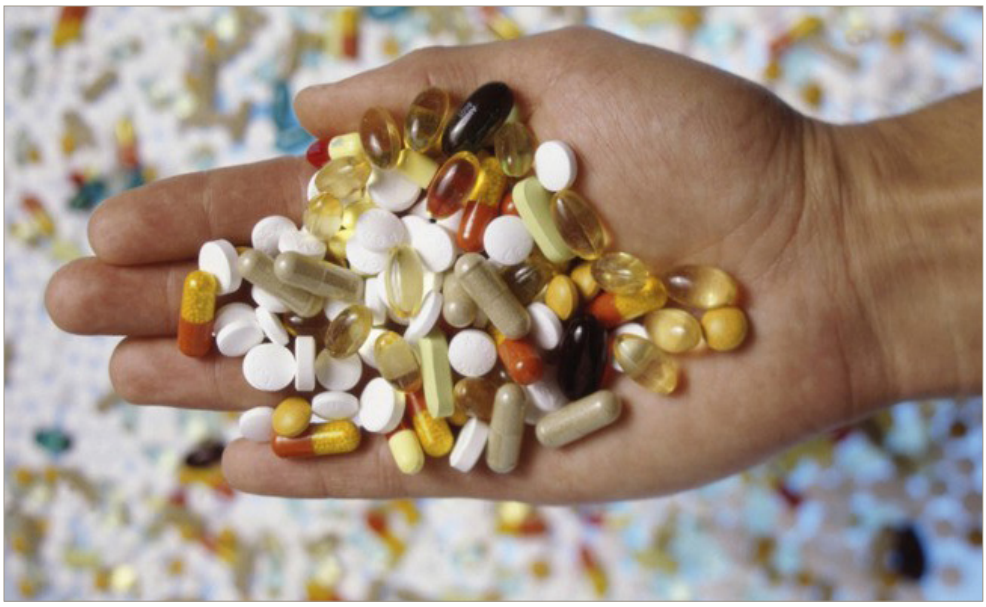
SOUTH OKANAGAN SIMILKAMEEN



Shared Care Polypharmacy Risk Reduction in Acute Care

2016 - 2018

FINAL REPORT

October 2018

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EXECUTIVE SUMMARY

One of six provincial prototypes, the Shared Care Polypharmacy Risk Reduction in Acute Care project addressed opportunities for improvement in the medication journey for patients entering and exiting a single general medical ward at Penticton Regional Hospital (PRH). The project working group included specialists, family physicians, Interior Health (IH) administration, nursing staff, a pharmacist and a provincial physician lead.

After mapping the current patient medication journey through emergency, admissions and discharge in order to identify gaps in process and communication, the working group identified three main goals:

- **Polypharmacy Risk Reduction:** Trial the use of acute care pharmacists to complete medication reviews for high-risk patients, and encourage physicians to conduct meaningful medication reviews to ensure that patients are getting the right medications at the right time.
- **Discharge Reconciliation and Prescription:** Improve workflow to aid physicians in completing a medication reconciliation at discharge, and encourage them to complete the discharge prescription form in full.
- **Effective Discharge Communication:** Improve communication amongst acute care at PRH, the patient, the family physician and the community pharmacist.

The project identified that acute care pharmacists can play an important role in polypharmacy risk reduction by conducting medication reviews prior to patient discharge. Small changes in workflow helped streamline form preparation to aid medication reconciliation and reduce physician frustration at discharge.

Both physicians and community pharmacists have stated that the current Interior Health (IH) medication discharge form is difficult to read. In fact, sections of it are often left incomplete. It was identified that physicians are unclear of their role and level of responsibility in the medication discharge process. Some improvements were made in the communication of medications back to the family physician to aid transition back to community.

In order to reduce the risk of polypharmacy related adverse drug events (ADEs) the project recommends the co-design of a medication optimization strategy, which would include mandated protocols around who in the acute care setting is accountable for medication review and reconciliation prior to discharge. Discharge medication lists must be must clear, concise and understandable for effective communication to patients, community care-givers, family physicians and community pharmacists. In addition, there is a need for additional education on meaningful medication review.

INTRODUCTION/BACKGROUND

Polypharmacy Risk Reduction in Acute Care makes sense in the South Okanagan Similkameen, as we have a higher-than-average elderly population. In fact, 30.7% of our region's patients are over 65, compared to the provincial average of 17.5%. Older adults are 7-times more likely to be admitted to hospitals for Adverse Drug Events (ADEs). These Adverse Drug Events involve patients who are on five or more prescription drugs[1,2].

Previous to the start of the Polypharmacy Risk Reduction project, the SOS was a prototype site for the Division of Family Practice Residential Care Initiative, which saw the successful implementation of best practices. Our region has strong community momentum and engaged Residential Care physician champions. The Polypharmacy Risk Reduction in Acute care project intended to build on this increased awareness and the presence of physician champions to explore potential for improvements in an acute care setting at Penticton Regional Hospital (PRH).

An Acute Polypharmacy Working Group was established in the spring of 2016 with representation from:

- Specialist and family physicians
- Interior Health administration, nursing, and pharmacy
- Provincial Polypharmacy Risk Reduction (PPhRR) clinical leadership

The group was tasked with mapping the current patient medication journey through emergency, admissions and discharge in order to identify gaps in process and communication, and to determine opportunities for improvement **(Appendix A)**. Given the limited timeframe and potential scope of a project on acute polypharmacy, the working group agreed that emphasis should be placed on optimizing the medication journey for patients entering and exiting a single ward at PRH. A general medical ward (SP3) was chosen because it captured a range of patients and most discharge procedures are completed by family physicians.

[1] BCStats (2016) Population Estimates

[2] BMJ 2004:329(7456

PROJECT OVERVIEW

The general aim of the project was for patients hospitalized at PRH to move back to the community with a list of medications that makes sense for them. This meant co-designing, optimizing and implementing sustainable processes, which allow for effective communication regarding medications (Appendix B).

Goal 1. Polypharmacy Risk Reduction

Polypharmacy is a risk factor for Adverse Drug Events (ADE). This risk increases exponentially with the number of medications a patient is taking. Interactions between multiple medications and/or unnecessary doses can have serious impacts on the safety and quality of life for elderly patients.

Acute Care Pharmacy

It was suggested that the clinical skills of acute care pharmacists could be used to aid polypharmacy risk reduction for high risk patients. Pharmacists spend a large percentage of their time in the dispensary but could be available for medication reviews throughout the hospital. Reviews can be triggered in rounds or through physician orders, however, few physicians take advantage of this service due to lack of awareness and availability, which is dependant upon PRH pharmacy capacity.

The pharmacist and the nurses from SP3 developed eight criteria to target high risk patients for medication review:

1. Multiple admissions in short period of time
2. Transfers between facilities or levels of care
3. Multiple sedatives (including psychotropics)
4. ≥10 medications prior to admission
5. Poor medication compliance
6. Admission due to a possible adverse drug reaction
7. Nursing concerns regarding patient ability to manage medications at home
8. Frequent falls

The pharmacist conducted medication reviews only when the pharmacy schedule permitted.

Meaningful Medication Review

Meaningful medication review is often assumed to be the same as medication reconciliation. Both require accurate medication lists, standard process, collaboration and clear communication to be effective. However, a meaningful medication review assesses the appropriateness of a particular patient's medication and management and is, therefore, closely tied to polypharmacy risk reduction.

Physicians are often limited in how they view their role in conducting a meaningful medication review. The working group identified, created and publicised useful educational tools and resources to remind physicians to examine their patient's medications in a meaningful way.

Goal 2. Discharge Reconciliation and Prescription

Physicians are responsible for populating the discharge prescription form. To do so accurately they need to reconcile which medications the patient was admitted with, which ones they were given during their hospital stay and which ones they need to take when they get home. The working group identified two changes that could improve the discharge reconciliation process and could, therefore, potentially reduce the risk of an ADE.

Discharge Workflow

Physicians report that discharge medication lists and admission reconciliation forms are sometimes difficult to locate at the time of discharge — they may need printing and/or can't easily be found in the patient's chart. Emphasis was placed on anticipating discharge more effectively so that the unit clerk and nurses can print out forms in advance and make sure that all forms are placed in the same location in the patients charts for easy retrieval and comparison by the discharging physician.

Completion of the Discharge Prescription Form

It was identified by the acute care pharmacist that medication reconciliation is not always completed by physicians prior to discharge. In addition, local community pharmacists indicated that the discharge prescription forms they receive are often hard to read and lack critical information on what medications have been added, stopped or changed during the patients hospital stay and frequently contain no rationale for any medication change. Depending on the time of day discharge takes place and the family physician schedule, it can be challenging to get timely clarification on which medications the patient should be taking, at what dose and for how long.

Physicians in the working group noted that the Interior Health(IH) discharge prescription form contains a font style and size that is difficult to read. They also outlined areas of the discharge prescription form that should contain critical information that would be needed by the patient and/or community pharmacist to help reduce the potential risk of an ADE.

The acute care pharmacist and a SP3 nurse from the working group completed a medication discharge form audit over a one-week period in order to ascertain how many medication reconciliations were completed by physicians (both general physicians and specialists) and information missing from the discharge prescription form.

The audit was repeated two weeks after a CME outlining the importance of populating the prescription form. This was done to help determine the impact increased awareness may have on the polypharmacy risk associated with incomplete medication discharge forms.

Goal 3. Effective Discharge Communication

Effective discharge communication between acute care at PRH, the patient, his/her family physician, and a community pharmacist requires a standardized pathway. Current gaps in communication were documented and the group brainstormed ways to improve them.

Physician Education - CMEs

Polypharmacy risk reduction was introduced to physicians at PRH in a series of CMEs delivered at Physician Rounds. The first two CMEs addressed the concept of polypharmacy risk reduction and highlighted general areas that physicians should be addressing in their practice. The third CME specifically outlined the results of the project with suggestions on how to improve medication outcomes and reduce risk by standardizing the discharge process and conducting a meaningful medication review **(Appendix C)**.

To increase physician awareness and document progress, a report card on the acute polypharmacy project was delivered to the mailboxes of all physicians with hospital privileges **(Appendix D)**.

PROJECT RESULTS

Polypharmacy Risk Reduction

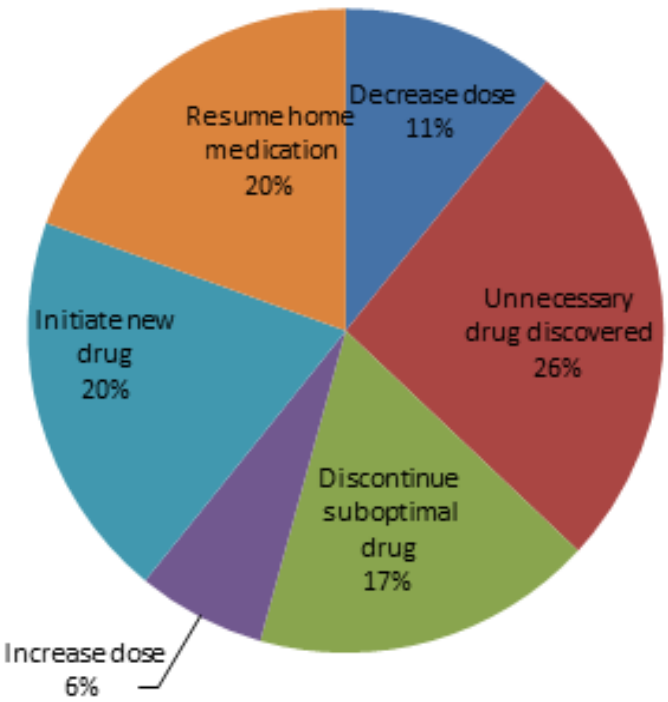
Pharmacist Review

Data collected by the PRH pharmacist conducting polypharmacy medication reviews for high-risk patients on SP3 supported the value of completing a medication review for high-risk patients who are in acute care.

Data Summary:

- 37 days of data collection (between May 2017-January 2018)
- 42 patients met criteria for medication review
- 31 patients were reviewed
- 21 notes left in chart
- 1.95 medication change recommendations per patient

Figure1: Acute Care Pharmacist Recommendations



The data shows that 68% of the high-risk patients under review had medication profiles that could be improved, with medications that could be stopped, replaced or dosages modified. Physicians appeared to be taking note of pharmacist recommendations, with 93% of the changes being implemented. Pharmacist reviews also indicated that the top therapeutic indications that could result in a higher potential for polypharmacy related ADE are COPD, hypertension, pain and diabetes, highlighting which patients might be at higher risk.

PROJECT RESULTS

Chart Stamp and Poster

In an attempt to increase awareness of the potential use of hospital pharmacists for at-risk patient medication review and to alert physicians to completed reviews, a stamp was added to the patient chart. A poster was created to educate physicians on what a polypharmacy review involves and was placed in the nurses station and around the ward (Appendix E).

A pharmacist button was also added to the ward communication whiteboard in the nurses station to indicate pharmacist involvement to the entire care team.

Meaningful Medication Review Educational Poster and Handout

A poster was developed featuring the kinds of questions physicians should be asking themselves when doing a meaningful medication review. The poster was intended for use in clinic offices as a review of best practice (Appendix F).

A handout with a list of online resources outlining best practices for completing a comprehensive and meaningful medication review was handed out at the CME (Appendix G).

Impact

PRH pharmacy and SP3 nursing staff have confirmed that the number of requests for medication reviews by a pharmacist has increased since the start of the project. This should ultimately have an impact on polypharmacy outcomes.

Capturing data on meaningful medication reviews is difficult as a practice change would require individual/team physician reflection and desire to change standard care requirements on medication review. There is no indication of any significant change in practice.

Discharge Reconciliation and Prescription

Chart Organization and Discharge Workflow

The unit clerk and nurses developed a standardized workflow to ensure that forms needed at discharge are available and always placed in the same location in patient charts. The group also suggested making a copy of the discharge prescription form and keeping it in the chart after discharge in order to be able to refer back to it if necessary.

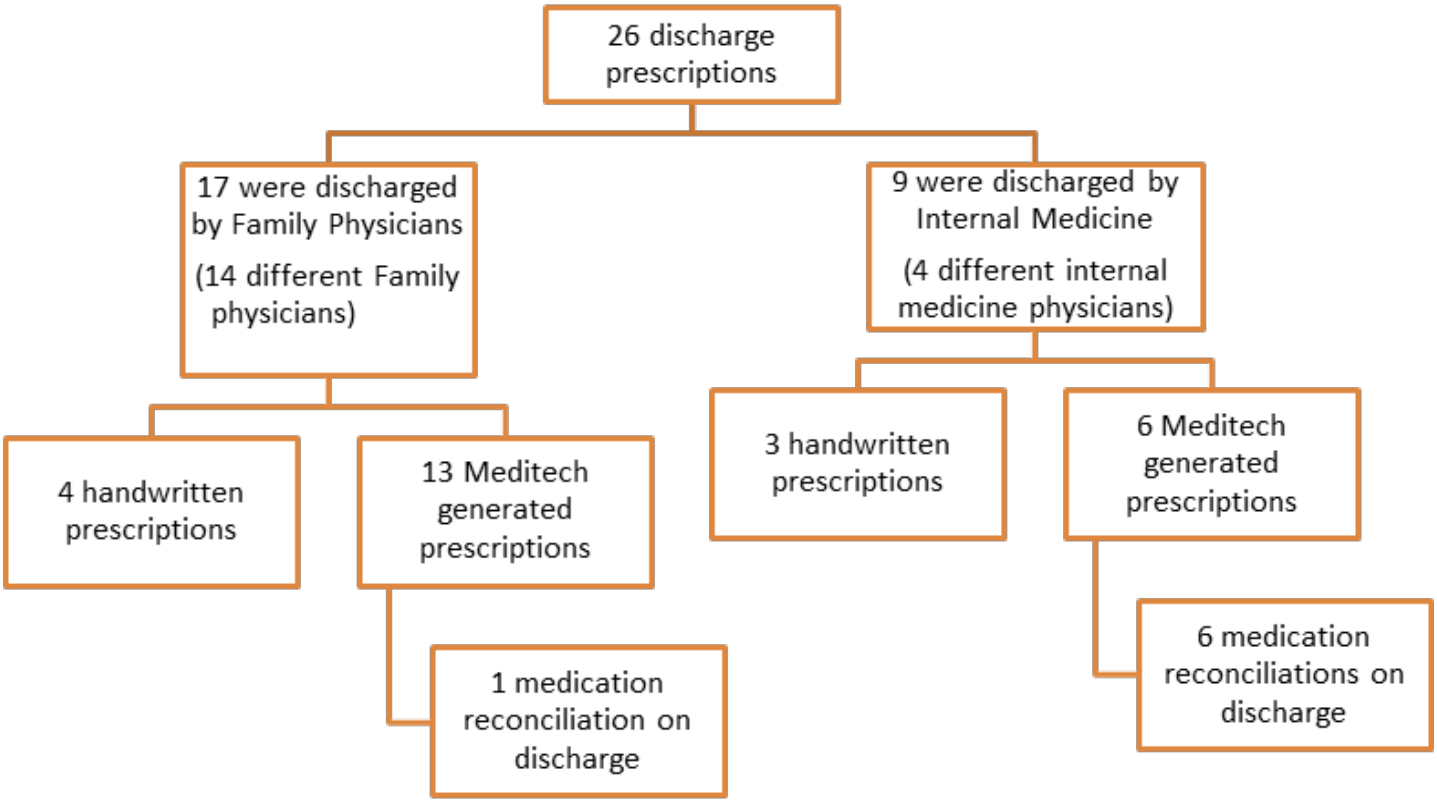
The working group modified a workflow document developed by a prototype site in Kamloops. The pathway outlines the role of the unit clerk, nurse and physician in the discharge process with emphasis on the need to complete a discharge prescription (Appendix H).

PROJECT RESULTS

Medication Discharge Form

The medication discharge audit conducted over a one-week period in March 2018 examined 26 discharge prescriptions. The most responsible physician (MRP) conducted the discharge and was either a family physician or internal medicine physician.

Figure 2: Medication Discharge Audit



Medication discharge forms (Appendix I) were often not fully populated by physicians upon discharge of patients from hospital. Sections of the discharge form that were often left blank include:

- Details on quantity, dosage and rationale for changes for therapeutic interchanges and medications requiring special authority.
- Information on additional medications that have been started, stopped or changed while in the hospital (with rationale for changes).
- Information about medications that need to be discontinued once the patient gets home.
- Request for a medication review from the community pharmacist. Both community pharmacists and discharging physicians confirmed that this is very rarely completed.

PROJECT RESULTS

Impact

Chart reviews by nursing staff and physicians indicate that forms are now consistently found in the same location in the chart, which helps to make the discharge process more streamlined.

The repeat medication discharge audit conducted after the CME did not result in any change in the number of fully completed discharge prescription forms. Brief interviews with attending physicians suggests that the lack of impact could be related to the short timeframe between the CME and the number of physicians discharging from SP3 over that period. In addition, behavioural change often requires some combination of targeted quality improvement, prolonged exposure to best practice or required policy.

Effective Discharge Communication

Linked closely with improvements in discharge reconciliation and prescription, effective communication of the updated medication list to patients, family physicians and community pharmacists is a critical step in preventing errors and reducing the potential for polypharmacy related ADEs.

Changes implemented by the project are included in the standardized workflow poster/handout **(Appendix H)** and include:

- Faxing the completed medication discharge form to the community pharmacist and the family physician.
- Discussing the medication discharge form and any changes in medication with the patient prior to leaving the hospital. Discussing self-management using the a patient handout called: "5 Questions to Ask" **(Appendix J)**.
- Creating a stamp to be used on the patient discharge form reminding patients to visit their family physician within seven days of discharge to discuss their medication.

Impact

The acute care pharmacist and nurses working on SP3 continue to work on this project initiative and are looking to ways of spreading the learnings to other wards at PRH. The following impacts have been recognized:

- An increase in the number of physicians requesting a medication review from an acute care pharmacist. However, the requests are coming from the internists rather than the GPs. There is no apparent increase in use by GPs.
- Some indication that the discharge prescription forms are being populated more fully — another audit is scheduled for September/October 2018.
- Completed discharge prescription forms are now being faxed directly to the community pharmacist and the family physician 100% of the time.
- Internal audit indicates that the discharge forms are always located in the same place in the patients chart.
- Internal audit indicates that a copy of the discharge prescription form is now being kept in the chart after discharge 100% of the time.
- Family physicians have stated that they benefit from receiving the medication discharge form for their patients.

KEY LEARNINGS

- Acute care pharmacists can play an important role in polypharmacy risk reduction if they can be utilized prior to patient discharge. Physicians were unaware that they could access pharmacists to aid medication review for high-risk patients. They valued the recommendations.
- Meaningful medication reviews are best practice for polypharmacy risk reduction but difficult to instill as a behavioural change.
- Physicians find the discharge process frustrating and time consuming due to lack of coordination in care. Standardized workflows help with streamlining discharge.
- Physicians are somewhat unclear of their role and responsibilities in the discharge process with regards to medication reconciliation and review, both of which have significant impacts on polypharmacy risk reduction. Effective communication of discharge medications is necessary in order to transition patients back to community safely. An improved workflow and clear role definition could significantly reduce the number of polypharmacy-related ADEs.
- Both physicians and community pharmacists find that the Interior Health (IH) discharge medication form is difficult to read but especially after being faxed. Criticisms include: font style and size, and a lack of clarity regarding what information is need in each section.

CHALLENGES

- Lack of influence on patient medication history prior to admittance to SP3. Due to a lack of clear and binding protocols, it is unclear if medication reviews have taken place at other locations in the hospital.
- Lack of ability to adapt/change the IH medication discharge form to make it clearer for physicians to complete and community pharmacists to read.
- No access to re-admission data for PRH.
- Realization that getting physicians to do a meaningful medication review is a major behavioural change. It will require a multi-level approach to become a sustainable practice.

RECOMMENDATIONS

- Spread the learnings from the project to other wards in PRH.
- Increase access to acute care pharmacists to help ensure that medication reviews take place prior to discharge for high-risk patients. This will require a clear and concise protocol around the definition of "high-risk" and require a change in schedule and/or increased capacity for the PRH pharmacy.
- Co-design a "Medication Optimization" strategy:
    - Create, implement and mandate clear protocols around who in the acute setting is accountable for medication review and reconciliation prior to discharge.
    - Provide physicians and residents sufficient education to aid compliance.
    - Identify, list and educate physicians to Potentially Inappropriate Medications (PIMs) to focus the review prior to discharge.
    - Modify the IH medication discharge form so that it is easy for patients, community pharmacists and family physicians to read. How to populate the document must also be clarified.
    - Create clear links to the transition nurse and/or the Quick Response Team (QRT) to make sure communication about medication changes are conveyed to community caregivers, either at residential sites or private homes.
    - Clearly communicate with community pharmacists to maintain best practice and signal the need for a more detailed medication review.
- Access IH data on patient readmission to PRH to aid evaluation of quality improvement initiatives.
- Address the clear need for interoperability of technology surrounding medications, such as MediTech, physician EMRs and Pharmanet, to aid the medication review process.

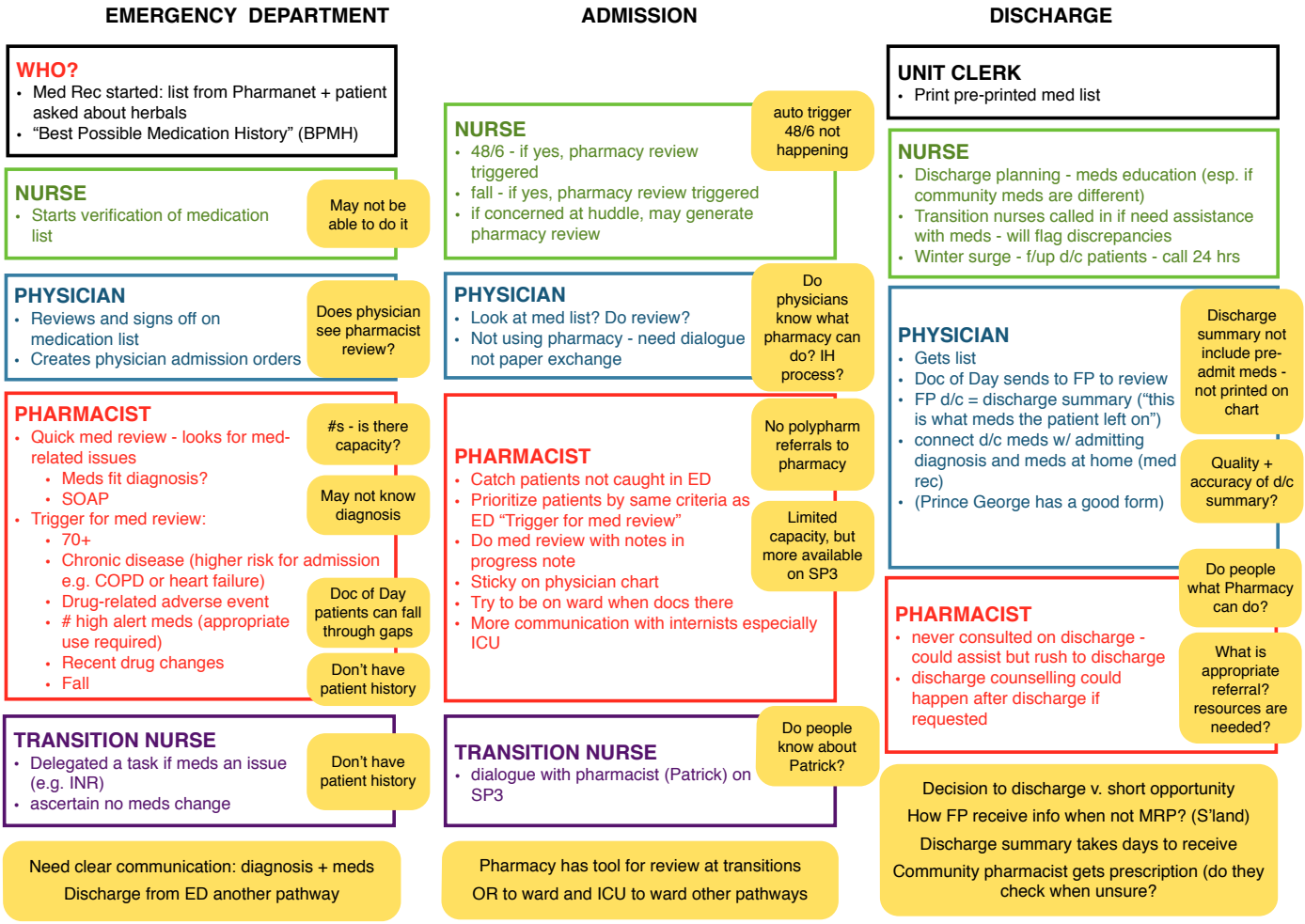
APPENDIX A

Acute Care Patient Medication Pathway

ACUTE POLYPHARMACY RISK REDUCTION PROJECT ON SP3 - Project Goals					
Objectives	**Project Activities**	**Change in Practice**	**Who?**	**Tools**	**Education**
Goal 1: Polypharmacy Risk Reduction					
Pharmacist involvement in medication reviews for high risk patients	Identification of 8 risk factors + major medication groups	Pharmacist review identified on the white board + in the chart	Physicians, nurses, pharmacists, allied health		• Report Card • CME
	Pharmacist conducts medication reviews when time permits	Physicians can request a pharmacist review		Med Review Chart Stamp + Poster	
Meaningful medication review	Identification and creation of useful educational tools and resources	Physicians examine medications in a meaningful way	Physicians	"5 Reminders: Reviewing Medications With Your Patient" Poster	• Poster • CME
Goal 2: Discharge Reconciliation and Prescription					
Make completing discharge medication reconciliation more seamless	Print medication discharge forms in advance and place in the same location in the chart	Place forms in known location in the chart	Physicians, nurses, unit clerk, pharmacist	A, B, C, D poster for PRH physicians and unit clerk	• Poster • CME
Encourage physicians to complete the medication discharge form accurately	Identification of gaps in information given to patients, GPs and community pharmacists and outline the risks associated with this lack of knowledge	Populate the medication discharge form with details on any medication changes (new, changed, discontinued) and include rationale	Physicians		
Goal 3: Effective Discharge Communication					
On discharge from PRH provide patients, GP's and community pharmacists with clear instructions and rationale for current medications	Identification of the current gaps in communicating medication changes	All sections of the medication discharge form completed and given/faxed to the patient, GP and community pharmacist	Physicians, nurses, unit clerk	A, B, C, D poster for PRH physicians and unit clerk	• Posters • CME
		Spend the time to go over the reconciled medication discharge form with the patient	Physicians, nurses	"5 Questions to Ask" Medication self-management poster for physicians to give/show patients	
	Prompt the patient to visit their GP after discharge from PRH and to discuss medications during that visit	Stamp the patient discharge form	Nurses	Stamp	

APPENDIX B

Project Summary Table



A partnership of
Penticton Physician Medical Society
The Division of Family Practice

TUESDAY ROUNDS

Tuesday Rounds

PRH

Speakers:

Dr. Mark Lawrie
Dr. Shannon Walker
Patrick Edwards, pharmacist

PRH Education Room

Tuesday

April 17, 2018

8am – 9am

Light breakfast provided

This Group Learning program has been certified by the College of Family Physicians of Canada and the British Columbia Chapter for up to 1 Mainpro+ credits.

The PRH CPD Program is a self-approved group learning activity (Section 1) as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada

How to not mess up the discharge prescription… and why it matters.

- Appreciation & development of a meaningful medication review in high risk patients.
- Recognize initiatives on SP3 currently underway to help reduce polypharmacy risk.
- Discuss how to efficiently conduct a medication reconciliation on discharge & why it's important.

The Penticton Physician Medical Society and Division of Family Practice have partnered to deliver physician-driven, needs-based continuing medical education.

Our CME Planning Committee is excited to engage local specialists to provide learning opportunities for both family physicians and specialists.

Submit questions or clinical challenges you would like to see addressed at a future event. Email Kristen Hart at kristen.hart@sosdivision.ca or fax 778-476-5992.

Upcoming Topics:

May 1st : Dr. Holly Wiesinger - IBD

May 8th: Dr. Kevin Renaud- Fibroids & heavy bleeding

South Okanagan Similkameen Division of Family Practice

CME Planning Committee

Dr. Jack Kooy, Dr. David Paisley, Dr. Jacqueline Stewart, Dr. Chris Toneff, Dr. Elizabeth Watters, Tracy St. Claire, Julie Young, Kristen Hart

SharedCare Partners for Patients

Acute Polypharmacy on SP3 PROJECT REPORT

Spring 2018

Project goals

Develop ways of decreasing the risks associated with acute care polypharmacy and discharge planning through:

- Polypharmacy Risk Reduction
- Discharge Medication Reconciliation
- Improved Communication to Community Partners

Pharmacy reviews

CRITERIA FOR AN SP3 MEDICATION REVIEW

Project team identified 8 criteria to target patients for a med review:

Multiple readmissions (>2)	Transfers between facilities or levels of care
Poor medication compliance	Multiple sedatives (including psychotropics)
Nursing concerns	≥10 medications prior to admission
Frequent falls	Admission due to possible adverse drug reaction

Note: Pharmacist data collection period was over May 2017– Jan 2018

42 Days of data collection

31 Patients reviewed

37 Met criteria for review

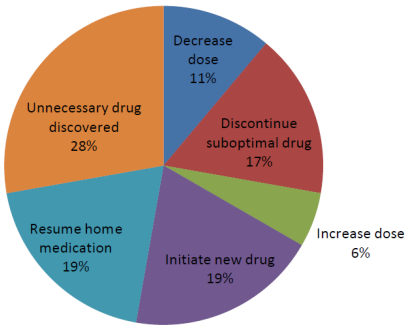
17 Notes left

1.95 Recommendations per patient chart reviewed

93% of recommendations were accepted by the physicians

Average patient age: **82**

PHARMACIST RECOMMENDATIONS TO PHYSICIANS



Top 5 therapeutic indications

- COPD
- Hypertension
- Pain
- Diabetes
- Dyslipidemia

Patrick Edwards (PRH Pharmacist) has been doing pharmacy reviews for at risk patients on SP3

Is your patient at risk?

Meaningful review

What information does your patient, their GP and their community pharmacist need in order to reduce the risk of an adverse drug reaction?

Find out at ...

PRH TUESDAY ROUNDS
8-9am, April 17th

How to not mess up the discharge prescription ...and why it matters

Shared Care Project Lead
kathleen.jagger@sosdivision.ca
cell: 250 878 1535

Committee: Dr. Mark Lawrie (GP), Dr. Chad Dyck (General Internist), Dr. Shannon Walker (Respirologist), Dr. Marius Snyman (GP), Margaret English (PPhRR Initiatives Lead), Dr. Chris Rauscher (PPhRR Physician Lead), Patrick Edwards (SP3 Pharmacist), Lois Neufeld (PRH Nurse Manager), Christine Rutherford (PRH Pharmacy Professional Practice Lead), Karen Lapointe (PRH Clinical Pharmacist Practice Lead), Sharon Fekete (Nurse Manager), Jessica Nattress (SP3 Patient Care Coordinator)

BRITISH COLUMBIA doctors of bc
South Okanagan Similkameen Division of Family Practice
www.sharedcarebc.ca

ATTN: PHYSICIANS

HAVE YOU SEEN THIS STAMP ON YOUR PATIENT'S PROGRESS NOTES?

POLYPHARMACY REVIEW

WHAT DOES THIS STAMP MEAN?

Your patient's progress notes have been reviewed by a hospital pharmacist, and may contain recommendations to change the number, type or dose of drugs.

WHAT SHOULD YOU DO WHEN YOU SEE THIS STAMP?

You may decide to make the recommended changes.

If you decide not to make recommended changes, please leave a comment on the progress notes advising the pharmacist of your rationale. This will help with future recommendations.

This stamp was developed by physicians, nurses, and hospital pharmacists working on SP3 as a part of a Shared Care initiative aimed at decreasing the risks associated with Acute Care Polypharmacy. Watch for more project updates and an Acute Care Polypharmacy CME in early 2018.

More information: **kathleen.jagger@sosdivision.ca**

SharedCare Partners for Patients

South Okanagan Similkameen Division of Family Practice A GPSC Initiative

British Columbia doctors of bc

POLYPHARMACY

5 REMINDERS: REVIEWING MEDICATIONS WITH YOUR PATIENT

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

2. CONTINUE
What medications does the patient need to keep taking, and why?

3. PROPER USE
Does the patient know how and when to take each medication?

4. MONITOR
Does the patient know how to tell if medications are working, and about possible side effects?

5. FOLLOW UP
Are any tests needed, and when is the next visit?

In your review, remember to also ask about:

- **drug allergies**
- **vitamins and minerals**
- **herbal/natural products**
- **all medications, including non-prescription drugs**

Information adapted with permission from ISMP Canada
To learn more: SafeMedicationUse.ca

SharedCare Partners for Patients | South Okanagan Similkameen Division of Family Practice | doctors of bc

Polypharmacy Risk Reduction
Acute Care Setting

MEDICATION REVIEW - Online Resources

1. The “NOTEARS" Tool from England may help cover most topics in a Medication review. Easily found online. Lewis. T. 10- Minute Consultation Using the NO TEARS tool for medication review. BMJ 2004; 329:434

2. Shared Care BC -Polypharmacy Risk Reduction. Good videos about End of life discussions, some You Decide sheets for a few medications used in Frail Elderly http://www.sharedcarebc.ca/initiatives/polypharmacy

3. medstopper.com- web based tool for medication tapering suggestions

4. “thennt.com"- site for NNT values/evidence in many conditions/treatments.

5. Stages of medication review – ReMAX project from the UK – http://www.pcne.org/upload/files/141 Tomasz Oral 2016.pdf

6. Fraser Health Guide to Person-Centred Medication Decisions-an overview of the process-in depth with patients. https://www.slideshare.net/bcpsqc/polypharmacy-jan-16-17-no-notes-30318249

7. www.choosing wiselycanada.org – tool kits available for medication reduction

8. Canadian Deprescribing Network - www.deprescribingnetwork.ca/algorithms

9. STOPP/START Criteria - https://www.researchgate.net/publication/267046021_STOPPSTART_criteria_for_potentially_inappropriate_prescribing_in_older_people_Version_2

10. BEERS Criteria - http://bcbpsd.ca/docs/part-1/PrintableBeersPocketCard.pdf

South Okanagan Similkameen Division of Family Practice A GPSC initiative

SharedCare Partners for Patients

British Columbia

doctors of bc British Columbia Medical Association

POLYPHARMACY ABCDs for Physicians

How to Not Mess Up the Discharge Prescription:

Medication reconciliation provides a seamless discharge

ASSEMBLE

Look at admission Best Possible Medication History (BPMH) located under Physician Orders in chart

BPMH can be pulled from PharmaNet

- If BPMH is not in chart ask unit clerk to pull it

BE COMPLETE

Print discharge prescription

- If not printed, ask unit clerk to print

COMPARE

Compare admission medications with discharge medications

- Document discontinued meds (from admission)
- Review of medication: Continue, discontinue and change
  1. Write why medications were started or discontinued
  2. Check for substitutions, called *Therapeutic Interchanges*
  3. Clarify what medications to continue

DISCUSS

Discuss new medication list with patient

1. Explain why they are taking each medication
2. Explain what to do with old medications
3. Remind them to follow up with their physician and community pharmacist

Give medication list to unit clerk

- Clerk faxes medication list to patient's physician and community pharmacy, and makes a copy for the patient's chart
- Original copy is given to patient

SharedCare Partners for Patients | South Okanagan Similkameen Division of Family Practice | Interior Health

Materials adapted with permission from:

Thompson Region Division of Family Practice

APPENDIX I

Sample Pages: Interior Health Medication Discharge Form

[illegible] Regional Hospital [illegible]

550B Carmi Avenue, Penticton, BC V2A 3G6 250-492-4000

DISCHARGE PRESCRIPTION FORM

PHN:

Attending Physician: Age: 75 Sex: F DOB:

ALLERGIES:
ADRS: meperidine (From Demerol)
UNCODED:

*NOTE: This form is a prescription from your doctor and should be taken to your community pharmacy to be filled.
Indicate quantity and # refills for each med in spaces below.
Compare to all medications taken prior to hospitalization (BPMH).

ADDITIONAL MEDICATIONS

/ STOP \	Discontinued Medications These are medications to stop taking at home	/ STOP \

Date (dd/mm/yyyy)	Time	Physician Signature	Printed Name or College ID#
/ /			

[ ] Community Pharmacy, please complete a medication review.
Please fax copy to family physician
Please retain a COPY of completed form as part of the permanent record

Run Date/Time: 29/03/17 0931
By: EDWP6

CONFIDENTIAL - If received in error contact IH Privacy Office @ 1-866-980-5020

APPENDIX I

550B Carmi Avenue, Penticton, BC V2A 3G8 250-492-4000

DISCHARGE PRESCRIPTION FORM

PHN:

Attending Physician: Age: Sex: DOB:

ALLERGIES:
ADRS: meperidine (From Demerol)
UNCODED:

***NOTE: This form is a prescription from your doctor and should be taken to your community pharmacy to be filled.**
Indicate quantity and # refills for each med in spaces below.
Compare to all medications taken prior to hospitalization (BPMH).

Current PRN Medications	Physician Discharge Prescription
bisacodyl **10 MG Rectally PRN PRN** comments:	[ ] Discontinue [ ] Continue QTY: _____ #Refill: _____
docusate **100 MG Orally BID PRN** comments:	[ ] Discontinue [ ] Continue QTY: _____ #Refill: _____
glycerin adult SUPP **1 SUPP Rectally PRN PRN** comments:	[ ] Discontinue [ ] Continue QTY: _____ #Refill: _____
lactulose **15 to 30 mL Orally BID PRN** Physician, please call for Special Authority Pharmacare coverage at 1-877-657-1188 already in place [ ] completed [ ] comments:	[ ] Discontinue [ ] Continue QTY: _____ #Refill: _____
Prune Whip **15 to 30 mL Orally BID PRN** comments:	[ ] Discontinue [ ] Continue QTY: _____ #Refill: _____
sennosides **12 to 48 mg Orally daily PRN** comments	[ ] Discontinue [ ] Continue QTY: _____ #Refill: _____

Date (dd/mm/yyyy)	Time	Physician Signature	Printed Name or College ID#
/ /			

[ ] Community Pharmacy, please complete a medication review.
Please fax copy to family physician
Please retain a COPY of completed form as part of the permanent record

Run Date/Time: 29/03/17 0931
By: EDWP6

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.

ismp CANADA Institute for Safe Medication Practices Canada / Institut pour la sécurité des médicaments aux patients du Canada

cpsi icsp Canadian Patient Safety Institute / Institut canadien pour la sécurité des patients

South Okanagan Similkameen Division of Family Practice, A GPSC initiative

doctors of bc

SharedCare Partners for Patients

Canadian Society of Hospital Pharmacists / Société canadienne des pharmaciens d'hôpitaux

Canadian Pharmacists Association / Association des Pharmaciens du Canada

SafeMedicationUse.ca

Patients for Patient Safety Canada / Sécurité des patients Canada

Visit safemedicationuse.ca for more information.

CONTACT INFORMATION

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Shared Care Projects

South Okanagan Similkameen

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