

Medication Reconciliation at Discharge at Queensway Carleton Hospital

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Overview

Over the past few years, Queensway Carleton Hospital (QCH) has focused on enhancing its medication reconciliation processes at both admission and discharge. While admission improvements involved prioritising patients for Best Possible Medication Histories (BPMH), standardising documentation, and improving communication to physicians, this initiative spotlights the discharge process. The project aims to increase the completion rate of discharge medication reconciliation and improve the quality of information provided to patients and primary care providers. The priority issues addressed are patient safety and patient experience, with indicators including the proportion of discharged patients receiving a Best Possible Medication Discharge Plan and feedback from patients and primary care providers.

Key Elements of Initiative

Change Ideas Tested or Implemented

- Delivered education sessions and tip sheets on discharge medication reconciliation for departments with low completion rates.
- Developed a report from the electronic health record using the “No Action on Home Meds” flag to identify incomplete discharge medication reconciliations.
- Sent department report cards with individual physician data to Department Chiefs for team discussions.
- Improved discharge prescription and Home Medication Summary reports based on stakeholder feedback; the summary highlights change to home medications at discharge.

Teams Involved

- Physicians, Inpatient Nurses, Pharmacists, Pharmacy Technicians, Clinical Managers, Patient Care Directors, Patient Family and Advisory Committee, Community Pharmacies, Primary Care Physicians, ACC Clerks, Clinical Informatics.

Target Population

- Discharging Physicians
- Discharged Patients and Primary Care Providers

Objective of Change Ideas

- Increase completion rate of discharge medication reconciliation.
- Improve transfer of medication information to patients/substitute decision makers and their Primary Care Providers (e.g., Primary Care Physician, Pharmacist).

Measurement of Progress

- Tracked completion rate over time, aiming for >90% (stretch target >95%), by reviewing each discharge for completed reconciliation.
- Used “No Action on Home Meds” to indicate incomplete reconciliation.
- Gathered feedback from the Patient Family and Advisory Committee (PFAC) and retail pharmacies.

Implementation Experience: Successes & Challenges

Results/Early Wins

- Psychiatric department improved completion rate by nearly 20% (now well above 90%) through education and tip sheets.
- All surgical areas now above 80% completion after introduction of report cards; previously, two areas were below this mark. Orthopedics now has a 93% completion rate and General Surgery is at 87%.
- Overall hospital completion rate is above 89%, up from a steady 85% before report cards.

- Positive feedback from PFAC and Community Pharmacies regarding changes to discharge prescription and Home Med Summary reports.

Enablers of Success:

- Collaborative approach with all stakeholders, including patient representatives and community pharmacists.
- Dedicated Clinical Informatics resources for timely report redesign/building.
- Engaged physicians who understood the importance of medication reconciliation.
- Objective, quantitative data enabled targeted training and recognition.
- Senior Leadership Team prioritised the initiative, ensuring resource allocation.

Challenges & Solutions:

- Discharge medication reconciliation completion report occasionally misattributed discharging physician, mainly in surgery groups; acknowledged to stakeholders, minimal impact on rates, increased awareness and motivation.
- In our electronic health record, Childbirth Nurses were often not confirming the home medications on admission resulting in physicians not having the ability to reconcile the home medications in the system on discharge. Obstetrics group faced unique challenges due to most patients having no medications or only multivitamins; extra steps required in the system for discharge, often not completed. Ongoing work with Obstetrics to improve reconciliation when additional medications are involved.

Advice for Other Teams

- Don't treat discharge medication reconciliation as a tick-box for accreditation.
- Address lack of understanding and barriers by bringing stakeholders together to understand each other's processes and challenges.
- Set clear principles for stakeholder meetings, ensuring work isn't simply shifted to another group.

Future Steps & Sustainability

Building on the Work:

- Continue striving for 90% completion rate and stretch target of 95%.
- Maintain monthly report cards for physician groups and offer individualised training as needed.

- Implement new standardised documentation for medication reconciliation on admission, aiming to streamline discharge process for Obstetricians.

Embedding into Policy and Routine:

- Corporate medication reconciliation policy draft completed.
- Routine workflows established within the electronic health record.
- Discharge Medication Reconciliation tracking to be added to Safe Medication Administration Committee Audit programme for ongoing monitoring.

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