Evolving Home Care Quality Practices in Medication Management, Collection of a Best Possible Medication History and Medication Reconciliation

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Agenda

- Background
- Provincial Professional Practice Framework
- Policy Development
- Best Possible Medication History and Medication Reconciliation Fundamentals
- Medication Reconciliation Resources
- Summary
- Demonstration of the Champlain Best Possible Medication History Electronic Form
Background

In 2013, more than 1.8 million Canadians received publicly funded home care services. Most (70%) were seniors age 65 and older.

Patients being cared for in their homes are increasingly complex with high or very high care needs (using RAI-HC Maple scoring). In 2010-11, 41.9% of patients were complex, and in 2013-14, this rose to 48% of patients.

Patients who are complex often experience more co-morbid conditions and are dependent in their IADL and ADL abilities. These patients are at higher risk of experiencing an adverse event such as a medication incident.

Safety in home care has become a national focus and several recent safety reviews confirm that medications are a major cause of adverse events for patients at home. Many of these medication related adverse events are considered to be preventable.


Evolving Patient Safety through Consistent Medication Management Practices Across LHIN Home Care

- Rapid Response Nurse Program to support at-risk patients transitioning from the hospital

- Local policy and practices related to medication reconciliation

- Creation of a provincial professional practice framework to promote consistent practice across Home Care

- Provincial policy including:
  - Consistent medication management activities;
  - Clear expectations through defined roles and responsibilities for Best Possible Medication History (BPMH) and medication reconciliation; and
  - Tools to support practice
Provincial Professional Practice Framework
Provincial Professional Practice

• In 2014, Home Care identified a need to establish a common, formal and consistent approach to ensuring evidence informed Professional Practice across the province

• Professional Practice Leads came together and articulated a new definition for Professional Practice;
  • *Professional Practice supports health care professionals working together, enhanced by a mutual understanding of, and respect for, the contributions of various professions. Professional practice provides the structures required to support competency in evidence informed practice, collaborative care provision, and achievement of high quality, safe and patient and caregiver-centered clinical outcomes*

• The Provincial Professional Practice Advisory Council (PPPAC) was established March 2015
Professional Practice Framework

• Reflect the values of Home Care
• A blueprint for interprofessional practice
• Reinforces the prerequisites for the promotion of safe, competent and ethical practice, which are inherent in the professional standards of practice

Dimensions of Practice

Adopted from: Shands Jacksonville Medical Centre Professional Practice Framework for Nursing
## Professional Practice Framework

### Defining Dimensions of Practice

<table>
<thead>
<tr>
<th>Evidence Informed Practice</th>
<th>Quality, Risk &amp; Safety</th>
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<tbody>
<tr>
<td>- Supports the review and implementation of core competencies for Care Coordination</td>
<td>- Learn from adverse and risk events and support the follow-up on recommendations to prevent them in future</td>
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<td>- Reviews and ensures practice standards inform practices in LHIN Home Care</td>
<td>- Collaborates in the development of quality improvement initiatives</td>
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<td>- Maintains an active awareness of professional trends across all disciplines, ensuring adoption of leading evidence into practice</td>
<td>- Monitors areas of risks as related to practice and collaborates in the development of risk mitigation strategies</td>
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<td>- Participation in research activities as required</td>
<td>- Monitors performance against practice standards and ensures adherence to these standards</td>
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<td>- Supports Clinical Supervision of students as required</td>
<td>- Provides input into development of Infection prevention and control program</td>
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<td>- Participates in review/discussion related to ethics/ethical decision making</td>
<td>- Linking care with Dimensions of Quality (HQO) i.e. access to service and quality of service</td>
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<td>- Assists in determining scope of practice vs scope of service</td>
<td>- Collaborate in the review of legislation, regulations and accreditation standards as they relate to Home Care practices</td>
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<td>- Supports interprofessional collaboration with system partners to promote evidence informed patient care</td>
<td>- Provide input in policies development for direct care staff</td>
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<td>- Promotes the dissemination of professional practice activities and innovations at a regional and provincial level</td>
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<tr>
<th>Organizational Support &amp; Services</th>
<th>Professional Growth</th>
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<tr>
<td>- Collaborates in the development and review of learning programs</td>
<td>- Provides input into the development of interprofessional orientation</td>
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<td>- Advocates for resources, education and research to promote professional development, leadership and evidence-informed clinical outcomes</td>
<td>- Recommend learning priorities and education programs to support professional practice</td>
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<td>- Supports Human Resources to address practice issues e.g. case reviews; hours of work; safety protocols</td>
<td>- Support knowledge translation through coaching, mentoring and preceptor activities</td>
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<td>- Supports local credentialing processes</td>
<td>- Support professional development and education of all staff</td>
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<td>- Provides feedback for performance appraisals</td>
<td>- Problem solving related to patient care</td>
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<tr>
<td>- Leads, mentors, coaches to collaborate in effective strategies across professional disciplines to address: practice issues, practice development, promotion and enhancement of competencies, and to create and sustain a quality working environment</td>
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Policy Development
Provincial Medication Management Policy

- Developed to standardize the Home Care activities and roles for care coordinators, Direct Care Nurses, and other health professionals (e.g. pharmacy)
- Medication management activities are outlined
- Medication management activity exclusions are outlined
Medication Management Activities for Home Care

Activities Included:

• Collection via the standardized assessment within scope
• A Best possible Medication History (BPMH) or Medication Reconciliation will be obtained within scope
• Nurse Practitioners prescribing medications within their scope of practice
• Clinical medication review will be conducted within scope of practice e.g. pharmacists
• Verbal orders within scope of practice and within specific circumstances
• Administering of medications within scope of practice
• Documentation according to standard of practice
• All health care staff will have access to ISMP List of High-alert Medications

Activities Excluded:

• Transcribing medication orders
• Selecting and procuring medication
• Storing or stocking medication
• Compounding and dispensing medications
• Transporting, removing, or disposing of medications
• Receiving, storing, providing, selling or supplying sample medications
Provincial Best Possible Medication History and Medication Reconciliation Policy

• Outlines expectations for care coordinators, Direct Care Nursing Services and allied health professionals related to medication management, BPMH and medication reconciliation

• Confirms a common provincial BPMH form and minimum expectations if a local form is chosen

• Introduces job aides to support staff with implementation:
  • Medication Management for Care Coordinators
  • Best Possible Medication History and Medication Reconciliation Process
Best Possible Medication History and Medication Reconciliation Fundamentals
Medication Management, BPMH and Medication Reconciliation

Best Possible Medication History and Medication Reconciliation, along with Clinical Medication Review, are all distinct parts of the Home Care comprehensive medication management program.

The process begins with the collection of a BPMH, and where indicated by the patient needs, ends with a Reconciled Medication List.

1. Developed collaboratively by the Canadian Pharmacists Association, Canadian Society of Hospital Pharmacists, Institute for Safe Medication Practices Canada, and University of Toronto Faculty of Pharmacy, 2012.
2. www.health.gov.bc.ca/pharmacare
3. ISMP Canada. Medication Reconciliation in Acute Care: Getting Started Kit. 2011
4. ISMP Canada. Medication Reconciliation in Acute Care: Getting Started Kit. 2011
What is Medication Reconciliation?

Definition:
A formal process in which health care providers partner with patients and family caregivers to ensure accurate and complete medication information transfers at transitions of care.

Purpose:
To prevent patient harm from medication and/or adverse drug events as the patient transitions across the continuum of care.

End goal:
To develop a point-of-time Reconciled Medication List that is shared and communicated with the patient and family caregivers, along with health care providers at transitions of care.
What Factors Contribute to Patient Adverse Events in Home Care

• 68% of reported medication incidents in home care occurred following hospital discharge

Major themes included:
1. Communication breakdown
2. Lack of patient engagement in their medication regimen
3. Unclear or conflicting medication plans

What Adverse Events Occur in Home Care?

• Errors or discrepancies after transitions in settings or to different providers

• Adverse drug events with patients taking high alert medications
  • Majority of preventable medication related errors result from high-alert medications

• Polypharmacy with patients taking multiple medications
  • 50% of adults take one or more medications that are not medically necessary
  • As comorbidities increase, so do medications, leading to
    • Increased medication discrepancies
    • Additive side effects
    • Drug interactions


• Patient non-adherence to their medication regimens
  • 5.4% of all hospitalizations are due to medication non-adherence
    • Complex medication regimens
    • Communication gaps
    • Drug expense and access to the medication ordered

Medication Adherence Table. Available at: http://www.acpm.org/?MedAdherTT_ClinRef#Table1
Where in the Home Care Experience Should Medication Reconciliation be Completed?

Upon an existing home care client’s transition of care:

- Transition to Any time acute care services are accessed (emergency, inpatient care)
- Admission to respite care
- Return to Home Care
Where in the Home Care Experience Should Medication Reconciliation be Completed?

Upon an existing client’s planned transition to alternate care facility/organization, self-care (end of service)

Home Care Client

Transition to

Long Term Care or Other Home Care Organization
When To Do Medication Reconciliation?

- The sooner the better—usually within the first 2 visits
- Helps to prevent the perpetuation of medication errors
Medication Reconciliation in Home Care

Timely medication reconciliation can identify and correct…

- Medication non-adherence due to lack of knowledge
- Address under or over dosing due to problems with communication
- Utilization of unordered medications

Helps to identify patients who require further interventions necessary to safe medication regimens e.g. weekly pill planners, blister packs

Connect with patients before adverse events happen!
Steps in Medication Reconciliation in Home Care

STEP 1. Collect-the Best Possible Medication History

STEP 2. Compare – Identify discrepancies

STEP 3. Correct – Resolve discrepancies

STEP 4. Communicate – The reconciled medication list
Step 1 - Collect

**Collect** – Collect the Best Possible Medication History

- Interview the patient/family caregiver using a systematic process to determine actual medication use by the patient.
- Review at least one other reliable source of medication information.
- Review for any high alert medication that the patient may be taking using the ISMP “Do Not Use” List.
- Document the BPMH including the drug name, dose and/or strength, route and frequency for each of all types of medication.
- Document using the common BPMH Form.
Tips for Collecting a BPMH

Use a Systematic Process for Collecting a BPMH

• Talk and listen to the patient/caregiver
• Ask for a current medication list (they may or may not have one)
• Ask about their current actual medication use and not just what is prescribed

“How do you take you medications each day?” Open the vial and ask, “tell me how you use/take these.”

• Ask open ended questions
• Ask specifically about special types of medications e.g. prescription and non-prescription; vitamins and supplements; medications taken on an as-needed basis; medications taken cyclically such as once a month; or non-oral medications such as drops, inhalers, sprays, patches, injections, and other
Tips for Collecting a BPMH

Sources of Information

• Patient/ Caregiver recall
• Medication vials
• Bubble packs/ dosettes
• Discharge orders or summaries from other facilities (hospital, Long term Care, others)
• Patients own or previous medication list
• Community pharmacy
• Ontario Drug Benefits Profile Viewer
• Other

START with the most recent sources, KNOW their limitations, and LOOK BACK six months
Step 2 - Compare

**Compare** – Identify discrepancies

- Compare the BPMH with the most current information contained in the patient’s recorded medication information sources
- Identify and document the differences or discrepancies between the BPMH and recorded medication information sources
Identify Medication Discrepancies

Identify Discrepancies

**Medication Information from multiple sources**
- Medication containers, bottles, vials,
- Community pharmacy list
- Hospital Discharge Summary
- Drug Profile Viewer

**Client and Family Interview**
- When and where possible
- Determine what the client is ACTUALLY taking.

Identify & document discrepancies between the sources of information

BPMH
Common Types of Medication Discrepancies

Omission
- Home med not listed
- Home med not ordered
- Discharge med not included in instructions

Commission
- Discontinued med is listed or ordered
- Therapeutic duplication due to formulary substitution
- Double-dosing via two routes (e.g., IV and PO)

Description
- Dose time missed
- Dose inappropriate
- Extra dose given
- Different frequency

**Step 3 - Correct**

**Correct – Resolve discrepancies**

- Correct the discrepancies as appropriate through discussion with the patient/ caregiver and health care provider(s) as appropriate.
- Update the BPMH to accurately reflect the patient’s current medication regimen with the resolved discrepancies. This becomes the **Reconciled Medication List**.
- Make sure the Reconciled Medication List is easily visible and accessible in the patient record.
Communicate – Ensure continuity of medication information

• Communicate any medication changes to the patient and verify the patient’s/caregiver’s understanding of their medication regimen.

• Provide the Reconciled Medication List to:
  • Patient/caregiver (via mail if no in-home visit is scheduled)
  • Others involved in the patient’s circle of care and convey the rationale for any changes that may have been made (primary care provider, community pharmacist and others involved in medication administration)
Roles for Care Coordinators

Collect a Medication List
• Using the medication list from the standardized assessment instrument, assess the patients ability to understand and manage their medication, including:
  • General purpose of medications
  • Taking medications as prescribed
  • Use of PRN medication and over the counter products

Identify and Teach
• Identify high alert medications
• Instruct patients to return discontinued medications to the pharmacy
• Instruct patient to take their medication list and/or medications to all medical appointments
Roles for Care Coordinators

Follow-up and Share
• Follow-up with primary care or pharmacist when the patient is not taking medications as prescribed
• Share the medication list with the patient, caregivers, and circle of care as appropriate

Refer for Medication Reconciliation When There Is…
• Significant change in the patient’s health status
• Taking three or more high alert medications
• Lack of adherence to medication regimen e.g. poor understanding, impaired cognition, low health literacy
• Recent discharge from hospital, and has three or more morbidities OR is taking 6 or more medications
• High utilization of the health care system e.g. several prescribers, 10 or more outpatient visits in 1 year, 3 or more Emergency Department visits in 6 months, 3 or more hospital admission in 1 year
• Request by a physician or referral source
Roles for Direct Care Nurse and Allied Health Professionals

- Collection of a formal Best Possible Medication History
- Completion of medication reconciliation
- Completion of clinical medication review within the scope of practice of the practitioner e.g. pharmacist, Nurse Practitioner, other
Medication Reconciliation Resources
Common Best Possible Medication History Form

<table>
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<tr>
<th>Medication Management</th>
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<tbody>
<tr>
<td>Medication Name</td>
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<tr>
<td>Dose</td>
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<tr>
<td>Route</td>
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<td>Reason for Use</td>
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<td>Medication Details</td>
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<td>Additional Notes</td>
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Health Shared Services
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Education Job Aids

Medication Management for Care Coordinators

Committed to safe and quality care for patients by ensuring compliance with evidence-informed practices in Medication Management, collection of the Best Possible Medication History, and Medication Reconciliation that will reduce patient harm and result in decreased medication-related patient safety incidents.

1. Collect Medication List
   - Using the form from the standardized assessment instrument, assess patient’s ability to understand and manage their medications including: general purpose of medications, taking medication as prescribed, and use of IVT and over-the-counter products.

2. Identify and Teach
   - Identify high alert medications (see link below)
   - Instruct patient to return discontinued medications to pharmacy.
   - Instruct patient to take medication list to all medical appointments.

3. Follow-Up and Share
   - Follow-up with Primary Care Provider or Pharmacist when patient is not taking medications as prescribed.
   - Share the most current medication list with patient, caregiver, and circle of care as appropriate.

4. Refer for Medication Reconciliation if
   - Significant change in health status
   - Three or more high alert medications
   - Lack of adherence to regime e.g. poor understanding, impaired cognition, or low health literacy
   - Discharge from hospital within last 2 weeks, and has 3 co-morbidities OR 6+ medications AND/OR medication change during hospital stay
   - High utilization of health care with multiple prescribers e.g. more than 10 outpatient visits in the past year, 3 or more ED visits in the past 6 months, 3 or more hospital admissions in the past year
   - Requested by a physician or referral source.

For More Information:
- Policy: Best Possible Medication History and Medication Reconciliation
- High Alert Medications: https://www.ismp.org/communityResources/ambulettenhighalert.asp
- ISMP Error Prevention Abbreviations: www.ismp.org/tools/errorpreventionabbreviations.pdf

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Medication Reconciliation Process

- Collect - the Best Possible Medication History (BPMH)
  - Interview the patient/family caregiver using a systematic process to determine actual medication use by the patient.
  - Review at least one other reliable source of information to obtain and verify all of a patient’s medication use (prescribed and non-prescribed).
  - Review high alert medications (link below)
  - Document the BPMH with consideration to error prone abbreviations (link below)

- Compare - Identify discrepancies
  - Compare the BPMH with the most current information found in the patient’s recorded medication information sources.
  - Identify and document discrepancies e.g. missing medication, discontinued medication, taking a medication diff erently than prescribed.

- Correct - Resolve discrepancies
  - Correct or resolve discrepancies through discussion with the patient/family caregiver and/or healthcare professional(s) as appropriate, i.e., reconcile.
  - Update the BPMH (as needed) to accurately reflect the patient's current medication regimen once discrepancies are resolved. This updated list becomes the reconciled medication list.
  - Document the reconciled medication list in a clearly visible and accessible place.

- Communicate - the reconciled medication list
  - Communicate any medication changes to the patient/family caregiver and verify their understanding of the updated medication regimen.
  - Provide the reconciled medication list, whenever possible, to patient/family caregiver and others involved in the patient’s circle of care as appropriate.
  - Convey the importance of keeping an up-to-date medication list.

For More Information:
- Policy: Best Possible Medication History and Medication Reconciliation
- High Alert Medications: https://www.ismp.org/communityResources/ambulettenhighalert.asp
- ISMP Error Prevention Abbreviations: www.ismp.org/tools/errorpreventionabbreviations.pdf
ISMP Resources

5 QUESTIONS TO ASK ABOUT YOUR MEDICATIONS when you see your doctor, nurse, or pharmacist.

1. CHANGES?
   Have any medications been added, stopped or changed, and why?

2. CONTINUE?
   What medications do I need to keep taking, and why?

3. PROPER USE?
   How do I take my medications, and for how long?

4. MONITOR?
   How will I know if my medication is working, and what side effects do I watch for?

5. FOLLOW-UP?
   Do I need any tests and when do I book my next visit?

Keep your medication record up to date.

Remember to include:
- drug allergies
- vitamins and minerals
- herbal/natural products
- all medications including non-prescription products

Ask your doctor, nurse or pharmacist to review all your medications to see if any can be stopped or reduced.

Visit safemedicationuse.ca for more information.
Summary

• Home Care has been working to evolve patient safety through provincially consistent medication management practices

• In 2014, the Provincial Professional Practice Advisory Council (PPPAC) was formed, including:
  • Defining a Professional Practice Framework and Dimensions of Practice

• Early efforts have focused on the development of common policies to promote provincial consistency for:
  • Medication management
  • Collection of a Best Possible Medication History and medication reconciliation

• A comprehensive approach to facilitate patients accessing effective medication reconciliation can prevent patient harm from medication and/or adverse drug events as the patient transitions across the continuum of care

• PPPAC has developed a wide-range of resources to support care coordinators, Direct Care Nursing Services and other allied health providers in effective medication management
Best Possible Medication History and Medication Reconciliation?
Champlain
Best Possible Medication History Electronic Form

Demonstration