White Rock-South Surrey Division of Family Practice
A GPSC initiative

SharedCare
Partners for Patients

POLYPHARMACY RISK REDUCTION INITIATIVE

PEACE ARCH HOSPITAL (PAH)

ACUTE CARE FOR ELDERS (ACE) UNIT

August 13, 2018

1. **Project Description:**

The PAH site has focused on mapping out the current medication review process in the Acute Care for Elders (ACE) Unit, identifying gaps, recording attempts to bridge these gaps, and collecting lessons learned. The goal at this site is to develop a more comprehensive process for meaningful medication review (i.e. are medications correct and appropriate?) and improve communication between pharmacists and hospitalists and between hospitalists and community GPs.

2. **Working Group Members:**

Dr. Chris Rauscher	Clinical Physician Lead, Shared Care Polypharmacy Risk Reduction Initiative
Margaret English	Shared Care Lead
Dawn Benson	PAH Operations Team
Jennette Coates	PAH Operations Team
Carolyn Bubbar	ACE Unit Pharmacist
Dr. Allison McKnight	ACE Unit Hospitalist at PAH
Dr. Mary Grace Parr	ACE Unit Medical Lead
Heather Essu	ACE Unit Nurse Educator
Veera Grewal	Project Coordinator – WRSS Division

3. **Timeline & Specifics of Work:**

Date	Project Tasks	Details
May 27, 2016	**Mapping the Patient's Journey**	The ACE Unit team met to map out the patient's journey through the hospital (ER, acute, recovery, pre-discharge, discharge, post-discharge) in relation to polypharmacy.
Dec 15, 2017	**Project Team Meeting**	The team identified barriers to meaningful medication reviews and brainstormed potential solutions (*see Problems & Solutions identified below*). The team decided that the pharmacist would review the best possible medication history (BPMH) done in ER and clarify if discrepancies exist. If so, a new BPMH would be documented in the Med Rec section of the chart to assist the hospitalist in doing meaningful medication reviews (MMRs). Additionally, the Medication (Med) Reconciliation form created by the pharmacist would be completed and attached to the

		patient's file for the hospitalist to be aware of what steps of MMR have been completed.
April 13, 2018	**Project Team Meeting**	The team met to discuss the impact of the increased documentation (updated BPMH and Med Rec Form) on the MMR process. It was determined that the Med Rec form listing the steps for MMR was not being used by hospitalists. The team decided to stop using the Med Rec form. The team decided to use the steps listed on the Med Rec form to create a poster outlining the steps to MMR. The intent of the poster is to update the other units on what the team has been working on to provide an example of a streamlined MMR process. Because it was confirmed that hospitalists find the updated BPMH valuable, it was decided that attaching the updated BPMH to the patient's file would become integrated into the MMR process.
June 21, 2018	**PAH Hospitalist Meeting**	The team shared the MMR poster at the hospitalist meeting to obtain feedback. Overall, the poster was well-received by the hospitalists and there was agreement on the importance of the BPMH step, as the admission med rec BPMH is often inaccurate.
June 22, 2018	**Final Wrap-Up Team Meeting**	The team met to discuss the successes, challenges, lessons learned and future opportunities of the PPhRR initiative. The team decided that the PPhRR Initiative will be transitioned over from Shared Care to the PAH Administration under the **Patient Medication Safety & Quality Committee,** (which Dawn Benson participates on) to sustain the work. The team created a communication plan to spread the work of the initiative throughout the hospital and a list of next steps.

4. Identified Problems and Solutions:

Problem	Solution
Problem 1: The BPMH done in ER does not always represent an accurate medication history Hospitalists often need to determine the list of pre-admission medications on their own, which is time-consuming. Pharmanet does not always have reliable and accurate medication information.	**Solution**: Pharmacist to document patient's Best Possible Medication History (BPMH) upon admission (if the ER admission medication is inaccurate) and attach the updated BPMH to the patient's file in the MED REC section for the hospitalist to access.
Problem 2: When the med reconciliation form has been signed by a physician, it's often assumed that the signing physician has already completed a MMR for the patient and the medications aren't reviewed again by the hospitalist. In some cases, significant medications are missed, or past unnecessary medications are restarted.	**Solution**: All MMR steps that have been completed so far are indicated in the patient's progress notes for hospitalists to review and be aware of outstanding steps in the process.
Problem 3: Patients often don't understand their medications and the rationale for taking them; patient education is a valuable missing component in the MMR process.	**Solution:** Patients to receive a Medication Calendar prior to discharge with a list of medication names, strength, instructions for use and a list of 'Meds Stopped by Doctor in Hospital'. Patient will be advised not to restart stopped medications unless advised by their GP and to bring their medication calendar to their first appointment with their GP after discharge.
Problem 4: When the Unit Clerk prints the Discharge prescription from the EMR, it is sometimes printed prematurely, and changes are made to medications after it is printed. In these cases, the discharge prescription may not reflect the most recent medication list. The physician compares the discharge prescription medications to the BPMH to determine changes made to meds while in hospital. If either of these documents are inaccurate there is a potential for miscommunication and errors.	**Solution**: Emphasize to the Unit Clerks that the Discharge Prescription needs to be printed from the EMR on the *day of* the patient's discharge for the hospitalist to do MMR.
Problem 5: Currently, the discharge prescription is not consistently being faxed to GPs. Community GPs want to have access to their patient's discharge prescription with a note about why medications were added or changed.	**Solution**: Hospitalists to be more vigilant about indicating the rationale for medication changes on the Discharge Rx. Hospital administration to emphasize to Unit Clerks that the Discharge Rx must be faxed to the patient's GP and community pharmacy. Patients will be asked to take their Medication Calendar (which indicates medication changes and information) to their first GP appointment after discharge.

5. **New Practices Introduced:**

- Increased and more comprehensive documentation (i.e. MediNet form for BPMH, documenting rationale for med changes on Discharge prescription).
- Efforts to review the PRNs (as needed medications) earlier for meaningful medication review rather than the day before/day of patient discharge.
- Better communication between hospitalists and pharmacists
- More effort and care from hospitalists to include a rationale for medication changes when completing the discharge prescription (Rx).
- Increased efforts of the hospital to ensure that the Discharge Rx is faxed to the patient's community GP and community pharmacist with a rationale for medication changes and any medication issues for follow up.

6. **Impact of New Practices** *(As identified by the Working Group):*

- More effective communication between hospitalists and pharmacists, which facilitates the completion of meaningful medication reviews.
- Increased communication between hospitalists and community GPs regarding medication changes and medication issues that need GP follow-up.
- Increased awareness for Hospitalists on how pharmacists can support them to conduct meaningful medication reviews.
- Hospitalists are better able to conduct medication reviews by having an accurate list of pre-admission medication history (BPMH) attached to the patient's chart.
- Decreased risk of polypharmacy for patients.
- Increased patient education about medications through receiving the medication calendar in hospital.

7. **Lessons Learned:**

✓ Pharmanet is not a reliable source of patient medication history, as it can include medications that patients were prescribed in the past and are not currently using. It may also exclude medications that patients are on and excludes non-prescription medications, such as herbal medicines or over-the-counter medication. For hospitalists to do meaningful medication reviews (i.e. med reconciliation), at a minimum, they need a list of the patient's best possible medication history (BPMH) attached to the patient file.

✓ Documenting the BPMH in the patient's chart under the MED REC section has been extremely helpful for hospitalists because it's a location that's easily accessible when reviewing the patient's progress.

✓ The ACE Unit Pharmacist was not able to access the hospital dictation system to dictate patients' medication history directly into Meditech. If this access was possible, her dictated notes would be immediately available to hospitalists and family physicians. Pharmacists at other sites may run into a similar problem when requesting access to their hospital dictation system.

✓ Given the inability for pharmacists to access the hospital dictation system, the MediNet form is a better solution to documenting accurate BPMH, as anyone with MediNet access can generate and use this form.

✓ The Med Reconciliation form that was created to keep hospitalists updated on what steps have already been done in MMR was not useful to hospitalists. The information on this form was already being captured in the

patient's progress notes. Other than person to person communication, the progress notes on the patient's chart seems to be the best way for the pharmacist to communicate with the hospitalist about MMR.

- ✓ Hospitalists in PAH need to be reminded that they can access pharmacists on other units in the hospital when they're in needing assistance with BPMH, MMR, and med calendars for patients. This can be done by writing a request for assistance to the pharmacist on the patient's chart or by contacting the pharmacist through the main dispensary by phone or pager.

- ✓ In other hospitals, there will likely be issues for hospitalists to access pharmacists for assistance with MMR. The process of MMR in hospitals needs to be designed without relying on pharmacists, as MMR is ultimately the physician's responsibility.

- ✓ As other hospital staff including, unit clerks, pharmacists and nurses support hospitalists to do MMR**, the most critical part for hospitalists to do is document patients' medication changes and the rationale for the changes in the discharge Rx and discharge summary** (i.e. which medications were stopped in hospital and why).

- ✓ For discontinued medications, the Discharge Prescription needs to indicate 'STOP MEDICATION' for the community pharmacy to stop refills. If this is not indicated on the discharge Rx, the medications that were stopped in-hospital will remain as refillable prescriptions in the community pharmacy.

- ✓ Patients like the Medication Calendars, as they're useful for their family members and their GP. It would be helpful to have the Med Calendar automatically be created (i.e. through EMR) rather than having to create it manually using a Word document. Pharmacists can create Med Calendars for patients, if a nurse or physician requests it. The Med Calendar needs to be created by a qualified staff person, as there is a high chance for error in documenting medication information.

8. Future Opportunities:

Within PAH: To continue the spread and sustainability for this project, the following next steps will be explored by the PAH Patient Medication Safety & Quality Committee:

- Spread lessons learned and MMR resources to other units in PAH and support them to establish a more streamlined process of MMR.
- Communication to the community GPs (i.e. what's the best way to communicate med changes and outstanding med items for their review?).
- The Discharge Med Rec form could be edited to include prompts for hospitalists to include more notes for GPs regarding why medications were stopped (i.e. heading for 'Rationale for Stopped Meds).
- Work on engaging the Nurses throughout PAH.
- Work on implementing a new PRN tracking form (tally of PRNs used by patient, date of use, and effectiveness).
- Since many patients go from the ACE unit to the PATH unit before discharge, explore the PATH unit as a future site for the PPhRR work.
- Engage community pharmacists on the initiative to enhance their work with patient education.

- Explore how the MMR process would work when a pharmacist is not available to support the hospitalist.

Within Other Acute Settings:

- Not all hospitalists have received comprehensive education on polypharmacy, which hinders their ability to conduct meaningful medication reviews. Before implementing the PPhRR Initiative at other sites, hospitalists need to be able to access education on how to "de-prescribe" medications to increase their understanding of polypharmacy.

- The work done by the PAH Patient Medication Safety & Quality Committee needs to be communicated to the larger Fraser Health Patient Safety Committees.