Patients	Type 0	Type 1	Type 2	Type 3
Oct.2007	4	8	2	0	0
Nov. 2007	11	13	12	0	0
Dec. 2007	6	4	17	0	0
Jan.2008					
Feb.2008					

Inpatient Paediatric Nephrology

Month	# of Patients	Type 0	Type 1	Type 2	Type 3
Oct. 2007	7	32	0	1	4
Nov.2007	17	103	2	0	2
Dec.2007	5	19	0	0	0
Jan.2008	7	46	7	0	10
Feb.2008	8	44	4	2	6

Inpatient Paediatric Medical Surgical

Month	# of Patients	Type 0	Type 1	Type 2	Type 3
Oct.2007	Base. 34	46	7	17	26
Nov. 2007	9	34	2	1	8
Dec.2007	17	32	0	1	8
Jan.2008	6	17	0	0	7
Feb.2008	50	86	7	12	39

Inpatient Adult Gynaecology

Month	# of Patients	Type 0	Type 1	Type 2	Type 3
Oct.2007	43	107	54	2	14
Nov.2007	36	94	22	0	4
Dec.2007	23	53	26	1	12
Jan.2008	37	110	43	5	20
Feb.2008	32	74	23	0	18

#5 Resources

- protected time & adequate staffing for data management & collaboration
- **Increase collaborative opportunity**
- **“True” protected time. Can it exist for the Team ?**
- **Enlist more champions**

#6 Spreading Medication Reconciliation

- “keeping patients safe” (a strategic direction)
- PDSA momentum
- ease of data management and data presentation
- timelines for spread

Availability of resources?(Quality &Pharmacy)

How long should data for a team be stable? (SHN)

How can outcome data be presented simply for teams? (SHN)

Unit request or reluctance to test change? (Team specific)

CCHSA ROP -admission, transfer and discharge - a driver

Future IWK Spread plans

ER - no pharmacist currently

PMU (Paediatric medical unit)

PNC Ambulatory Clinic (Adult)



CEO

Executive Director
Quality and Decision Support

Director
Quality & Patient Safety

Director Pharmacy

Senior Leadership

QIC CH
(2teams)

QIC MH
(1 team)

QIC WH
(1 team)

Implementation Team

Pharmacist
Nephrology

Pharmacist
MSNU

Pharmacist
Mental Health

Pharmacist
Gynaecology

Peds
Team
#1

Peds
Team
#2

Peds
Team
#3

WH
Team
#4

Multidis. Teams: managers, nursing, pharmacists physicians

← Spread →

Resources

Front Line

Models and Processes



IWK Health Centre

**Sustainability within all the critical factors
affects sustainability of the whole**

Thank you